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ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(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
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on April 27-28, 2016. The complaint investigation was initiated by the Lee County Department of Social Services on April 8, 2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician and pharmacy notification for 2 of 5 sampled residents (Residents #2 and #5) regarding orders for International Normalized Ratio (INR) laboratory results and medication orders for high blood pressure, enlarged prostate, anxiety, seizure, blood thinner, and cholesterol medications. The findings are: A. Review of Resident #5's current FL 2 dated 4/13/15 revealed: -Diagnoses included bladder outlet obstruction, CVA, Atrial Fibrillation, urinary tract infections (UTI), and a history of epilepsy. -Medications included Coumadin 8 mg at bedtime (used to treat and prevent blood clots). Review of Resident #5's Resident Register	D 273		

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revealed an admission date of 6/04/14.

1. Review of Resident #5's record revealed:
-A physician's order dated 12/30/15 to change Coumadin to 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday.
-A physician's order dated 2/24/16 to change Coumadin to 4 mg on Monday, Wednesday and Friday, and 8 mg on Tuesday, Thursday, Saturday and Sunday and to repeat INR in 2 weeks (due 3/09/16).
-Lab results collected 3/15/16 and reported to the physician on 3/16/16 that did not include an INR.
-No INR results were documented in Resident #5's record from 2/25/16 to 4/28/16.
-A physician's order dated 4/21/16 to obtain an INR on the next lab draw.

Review of Resident #5's January 2016 electronic Medication Administration Record (eMAR) revealed:
-An entry for Jantoven (a brand of Warfarin in place of Coumadin) 4 mg every Monday, Wednesday and Friday in the evening at 8:00 pm.
-An entry for Jantoven 8 mg every Tuesday, Thursday, Saturday and Sunday in the evening at 8:00 pm.
-Jantoven was documented as administered as written on the eMAR from 1/01/16 to 1/31/16.
-Jantoven 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday was not documented as administered as ordered from 1/01/16 to 1/31/16.

Review of Resident #5's February 2016 eMAR revealed:
-An entry for Jantoven 4 mg every Monday, Wednesday and Friday in the evening at 8:00 pm.
-An entry for Jantoven 8 mg every Tuesday,

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Thursday, Saturday and Sunday in the evening at 8:00 pm.
-Jantoven was documented as administered as written on the eMAR from 2/01/16 to 2/29/16.
-Jantoven 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday was not documented as administered as ordered from 2/01/16 to 2/24/16.

Review of Resident #5's March 2016 and April 2016 eMARs revealed Jantoven was documented as administered as ordered from 3/01/16 to 4/27/16.

Interviews 4/27/16 at 1:40 pm and 4/28/16 at 10:00 am with the Administrator revealed:
-The facility had changed to eMARs 10/2015 with a new phone/internet system at the same time.
-She reviewed new orders and verified they were entered correctly on the eMAR.
-She had not noticed the Coumadin entry was incorrect on the January and February 2016 eMARs.

Interview on 4/27/16 with the facility's contract pharmacy representative revealed:
-The pharmacy entered medication orders into the eMAR system.
-The pharmacy system showed an order dated 12/11/15 for Jantoven 4 mg at bedtime.
-The pharmacy system showed an order dated 12/30/15 for Jantoven 8 mg every Monday, Wednesday and Friday, and Jantoven 4 mg every Tuesday, Thursday, Saturday and Sunday.
-The pharmacy system showed an order dated 2/24/16 for Jantoven 4 mg every Monday, Wednesday and Friday, and Jantoven 8 mg every Tuesday, Thursday, Saturday and Sunday.
-The January and February order entries looked correct on the Pharmacy side, but they were not

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correct on the eMAR side. "There was a glitch when some order entries carried over onto the eMAR. It was not caught by the facility's Administrator or staff".
-The pharmacy had swapped to the eMAR system when the facility did, so "it had been a learning curve for everyone".
-The facility was to double check orders entered onto the eMARs for accuracy and notify the pharmacy or physician as necessary.

Interview on 4/28/16 at 9:55 am with Resident #5's primary care physician revealed:
-The Coumadin clinic managed the lab and Coumadin dosage orders for Resident #5.
-He expected the facility to follow-up with labwork and medications as ordered.
-He expected the facility to administer Coumadin as ordered.

Interview on 4/28/16 at 1:40 pm with a Coumadin clinic representative revealed:
-The INR result in their system for Resident #5 was dated 2/24/16 and was 1.3 (normal is 0.8-1.2 per the laboratory result sheet).
-Resident #5 was due to have an INR done on 3/09/16 but the laboratory clinic never received a specimen to process.
-The clinic would follow-up to remind the facility if they missed a lab.
-There was not any documentation in the clinic's notes that the facility had been contacted, but "the staff person who handled that was currently on vacation and unable to confirm this".
-We expected the facility to have labs drawn as ordered.
-If a specimen was sent today, it would be processed, and the results sent to the physician for review. The results and any new orders would be sent to the facility today.

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D 273	Continued From page 4 Interview on 4/28/16 at 1:50 pm with Resident #5 revealed: -He took his medications as the facility administered them, and expected them to be as his physician ordered. He did not know what medications he was ordered, and could not remember that he was was on a blood thinner. -He had his labwork drawn at the laboratory clinic next door, and went whenever the facility staff took him. Interview with a Medication Aide (MA) on 4/28/16 at 4:25 pm revealed: -It was up to the physician when a resident should get an INR done and some were two weeks apart and others were 4 weeks apart. -The MAs would take the physician order and write down on the calendar when the next INR was due. -Once the lab was obtained they would cross it off the calendar. -The previous Resident Care Coordinator (RCC) was responsible for tracking laboratory results including the INRs. -This was now her responsibility and today was the first time she had recorded an INR and placed the follow-up blood draw on the calendar. Interview with a second MA on 4/28/16 at 4:39 pm revealed: -The MAs had a lab book that they would file all of the lab results. -The MAs knew a resident was to go to the laboratory clinic for their next scheduled labs because they would post them on a board that they were able to see everyday. -There were no lab draws due to be drawn per this board today. -The RCC that used to work at the facility left	D 273		

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several months ago and she had her own system of tracking.
-There was no specific person in charge of tracking lab orders and verifying when they were done.

Review of the scheduling calendar revealed no lab appointment for Resident #5 for an INR that was due 3/09/16.

2. Review of Resident #5's current FL 2 dated 4/13/15 revealed:
-Medications included Finasteride 5 mg daily (used to treat enlarged prostate), Metoprolol 25 mg twice daily (used to treat high blood pressure and heart failure), Zoloft 50 mg daily (used to treat anxiety and depression), Keppra 1000 mg twice daily (used to treat seizures), and Pravastatin 20 mg at bedtime (used to reduce cholesterol and triglyceride levels in the blood).

Review of Resident #5's record revealed:
-Physican's orders dated 12/24/15 to continue Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin.
-No orders were found in Resident #5's record to discontinue Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin.

Review of Resident #5's February and March 2016 eMARs revealed:
-An entry for Finasteride 5 mg daily was administered as ordered from 2/01/16 to 3/31/16 at 8:00 am.
-An entry for Metoprolol 25 mg twice daily was administered as ordered from 2/01/16 to 3/31/16 at 8:00 am and 7:00 pm.
-An entry for Zoloft 50 mg daily was administered as ordered from 2/01/16 to 3/31/16 at 8:00 am.
-An entry for Keppra 1000 mg twice daily was

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administered as ordered from 2/01/16 to 3/31/16 at 8:00 am and 7:00 pm.
-An entry for Pravastatin 20 mg at bedtime was administered as ordered from 2/01/16 to 3/31/16 at 7:00 pm.

Review of Resident #5's April 2016 eMAR on 4/28/16 revealed:
-An entry for Finasteride 5 mg daily at 8:00 am was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 8:00 am. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Metoprolol 25 mg twice daily at 8:00 am and 7:00 pm was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 7:00 pm. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Zoloft 50 mg daily at 8:00 am was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 8:00 am. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Keppra 1000 mg twice daily at 8:00 am and 7:00 pm was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 7:00 pm. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Pravastatin 20 mg at bedtime was administered as ordered from 4/01/16 to 4/12/16 at 7:00 pm. The last dose was administered on 4/12/16 at 7:00 pm. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.

Review of Resident #5's Medications on hand on the medication cart on 4/18/16 revealed Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin were available for administration.

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D 273	Continued From page 7 Interview on 4/28/16 at 9:35 am and 10:00 am with the Administrator revealed: -She was not aware that Resident #5 had 5 medications (Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin) that "fell off the MAR" on 4/12/16 and were not on the current eMAR as of 4/28/16. -She expected the pharmacy to contact the physician if a medication needed a renewal order. -A prompt showed on the eMAR that a medication needed to be renewed or discontinued anytime that resident's eMAR file was opened. -Since the Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin were "maintenance medications (that the resident had been taking for a long time)", and the medications were on-hand, she expected that they were to continue to be administered to Resident #5. -If a medication was to be discontinued, the medication was pulled from the med cart and returned to the pharmacy. -If a medication expired, the MA should notify the supervisor or Administrator to follow-up with the physician or the pharmacy. Interview on 4/28/16 at 9:45 am with a MA revealed: -When a medication order "runs out, we receive a notification prompt that the 'medication is in review' (on the eMAR) for about one week". -The MA should notify the supervisor or contact the physician or pharmacy to get the medication re-ordered. -She had not notified anyone when the prompt appeared on the eMAR. -Meds that were discontinued did not show on the resident's active medication list. They could be seen in the history area of the eMAR.	D 273		

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D 273	Continued From page 8 Interview on 4/28/16 at 10:30 am with the facility's contract pharmacy representative revealed: -Entries for Finasteride 5 mg daily, Metoprolol 25 mg twice daily, Zoloft 50 mg daily, Keppra 1000 mg twice daily, Pravastatin 20 mg at bedtime were in the pharmacy system but not on the eMAR as their order date had expired on 4/12/16. -When a medication's "stop date is exceeded", the pharmacy would send a notice to the physician to renew or discontinue the medication when they filled the medications for the next "cycle fill". She did not not have a note in the pharmacy system that a notice had been sent to Resident #5's physician. -If the stop date occurred in the middle of the month, the facility should contact the physician when they get the "box that pops up on the eMAR system tells them the medication needs to be renewed". -The pharmacy did not see the renewal box prompt from the eMAR system in the pharmacy medication order system. Interview on 4/28/16 at 11:05 am with a second MA revealed: -The Administrator and a MA Supervisor reviewed new orders and compared them to the eMARs when the orders were received. -If a medication "fell of the eMAR, but I noticed no discontinued order, then I gave the meds", Resident #5's Metoprolol, Zoloft, Keppra, and Finasteride. "Pravastatin is a bedtime medication, so I was not here for that medication". These were "maintenance medications" that Resident #5 had been taking for a long time. -MA's were to notify the supervisor to check with the pharmacy or physician about eMAR medication prompts. -The prompt in the eMAR only showed for "about one week", and "could not be seen today (3	D 273		

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weeks later)".
-She had not contacted the physician or the pharmacy regarding the medications not being on the eMAR.

Interview on 4/28/16 at 1:50 pm with Resident #5 revealed:
-He took his medications as the facility administered them, and expected them to be as his physician ordered.
-He did not know what medications he was ordered.

Interview on 4/28/16 at 1:55 pm with the contracted Pharmacist revealed:
-She was in the facility to perform the quarterly pharmacy reviews.
-She saw that Resident #5's Metoprolol, Zoloft, Keppra, Finasteride and Pravastatin had a discontinue note on the eMAR. She was to check in the pharmacy system and the Resident's record to see if the medications had been discontinued since her last review, then would follow-up with the physician and the facility.
-If a medication order was received by the pharmacy from a physician, the pharmacy faxed a copy to the facility for their records, and so orders could be verified by the facility staff. There was no order in the pharmacy system or in Resident #5's record that Metoprolol, Zoloft, Keppra, Finasteride and Pravastatin had been discontinued.

Interview on 4/28/16 at 3:40 pm with Resident #5's physician's office representative revealed:
-The office could view the Resident's eMAR and saw that the Finasteride, Keppra, Metoprolol, Zoloft and Pravastatin had a stop date of 4/12/16 and a discontinued note on the eMAR.
-"Normally the pharmacy sends a re-order form to

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the physician, or the facility contacted the physician" to address the renewals.
-The office records show that at the 3/14/16 visit, Resident #5 was still on Finasteride, Keppra, Metoprolol, Zoloft and Pravastatin.
-The latest visit on 4/18/16 was not completed in their office records, so she could not address if there were any medication order changes made.

B. Review of Resident #2's current FL 2 dated 10/29/15 revealed:
-Diagnoses included dementia, depression, chronic obstructive pulmonary disease, congestive heart failure, right hemiplegia, hypertension and systemic lupus erythematosis.
-Medication orders included jantoven 4mg 2 and 1/2 tablets (10mg) daily (also known as coumadin, a medication used to prevent heart attacks, strokes, and blood clots.)

Review of Resident #2's Resident Register revealed and admission date of 12/29/08.

Review of Resident #2's record revealed:
-A physician's order dated 8/24/15 to continue the current dose of coumadin 4mg 2 and 1/2 tablets daily and to re-check the INR in one month.
-A physician's order dated 9/21/15 to continue the current dose of coumadin 4mg 2 and 1/2 mg tablets daily and to return October 19, 2015 at 9:15 am to the physician office for repeat blood draw.
-There were no other International Normalized Ratio (INR) orders after this date and no other coumadin orders.
-A consultation report dated 8/24/15 with the INR result recorded as 2.02 (normal is 0.8-1.2 per the laboratory result sheet), a physician order to continue current dose of coumadin and repeat

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D 273	Continued From page 11 the INR in one month. Review of a Pharmacy Review dated 1/19/16 revealed the pharmacist recommended the facility to place the current INR laboratory result in the record. Review of the January 2016 electronic Medication Administration Record (eMAR) revealed an entry for jantoven 4mg 2 and 1/2 tablets daily and documented as administered at 5:00 pm daily from 1/01/16 through 1/31/16. Review of the February 2016 eMAR revealed an entry for jantoven 4mg 2 and 1/2 tablets daily and documented as administered at 5:00 pm daily from 2/01/16 through 2/29/16. Review of the March 2016 eMAR revealed an entry for jantoven 4mg 2 and 1/2 tablets daily and documented as administered at 5:00 pm daily from 3/01/16 through 3/31/16. Review of the April 2016 eMAR revealed an entry for jantoven 4mg 2 and 1/2 tablets daily and documented as administered at 5:00 pm daily from 4/01/16 through 4/26/16. Interview with Resident #2 during the initial tour on 4/27/16 at 9:53 am revealed: -Resident #2 took coumadin daily because she had a history of having three strokes. -Resident #2 could not recall the last time they obtained an INR laboratory result, but knew that it was "way overdue". A second interview with Resident #2 on 4/28/16 at 2:28 pm revealed: -Resident #2's family member used to work at the facility and would transport her to doctor's	D 273		

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appointments including her laboratory appointments.
-Resident #2's family member had not worked in the facility for about 6 months, but did not know the exact date.

Interview with a Medication Aide (MA) on 4/28/16 at 4:25 pm revealed:
-It was up to the physician when a resident should get an INR done and some were two weeks apart and others were 4 weeks apart.
-The MAs would take the physician order and write down on the calendar when the next INR was due.
-Once the lab was obtained they would cross it off the calendar. The lab was not written on the calendar but an appointment was, which was not kept.
-The previous Resident Care Coordinator (RCC) was responsible for tracking laboratory results including the INRs.
-This was now her responsibility and today was the first time she had recorded an INR and placed the follow-up blood draw on the calendar.

Interview with a second MA on 4/28/16 at 4:39 pm revealed:
-The MAs had a lab book that they would file all of the lab results but the PT/INR for Resident #2 was not in the book.
-The MAs knew the next scheduled labs because they would post them on a board that they are able to see everyday.
-There were no lab draws due to be drawn per this board today.
-The RCC that used to work at the facility left several months ago and she had her own system of tracking.
-There was no specific person in charge of tracking lab orders and verifying when they were

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ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

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D 273	Continued From page 13 done. Interview with contract Pharmacist on 4/28/16 at 2:06 pm revealed: -She did recommend the facility obtain an INR results for Resident #2 on her last consult 1/19/16. -She was not finished reviewing the resident records for the April 2016 quarterly review. -She would have expected the facility would have obtained the most recent labs for the record. -If the facility could not obtain a recent result she expected the facility would have obtained an order to have the PT/INR drawn from the physician, report the results and follow up physican orders for the coumadin and future blood draw. -If they had not obtained recent INR results she would contact the physician and make sure the lab was ordered. Interview with a Nurse from Resident #2's physician office on 4/27/16 at 2:31 pm revealed: -The last INR result they had on file at the office was in August of 2015 with a result of 2.02. -There was an appointment scheduled for October 19, 2015 but it was cancelled because "the facility did not schedule the transport." -The appointment was not rescheduled. -There were no other changes or labs drawn since August. Interview with Administrator on 4/27/16 at 2:40 revealed: -She was not aware that Resident #2 had not had an INR drawn since August 2015 and thought that there had been a follow up appointment. -She could not obtain any follow-up INR lab results for Resident #2. -Resident #2's family member used to take	D 273		

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D 273	Continued From page 14 Resident #2 to get her blood work drawn and must have been overlooked since the family member no longer worked at the facility. -The current RCC was responsible for tracking INRs and other labwork to assure that they were completed but she had not been employed at the facility for several months. A Plan of Protection was provided by the facility on April 28, 2016 as follows: -Effective immediately, the Administrator and RCC would audit all resident records to identify any orders that have been initiated. -Any un-met health care needs and un-intended orders would be reported to the physician and initiated as ordered. -Staff will be in-serviced on how to initiate referrals. -The Administrator and RCC will develop a policy to track lab orders, pharmacy referrals and other healthcare referrals and educate staff on the new policy and tracking method. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED, June 12, 2016.	D 273		
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.	D 358		

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D 358	Continued From page 15 This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 4 residents (#1) observed during a medication pass, and for 4 of 6 sampled residents (#1, #3, #5 and #6) related to errors with medications (Lactulose, Nexium, Vitamin B injections, and Coumadin). The findings are: A. Review of Resident #1's current FL2 dated 4/25/16 revealed: -Diagnoses included Altered Mental Status secondary to Acute Renal Failure, dementia, ischemic cardiomyopathy, chronic atrial fibrillation, gastric esophageal reflux disease (GERD), diabetes, and hypertension. -Medications included Lactulose 10 gm/15ml daily (used to treat constipation). Review of Resident #1's Resident Register revealed an admission date of 11/08/13. Review of the April 2016 electronic medication administration record (eMAR) revealed: -An entry for lactulose syrup 10gm/15 ml solution take two teaspoonful (10ml) once daily scheduled for 8 AM. Observation of the morning medication pass on 4/28/16 at 7:51 am revealed: -The Medication Aide (MA) prepared and administered Resident #1's oral medications and omitted administering the lactulose syrup. -At 9:20 am Resident #1 had not received the lactulose 10gm/15ml.	D 358		

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D 358	Continued From page 16 Interview with the MA on 04/28/16 at 5:01 pm revealed: -He had been working at the facility for about 2 weeks as a MA. -He thought he overlooked the lactulose because Resident #1 often refused it. -He had received training from the facility's Nurse on how to pass medication and administer the proper dosage. -He did administer the lactulose to Resident #1 at 9:20 am after it was brought to his attention that the medication was omitted during the morning medication pass. B. Review of Resident #3's record revealed -There was no order for cyanocobalamin 1000mcg/ml on the current FL2 dated 1/14/16. -A physician's order dated 12/24/15 for cyanocobalamin 1000mcg/ml give 1ml intramuscularly (IM) every Sunday for 4 doses then once a month (a medication used to treat vitamin B12 deficiency in people with pernicious anemia and other conditions.) -A physician's order dated 2/25/16 for cyanocobalamin 1000mcg/ml IM every month. Review of the January 2016 electronic Medication Administration Record (eMAR) revealed: -A computer generated entry for cyanocobalamin 1000mcg/ml inject one ml every Sunday for four doses then give once monthly scheduled at 8:00 am. -Handwritten MA initials on 1/04, 1/11, 1/18 and 1/25. Review of the February 2016 eMAR revealed: -A computer generated entry for cyanocobalamin 1000mcg/ml inject one ml every Sunday for fours doses then give once monthly scheduled at 8:00	D 358		

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am.
-Handwritten MA initials on 2/01-2/05, 2/07, 2/08, 2/10, 2/11 and 2/15/16.
-Computer generated initials on 2/06, 2/09 2/12, 2/13, 2/14, 2/16 and 2/17/16.

Review of the March 2016 eMAR revealed:
-A computer generated entry for cyanocobalamin 1000mcg/ml inject one vial once monthly scheduled at 8:00 am.
-Computer generated MAs initials 3/03-3/31/16 except for 3/11/16 which was blank.
-Handwritten circles around all of the MAs initials except for 3/15/16.
-No computer generated exceptions or hand written documentation explaining the circled initials.

Review of the April 2016 eMAR revealed:
-A computer generated entry for cyanocobalamin 1000mcg/ml inject one vial once monthly scheduled at 8:00 am.
-Computer generated initials 4/01-4/27/16 except for 4/11/16 which had hand written MA initials.

There was no cyanocobalamin in the facility available for administration.

Interview with a Nurse from Resident #3's physician office on 4/27/16 at 9:47 am revealed:
-The cyanocobalamin 1000mcg/ml was to be administered once a month and it was on Resident #3's admission paperwork dated 12/30/14 with a refill dated 5/07/15.
-The refill dated in December 2015 was written at the facility during one of the physician's visits.
-The cyanocobalamin had never been discontinued.
-They expected that Resident #2 was being administered cyanocobalamin monthly.

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D 358	Continued From page 18 -There was no home health order in Resident #2's record at the office. Interview with a Medication Aide on 4/28/16 at 4:08 pm revealed: -She did not know why she signed out the cyanocobalamin repeatedly but stated, "I probably just did not notice". -She knew not to give IM injections. -She notified the administrator (who was also a nurse) on the 15th of the month that an IM injection was due. Interview with the Administrator on 4/27/16 at 3:15 pm revealed: -She was not aware the cyanocobalamin was scheduled daily on the eMAR. -Her staff would notify her when injections were due and she would administer the injections. -She did give Resident #3 cyanocobalamin injections, but did not know when the last injection was administered. -She would have staff sign out that the injection was administered after she administered the injections. Interview with a representative from the contracted pharmacy on 4/27/16 at 10:15 am revealed: -The cyanocobalamin 1000mcg/ml was filled 7/17/15, 10/13/15, 1/07/16, 2/17/16, 2/26/16 and 3/24/16. -The pharmacy sent 1ml each time it was filled. -If Resident #3 was to receive one injection monthly since July 2015 she would have received 6 of 10 doses. -According to the order dated 12/24/15 cyanocobalamin 1000mcg/ml injection every Sunday for 4 doses then once a month she would have received 4 of 7 doses.	D 358		

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D 358	Continued From page 19 Interview with Resident #3 during the initial tour on 4/27/16 at 9:58 am revealed: -Resident #3 had not received her Vitamin B12 injection (cyanocobalamin) in months. -Resident #3 has been given monthly injection of cyanocobalamin for years. -Resident #3 was given the cyanocobalamin injections consistently for the first several months after admission. -Resident #3 asked one of the MAs about the injections on two separate occasions and never received any answers or the injection. A second interview with Resident #3 on 4/28/16 at 3:00 pm revealed: -She was receiving the cyanocobalamin injections around the 15th and over time they got later and later in the month. -The cyanocobalamin was showing up on her bill but was not being administered for at least two months. -She never had home health administer her injection. -The Administrator may have administered her injection but typically it was administered by the previous Resident Care Coordinator. -She never had a home health nurse administer the injections. C. Review of Resident #1's current FL2 dated 4/25/16 revealed: -Diagnoses included altered mental status secondary to acute renal failure, dementia, ischemic cardiomyopathy, chronic atrial fibrillation, gastric esophageal reflux disease (GERD), diabetes, and hypertension. -Medications included Nexium 40 mg daily (an acid blocker). Review of Resident #1's Resident Register	D 358		

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D 358	Continued From page 20 revealed an admission date of 11/08/13. Review of Resident #1's record revealed: -A previous FL 2 dated 4/06/16 with the same medications and doses ordered as on the current FL 2 dated 4/25/16. -A physician's order dated 1/14/16 for Nexium 40 mg twice daily for two weeks, then daily (to start 1/29/16). -A physician's order dated 3/21/16 to discontinue Nexium. Review of Resident #1's January 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for Esomeprazole (Nexium) 40 mg twice daily for 2 weeks with an origination date of 1/15/16 and a stop date of 1/29/16 and scheduled for administration at 8:00 am and 7:00 pm. Computer documentation of administration on 1/23/16 at the 8:00 am and 7:00 pm, and handwritten initials documented as administered for 8:00 am and 7:00 pm from 1/16/16 to 1/22/16 and from 1/24/16 to 1/29/16. -An entry for Nexium 40 mg daily at 8:00 am with an origination date of 1/15/16 and a stop date of 3/21/16. Documentation of administration on 1/16/16 to 1/31/16 at 8:00 am. -Documentation was that Resident #1 received Nexium 40 mg twice daily. and 40 mg daily from 1/16/16 to 1/29/16 for a total of three 40 mg doses of Nexium daily. Review of Resident #1's February 2016 eMAR revealed: -An entry for Nexium 40 mg daily at 8:00 am and documented as administered daily with handwritten initials from 2/01/16 to 2/05/16, 2/07, 2/08, and 2/10/16, and computer generated initials 2/06, 2/09, and from 2/11 to 2/29/16.	D 358		

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D 358	Continued From page 21 Review of Resident #1's March 2016 eMAR revealed: -An entry for Nexium 40 mg daily at 8:00 am with an origination date of 1/15/16 and a stop date of 3/21/16, and documented as administered daily from 3/01/16 to 3/21/16. A discontinued box was on the entry line. Review of Resident #1's April 2016 eMAR revealed: -An entry for Nexium 40 mg daily at 8:00 am with an origination date of 4/08/16 and documented as administered daily from 4/09/16 to 4/27/16. Review of Resident #1's medications on hand on the medication cart on 4/28/16 and available for administration revealed: -Nexium 40 mg daily was available as ordered. -No "house supply" bottles for Nexium 40 mg was observed. Interview on 4/27/16 at 1:40 pm and 4/28/16 at 10:15 am with the Administrator revealed: -The facility had used eMARs since 10/2015. They had swapped to a new phone and internet system at the same time which had caused them difficulties with synchronizing documentation of medications into the eMAR. -"If I have a medication in stock that is a frequently used medication like Nexium, Protonix or Omeprazole, then we will start that medication before it is stocked by pharmacy. We might borrow it from someone else if we needed to start the medication." -She approved new orders and verified the pharmacy entered the orders correctly on the eMAR. Interview on 4/27/16 at 3:30 pm with the facility's	D 358		

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contracted pharmacy representative for Resident #1 revealed:
-An order dated 1/15/16 for Nexium 40 mg twice daily for 2 weeks, then change to daily. The Nexium 40 mg twice daily order was filled on 1/20/16 with 28 tablets for 2 weeks. The Nexium 40 mg daily dose order was filled on 1/29/16 for 29 tablets.
-The delay in filling the medication was possibly to get approval for a non-generic medication as requested by the family.

Interview on 4/28/16 at 2:30 pm with Resident #1's family member revealed:
-She expected the facility to administer medications as prescribed by Resident #1's physician.
-She asked for Nexium to be non-generic. She was not aware that this could cause a delay in the medication being started, or that the facility might administer medication from a house supply.

Based on observations, record review and interviews with family and staff, it was determined that Resident #1 was not interviewable.

Interview on 4/28/16 with Resident #1's physician was unavailable.

D. Review of Resident #5's current FL 2 dated 4/13/15 revealed:
-Diagnoses included bladder outlet obstruction, CVA, Atrial Fibrillation, urinary tract infections (UTI), and a history of epilepsy.
-Medications included Coumadin 8 mg at bedtime (used to treat and prevent blood clots).

Review of Resident #5's Resident Register revealed an admission date of 6/04/14.

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Review of Resident #5's record revealed:
-A physician's order dated 12/30/15 to change Coumadin to 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday.
-A physician's order dated 2/24/16 to change Coumadin to 4 mg on Monday, Wednesday and Friday, and 8 mg on Tuesday, Thursday, Saturday and Sunday.

Review of Resident #5's January 2016 electronic Medication Administration Record (eMAR) revealed:
-An entry for Jantoven (a brand of Warfarin in place of Coumadin) 4 mg every Monday, Wednesday and Friday in the evening.
-An entry for Jantoven 8 mg was to be administered every Tuesday, Thursday, Saturday and Sunday in the evening.
-Jantoven was documented as administered as entered on the eMAR from 1/01/16 to 1/31/16.
-Jantoven was not administered as ordered on 12/30/15 for 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday from 1/01/16 to 1/31/16.

Review of Resident #5's February 2016 eMAR revealed:
-An entry for Jantoven 4 mg was to be administered every Monday, Wednesday and Friday at 8:00 pm.
-An entry for Jantoven 8 mg was to be administered every Tuesday, Thursday, Saturday and Sunday at 8:00 pm.
-Jantoven was documented as administered as entered on the eMAR from 2/01/16 to 2/29/16.
-Jantoven was not documented as administered as ordered on 12/30/15 for 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday from 2/01/16 to

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D 358	Continued From page 24 2/23/16. Review of Resident #5's March 2016 and April 2016 MARs revealed: -Jantoven was documented as administered as ordered from 3/01/16 to 4/27/16. Review of Resident #5's Medications on hand on the medication cart on 4/28/16 for administration revealed Jantoven was available as ordered. Review of a pharmacy review dated 1/19/16 revealed: -Laboratory results were noted, and no recommendations were made. -The Coumadin order entry on the January eMAR was not documented as being incorrect. Interviews 4/27/16 at 1:40 pm and 4/28/16 at 10:00 am with the Administrator revealed: -The facility had changed to eMARs on 10/2015 with a new phone/internet system at the same time. -She reviewed new orders and verified they were entered correctly on the eMAR. -She had not noticed the Coumadin entry was incorrect on the January and February 2016 MARs. Interview on 4/27/16 with the facility's contract pharmacy representative revealed: -The pharmacy entered medication orders into the eMAR system. -The pharmacy system showed an order dated 12/11/15 for Jantoven 4 mg at bedtime. -The pharmacy system showed an order dated 12/30/15 for Jantoven 8 mg every Monday, Wednesday and Friday, and Jantoven 4 mg every Tuesday, Thursday, Saturday and Sunday. -The pharmacy system showed an order dated	D 358		

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D 358	Continued From page 25 2/24/16 for Jantoven 4 mg every Monday, Wednesday and Friday, and Jantoven 8 mg every Tuesday, Thursday, Saturday and Sunday. -The January and February order entries looked correct on the Pharmacy side, but they were not correct on the eMAR side. "There was a glitch when some order entries carried over into the eMAR. It was not caught by the facility's Administrator or staff". -The pharmacy had swapped to the eMAR system when the facility did, so "it had been a learning curve for everyone". -The facility was to double check orders entered into the eMARs for accuracy and notify the pharmacy or physician as necessary. Interview on 4/28/16 at 9:55 am with Resident #5's primary care physician revealed: -The Coumadin clinic managed Coumadin dosage orders for Resident #5. -He expected the facility to administer medications as ordered. Interview on 4/28/16 at 1:50 pm with Resident #5 revealed: -He took his medications as the facility administered them, and expected them to be as his physician ordered. -He did not know what medications he was ordered.	D 358		
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 26 (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 observation, record reviews, and interviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate for 4 of 5 sampled residents (Residents #1, #3, #5, and #6). The findings are: A. Review of Resident #5's current FL 2 dated 4/13/15 revealed: -Diagnoses included bladder outlet obstruction, CVA, Atrial Fibrillation, urinary tract infections (UTI), and a history of epilepsy. -Medications included Coumadin 8 mg at bedtime (used to treat and prevent blood clots). Review of Resident #5's Resident Register revealed an admission date of 6/04/14. 1. Review of Resident #5's record revealed: -A physician's order dated 12/30/15 to change	D 367		

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Coumadin to 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday.
-A physician's order dated 2/24/16 to change Coumadin to 4 mg on Monday, Wednesday and Friday, and 8 mg on Tuesday, Thursday, Saturday and Sunday and to repeat INR in 2 weeks (due 3/09/16).

Review of Resident #5's January 2016 electronic Medication Administration Record (eMAR) revealed:
-An entry for Jantoven (a brand of Warfarin in place of Coumadin) 4 mg every Monday, Wednesday and Friday in the evening.
-An entry for Jantoven 8 mg was to be administered every Tuesday, Thursday, Saturday and Sunday in the evening.
-Jantoven was documented as administered as entered on the eMAR from 1/01/16 to 1/31/16.
-Jantoven was not documented as administered as ordered on 12/30/15 for 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday from 1/01/16 to 1/31/16.

Review of Resident #5's February 2016 eMAR revealed:
-An entry for Jantoven 4 mg was to be administered every Monday, Wednesday and Friday at 8:00 pm.
-An entry for Jantoven 8 mg was to be administered every Tuesday, Thursday, Saturday and Sunday at 8:00 pm.
-Jantoven was documented as administered as entered on the eMAR from 2/01/16 to 2/29/16.
-Jantoven was not documented as administered as ordered on 12/30/15 for 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday from 2/01/16 to

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D 367	Continued From page 28 2/23/16. Review of Resident #5's March 2016 and April 2016 MARs revealed: -Jantoven was documented as administered as ordered from 3/01/16 to 4/27/16. Interviews 4/27/16 at 1:40 pm and 4/28/16 at 10:00 am with the Administrator revealed: -The facility had changed to eMARs 10/2015 with a new phone/internet system at the same time. -She reviewed new orders and verified they were entered correctly on the eMAR. -She had not noticed the Coumadin entry was incorrect on the January and February 2016 MARs. Interview on 4/27/16 with the contract pharmacy representative revealed: -The pharmacy entered medication orders into the eMAR system. -The pharmacy system showed an order dated 12/11/15 for Jantoven 4 mg at bedtime. -The pharmacy system showed an order dated 12/30/15 for Jantoven 8 mg every Monday, Wednesday and Friday, and Jantoven 4 mg every Tuesday, Thursday, Saturday and Sunday. -The pharmacy system showed an order dated 2/24/16 for Jantoven 4 mg every Monday, Wednesday and Friday, and Jantoven 8 mg every Tuesday, Thursday, Saturday and Sunday. -The January and February order entries looked correct on the Pharmacy side, but they were not correct on the eMAR side. "There was a glitch when some order entries carried over into the eMAR. It was not caught by the facility's Administrator or staff". -The pharmacy had swapped to the eMAR system when the facility did, so "it had been a learning curve for everyone".	D 367		

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D 367	Continued From page 29 -The facility was to double check orders entered into the eMARs for accuracy and notify the pharmacy or physician as necessary. Interview on 4/28/16 at 1:50 pm with Resident #5 revealed: -He took his medications as the facility administered them, and expected them to be as his physician ordered. -He did not know what medications he was ordered. Interview on 4/28/16 at 1:55 pm with a facility's contracted Pharmacist revealed: -She was in the facility to perform the pharmacy review of resident records. She had started the other day but had not finished going through her notes to complete her reviews. -She had not noticed a discrepancy in the Coumadin orders and the eMAR entries. 2. Review of Resident #5's current FL2 dated 4/13/15 revealed medications included Finasteride 5 mg daily (used to treat enlarged prostate), Metoprolol 25 mg twice daily (used to treat high blood pressure and heart failure), Zoloft 50 mg daily (used to treat anxiety and depression), Keppra 1000 mg twice daily (used to treat seizures), and Pravastatin 20 mg at bedtime (used to reduce cholesterol and triglyceride levels in the blood). Review of Resident #5's record revealed: -Physican's orders dated 12/24/15 to continue Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin. -No orders were found in Resident #5's record to discontinue Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin.	D 367		

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Review of Resident #5's February and March 2016 eMARs revealed:
-Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin were documented as administered as ordered from 2/01/16 to 3/31/16.

Review of Resident #5's April 2016 eMAR on 4/28/16 revealed:
-An entry for Finasteride 5 mg daily at 8:00 am was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 8:00 am. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Metoprolol 25 mg twice daily at 8:00 am and 7:00 pm was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 7:00 pm. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Zoloft 50 mg daily at 8:00 am was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 8:00 am. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Keppra 1000 mg twice daily at 8:00 am and 7:00 pm was administered as ordered from 4/01/16 to 4/12/16. The last dose was administered on 4/12/16 at 7:00 pm. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.
-An entry for Pravastatin 20 mg at bedtime was administered as ordered from 4/01/16 to 4/12/16 at 7:00 pm. The last dose was administered on 4/12/16 at 7:00 pm. A stop date was entered as 4/12/16. A grey discontinued box was at the entry.

Interview on 4/28/16 at 9:35 am and 10:00 am with the Administrator revealed:
-She was not aware that Resident #5 had 5 medications (Finasteride, Metoprolol, Zoloft,

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Keppra and Pravastatin) that "fell off the MAR" on 4/12/16 and were not on the current eMAR as of 4/28/16.
-She expected the pharmacy to contact the physician if a medication needed a renewal order.
-A prompt showed on the eMAR that a medication needed to be renewed or discontinued anytime that resident's eMAR file was opened.
-Since the Finasteride, Metoprolol, Zoloft, Keppra and Pravastatin were "maintenance medications" (the resident had been taking them for a long time), and the medications were on-hand, she expected that they were to continue to be administered to Resident #5.
-If a medication order expired, the MA should notify the supervisor or Administrator to follow-up with the physician or the pharmacy.

Interview on 4/28/16 at 9:45 am with a MA revealed:
-When a medication order "runs out, we receive a notification prompt that the 'medication is in review' (on the eMAR) for about one week". After one week, the prompt disappeared.
-The MA should notify the supervisor or contact the physician or pharmacy to get the medication re-ordered.
-She had not notified her supervisor, the physician or the pharmacy that medication orders were needed.

Interview on 4/28/16 at 10:30 am with the facility's contract pharmacy representative revealed:
-Entries for Finasteride, Metoprolol, Zoloft, Keppra, and Pravastatin were in the pharmacy system but not on the eMAR as their order date had expired on 4/12/16.

Interview on 4/28/16 at 11:05 am with a second MA revealed:

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-The Administrator and a MA Supervisor reviewed new orders and compared them to the eMARs when the orders were received.
-If a medication "fell of the eMAR, but I noticed no discontinued order, then I gave the meds", Resident #5's Metoprolol, Zoloft, Keppra, and Finasteride. "Pravastatin is a bedtime medication, so I was not here for that medication". These were maintenance medications for Resident #5.
-MA's were to notify the supervisor to check with the pharmacy or physician about eMAR medication prompts.
-She had not contacted the physician or the pharmacy regarding the medications not being on the eMAR.

Interview on 4/28/16 at 3:40 pm with Resident #5's physician's office representative revealed:
-The office records show that at the 3/14/16 visit, Resident #5 was still on Finasteride, Keppra, Metoprolol, Zoloft and Pravastatin.

B. Review of Resident #1's current FL 2 dated 4/06/16 revealed:
-Diagnoses included altered mental status secondary to acute renal failure, dementia, ischemic cardiomyopathy, chronic atrial fibrillation, gastric esophageal reflux disease (GERD), diabetes, and hypertension.

1. Review of Resident #1's record revealed:
-A physician's order dated 2/22/16 for Pyridium 100 mg every 8 hours for 3 days (an analgesic for symptoms caused by Urinary Tract Infections).

Review of Resident #1's February 2016 eMAR revealed:
-An entry for Pyridium 100 mg every 8 hours for 3 days and scheduled to be administered at 7:00 am, 3:00 pm and 11:00 pm. It had an origination

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date of 2/22/16 and a stop date of 3/07/16.
-Pyridum 100 mg was documented as administered every 8 hours for 8 days starting on 2/22/16 at 3:00 pm. The last dose was documented as administered at 2/29/16 at 11:00 pm.

Review of Resident #1's March 2016 eMAR revealed:
-An entry for Pyridium 100 mg every 8 hours for 3 days and scheduled to be administered at 7:00 am, 3:00 pm and 11:00 pm. It had an origination date of 2/22/16 and a stop date of 3/07/16. There was a grey discontinued box on the entry.
-Pyridium 100 mg was documented as administered every 8 hours for 15 days starting on 3/01/16 at 7:00 am. The last dose was documented as administered at 3/15/16 at 3:00 pm. There were handwritten circles around the printed intials from 3/8/16 at 7:00 am to 3/15/16 at 3:00 pm.
-There were no entries at the "exception" area on the eMAR for why the Pyridium administration entries were circled, or for what reason.

Review of Resident #5's medications on hand on the medication cart on 4/27/16 revealed no Pyridum was available to be administered.

Interview on 4/27/16 at 3:30 pm with the facility's contract pharmacy representative revealed:
-The contract pharmacy staff entered orders into the eMAR.
-The physician's order for Pyridium 100 mg every 8 hours for 3 days was "received and filled 2/22/16 with 18, 50 mg tablets. This would be 6 tablets per day for 3 days."
-She would "enter an end date of 4 days in case the facility did not start the medication right away, but not everyone entered the orders this way"

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D 367	Continued From page 34 -The facility's Medication Aides (MAs) "could hit 'end' when the Pyridium ran out so the administration notices for Pyridium would be stopped on the eMAR. -If the Pyridium order was started on 2/22/16 at 3:00 pm, the last dose should have been 2/28/16 at 7:00 am. The facility staff would be out of medication. -The pharmacy had no refill orders or requests for Pyridium in their system. Interviews 4/27/16 at 1:40 pm and 4/28/16 at 10:00 am with the Administrator revealed: -The facility had changed to eMARs 10/2015 with a new phone/internet system at the same time. -She reviewed new orders and verified they were entered correctly on the eMAR. -She had not noticed the Pyridium order for Resident #1 continued on the March 2016 eMAR. No staff had notified her that there was no medication available. -The eMAR copies printed for Resident #1 showed Pyridium was documented as administered after the stop date. "I knew this was not possible since we did not have the medication after the stop date, so I had my staff circle the initialed entries. It was not possible to correct it on the eMAR." -The MA's needed to be more attentive to what they were documenting. Interview on 4/28/16 at 11:05 am with a MA revealed: -The Administrator and a MA Supervisor reviewed new orders and compared them to the eMARs when the orders were received. Interview on 4/28/16 at 2:30 pm with Resident #1's family member revealed they expected the facility to administer medications as ordered by	D 367		

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D 367	Continued From page 35 the physician. Based on observations, record review and interviews with staff, family and the resident, it was determined that Resident #1 was not interviewable. Interview on 4/28/16 with Resident #1's physician was not available. 2. Review of Resident #1's current FL 2 dated 4/25/16 revealed medications included Nexium 40 mg daily (an acid blocker). Review of Resident #1's record revealed: -A previous FL 2 dated 4/06/16 with the same medications and doses ordered on the current FL 2 date 4/25/16. -A physician's order dated 1/14/16 for Nexium 40 mg twice daily for two weeks, then daily. -A physician's order dated 3/21/16 to discontinue Nexium. Review of Resident #1's January 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for Esomeprazole (Nexium) 40 mg twice daily for 2 weeks with an origination date of 1/15/16 and a stop date of 1/29/16 and scheduled for administration at 8:00 am and 7:00 pm. Documentation of administration on 1/23/16 at the 8:00 am and 7:00 pm, and handwritten initials documented as administered for 8:00 am and 7:00 pm from 1/16/16 to 1/22/16 and from 1/24/16 to 1/29/16. -An entry for Nexium 40 mg daily at 8:00 am with an origination date of 1/15/16 and a stop date of 3/21/16. Documentation of administration on 1/16/16 to 1/31/16 at 8:00 am. -Documentation was that Resident #1 received	D 367		

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Nexium 40 mg twice daily. and 40 mg daily from 1/16/16 to 1/29/16 for a total of three 40 mg doses of Nexium daily.

Review of Resident #1's March 2016 and April 2016 eMARs revealed
Nexium 40 mg was documented as administered and discontinued and as ordered from 3/01/16 to 4/27/16.

Review of Resident #1's medications on hand for administration on 4/27/16 revealed Nexium 40 mg was available to be administered as ordered. There were no "house supply" Nexium observed.

Interview on 4/27/16 at 1:40 pm and 4/28/16 at 10:15 am with the Administrator revealed:
-The facility had used eMARs since 10/2015. They had swapped to a new phone and internet system at the same time which had cause them difficulties with synchronizing documentation of medications into the eMAR.
-"If I have a medication in stock that is a frequently used medication like Nexium, Protonix or Omeprazole, then we will start that medication before it is stocked by pharmacy. We might borrow it from someone else if we needed to start the medication."
-She approved new orders and verified the pharmacy entered the order correctly on the eMAR.

Interview on 4/27/16 at 3:30 pm with the facility's contracted pharmacy representative for Resident #1 revealed:
-An order 1/15/16 for Nexium 40 mg twice daily for 2 weeks then change to daily. The Nexium 40 mg twice daily was filled on 1/20/16 with 28 tablets for 2 weeks. The Nexium 40 mg daily dose was filled on 1/29/16 for 29 tablets.

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D 367	Continued From page 37 -The delay in filling the medication was possibly to get approval for a non-generic medication as requested by the family. Based on observations, record review and interviews, it was determined that Resident #1 was not interviewable. Interview on 4/28/16 with Resident #1's physician was unavailable. C. Review of Resident #3's current FL2 dated 1/14/16 revealed diagnoses included vitamin B12 deficiency, dementia, depression, chronic pain syndrome, delirium secondary to polypharmacy, generalized anxiety disorder, history of stroke and narcotic dependence. Review of Resident #3's Resident Register revealed that Resident #3 was admitted 12/30/14. Review of Resident #3's record revealed: -Current FL2 dated 01/14/16 revealed there was no order for cyanocobalamin 1000mcg/ml. -A physician's order dated 12/24/15 cyanocobalamin 1000mcg/ml give 1ml intramuscularly (IM) every Sunday for 4 doses then once a month (a medication used to treat vitamin B12 deficiency in people with pernicious anemia and other conditions.) -A letter from the contracted pharmacist dated 2/11/16 the listed 5 medications that required clarification which included cyanocobalamin 1000mcg/ml. The letter was stamped with a physician's signature and "D/C" (discontinue) was written over cyanocobalamin 1000mcg/ml. -Subsequent physician orders dated 2/11/16 that included cyanocobalamin 1000mcg/ml IM every month. -A physician order dated 2/25/16 for cyanocobalamin 1000mcg/ml IM injections every	D 367		

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D 367	Continued From page 38 month. Review of the January 2016 Electronic Medication Administration Record (eMAR) revealed: -A computer generated entry for cyanocobalamin 1000mcg/ml give 1ml IM every Sunday for 4 doses then once a month and documented as administered with hand written initials at 8:00 am on 1/04, 1/11, 1/18 and 1/25/16. -Computer generated initials with a circle on 1/23/16 with an exception documented as "withheld per MD/RN orders". Review of the February 2016 eMAR revealed a computer generated entry for cyanocobalamin 1000mcg/ml give 1ml intramuscularly every Sunday for 4 doses then once a month at 8:00 am and documented as administered 2/01-2/17 and discontinued 2/17/16. Review of the March 2016 eMAR revealed: -A computer generated entry for cyanocobalamin 1000mcg/ml inject contents of 1 vial once monthly at 8:00 am and documented as administered with computer generated initials and hand written circles around all of the initials which included 3/03-3/10, 3/12-3/14 and 3/16-3/31. -On 3/15/16 there was computer generated initials of a MA without a circle around them. -There was no documentation which explained the circled initials. Review of the April 2016 eMAR revealed: -A computer generated entry for cyanocobalamin 1000mcg/ml inject contents of 1 vial once monthly at 8:00 am and documented as administered with computer generated initials from 4/01 through 4/27/16. -On 4/09/16 the computer generated initials were	D 367		

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circled and the exception was documented as "withheld per MD/RN orders".

Interview with Resident #3 during the initial tour on 4/27/16 at 9:58 am revealed:
-Resident #3 had not received her Vitamin B12 injection (cyanocobalamin) in months.
-Resident #3 has been given monthly injection of cyanocobalamin for years.
-Resident #3 was given the cyanocobalamin injections consistently for the first several months after admission.
-Resident #3 asked about the injections on two separate occasions and never received any answers or the injection.

A second interview with Resident #3 on 4/28/16 at 3:00 pm revealed:
-She was receiving the cyanocobalamin injections around the 15th and over time they got later and later in the month.
-The cyanocobalamin was showing up on her bill but was not being administered for at least two months.
-She never had home health administer her injection.
-The Administrator may have administered her injection but typically it was administered by the old Resident Care Coordinator.

Interview with the pharmacist from the contracted pharmacy on 4/28/16 at 1:58 pm revealed:
-When the facility staff go in the computer to verify orders they can set up the day of the month and time they want to administer the medication.
-The pharmacy sent a technician out to train the facility staff on two separate occasions.
-The electronic MAR and order entry verification was a part of this training.
-She would expect that the facility go in and

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select time and date the medication should be given as a part of the entry verification process.
-She expected that the facility staff would call the pharmacy if staff did not know or remember how to verify the order entry and pharmacy staff could teach them over the phone.
-She expected that facility staff would call and request the pharmacy to change the time and date of a medication.

Interview with a Medication Aide on 4/28/16 at 4:08 pm revealed:
-She did not know why she signed out the cyanocobalamin repeatedly but stated, "I probably just did not notice".
-She knew not to give IM injections.
-She notify the administrator (who is also a nurse) on the 15th of the month that an IM injection was due.
-She was now responsible for checking the accuracy of the eMARs from month to month.
-It was the responsibility of the Resident Care Coordinator to check the accuracy of the MARs from month to month but she left the facility several months ago.
-It was now her responsibility to check the eMARs for accuracy from month to month and did so by comparing the medications that the pharmacy sent for the monthly cart fills with the eMARs on the computer.
-If the pharmacy sent something that was discontinued she would send it back to the pharmacy.
-There would be no way to know if there was an order in the record that the pharmacy never received and it would not be sent or in the eMAR.
-She does not know how to change data in the eMAR and would call the pharmacy if a change was required.
-She did not call the pharmacy about the

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D 367	Continued From page 41 cyanocobalamin injections. Interview with a second Medication Aide on 4/28/16 at 4:47 pm revealed: -She knew not to give IM injections and had not administered Resident #3 cyanocobalamin. -She would notify the Administrator if it came up on the eMAR. -They should have called and notified the pharmacy that the injection was scheduled for everyday and requested they change it. Interview with the Administrator on 4/27/16 at 3:15 pm revealed: -She was not aware the cyanocobalamin was scheduled daily on the eMAR. -Her staff would notify her when injections were due and she would administer the injections. -She did give Resident #3 cyanocobalamin injections but did not know when the last injection was administered. -She would have staff sign out that the injection was administered after she administered the injections. Interview with a Nurse from Resident #3's physician office on 4/27/16 at 9:47 am revealed: -The cyanocobalamin 1000mcg/ml was to be administered once a month and it was one Resident #3's admission paperwork dated 12/30/14 with a refill dated 5/07/15. -The refill dated in December 2015 was written at the facility during one of the physician's visits. -The cyanocobalamin had never been discontinued. -They expected that Resident #2 was being administered cyanocobalamin monthly. -There was no home health order in Resident #2's record at the office.	D 367		

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D 367	Continued From page 42 D. Review of Resident #6's current FL2 dated 6/11/15 revealed diagnoses included hypertension, generalized muscle weakness, diabetes mellitus, hyperlipidemia and cerebrovascular accident. Review of Resident #6's Resident Register revealed that Resident #6 was admitted 7/30/08. Review of Resident #6's record revealed: -A physician's order dated 12/04/15 to obtain Resident #6's finder stick blood sugar (FSBS) once a week. -A subsequent physician order dated 2/11/16 for FSBS once a week. Observation of medication pass on 4/28/16 at 7:32 am revealed an electronic Medication Administration Record (eMAR) entry prompting the MA to obtain a FSBS on Resident #6. Interview with MA on 4/28/16 at 7:33 am revealed he was not sure but he thought that the FSBS was obtained by third shift and he needed to check with his Supervisor. Interview with Quality Control Aide (QCA) on 4/28/16 at 7:35 am revealed: -The MAs obtained Resident #6's FSBS on Monday's only. -She selected the exception "withheld per MD/RN orders" because the order was for once a week only. -She knew the FSBS was obtained on Mondays only because she had worked there for two years and the order was changed to once a week several months ago. -She expected other staff would either know that the FSBS should be taken on Monday or they could ask when they should obtain it.	D 367		

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D 367	Continued From page 43 Review of the January 2016 eMAR revealed: -An entry to check FSBS once a week at 8:00 am. -Resident #6's FSBS was obtained 19 times out of the 4 days it was to be obtained. -Examples include a FSBS of 112 on 1/02, FSBS of 142 on 1/04, FSBS of 116 on 1/07, FSBS of 114 on 1/10, FSBS of 119 on 1/14, FSBS 118 on 1/16, FSBS of 102 on 1/21 and FSBS of 118 on 1/26/16. Review of the February 2016 eMAR revealed: -An entry to check FSBS once a week at 8:00 am. -Resident #6's FSBS was obtained 9 times out of the 4 days it was to be obtained. -Examples include a FSBS of 229 on 2/03, FSBS of 199 on 2/09, FSBS of 128 on 2/12, FSBS of 134 on 2/20 and FSBS of 225 on 2/27/16. Review of the March 2016 eMAR revealed: -An entry to check FSBS once a week at 8:00 am. -Resident #6's FSBS was obtained 16 times out of the 4 days it was to be obtained. -Examples include a FSBS of 294 on 3/01, FSBS of 205 on 3/06, FSBS of 228 on 3/07, FSBS of 198 on 3/10, FSBS of 198 on 3/11, FSBS of 182 on 3/23, FSBS of 221 on 3/24, FSBS of 158 on 3/25 and FSBS of 156 on 3/26/16. Review of the April 1-27, 2016 eMAR revealed: -An entry to check FSBS once a week at 8:00 am. -Resident #6's FSBS was obtained 11 times out of the 4 days it was to be obtained. -Examples include a FSBS of 146 on 4/02, FSBS of 112 on 4/03, FSBS of 189 on 4/07, FSBS of 172 on 4/08, FSBS of 213 on 4/11, FSBS of 178	D 367		

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D 367	Continued From page 44 on 4/12, FSBS of 182 on 4/17 and FSBS of 367 on 4/18. Interview with a MA on 4/28/16 at 4:16 pm revealed: -She knew that Resident #6's FSBS were taken only once a week. -She did call the pharmacy and requested the frequency be changed to once a week as according to the order, but did not know when. -She did not follow up with pharmacy to have the entry changed. -Someone did not fax the new order and that was why it was not changed in the eMAR. -She knew that the FSBS was taken on Mondays. -It was her responsibility to check the eMARs for accuracy from month to month and did so by comparing the medications that the pharmacy sent for the monthly cart fills with the eMARs on the computer. Interview with a second MA on 4/28/16 at 4:45 pm revealed: -She would initial the entry and pick the exception "withheld per MD/RN orders" because it says once a week. -She thought that the FSBS was obtained for Resident #6 on Mondays. -She never called the pharmacy to request the entry be changed because she overlooked it. -She did not know how to change the entries in the computer. -She expected that any one of the MAs should have called and requested the entry be changed. Interview with the pharmacist from the contracted pharmacy on 4/28/16 at 2:00 pm revealed: -When the facility staff go in the computer to verify orders they can set up the day of the week they want to take the FSBS.	D 367		

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D 367	Continued From page 45 -The pharmacy sent a technician out to train the facility staff on two separate occasions. -The electronic MAR and order entry verification was a part of this training. -She would expect that the facility go in and select time and day of the week the FSBS should be obtained as a part of the entry verification process. -She expected that the facility staff would call the pharmacy if staff did not know or remember how to verify the order entry and pharmacy staff could teach them over the phone. -She expected that facility staff would call and request the pharmacy to change the time and date of entry. Interview with the Administrator on 4/27/16 at 3:20 pm revealed: -She was not aware the FSBS were scheduled daily on the eMAR.. -She did have the Resident Care Coordinator (RCC) review eMARs from one month to another to assure accuracy, but the RCC was no longer employed at the facility. -The eMAR was new to the facility as of October 2015 and the facility staff were having problems that were not anticipated. Interview with Resident #6 on 4/28/16 at 4:30 pm revealed: -Resident #6 knew that her blood sugar was only to be obtained once a week. -Resident #6 denied any pain in her fingertips.	D 367		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing	D 400		

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D 400	Continued From page 46 practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review 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 adequate medication reviews were completed for 1 of 5 (Resident #5) sampled residents in the areas of changing Coumadin orders and incomplete laboratory value follow-up.	D 400		

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D 400	Continued From page 47 The findings are: Review of Resident #5's current FL2 dated 4/13/15 revealed: -Diagnoses included CVA, Atrial Fibrillation, and a history of epilepsy. -A physician's order for Coumadin 8 mg at bedtime (used to treat and prevent blood clots). Review of Resident #5's Resident Register revealed an admission date of 6/04/14. Review of Resident #5's record revealed: -A physician's order dated 12/30/15 to change Coumadin to 8 mg on Monday, Wednesday and Friday, and 4 mg on Tuesday, Thursday, Saturday and Sunday. -A physician's order dated 2/24/16 to change Coumadin to 4 mg on Monday, Wednesday and Friday, and 8 mg on Tuesday, Thursday, Saturday and Sunday. Review of Resident #5's January 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for Jantoven (a brand of warfarin in place of Coumadin) 4 mg every Monday, Wednesday and Friday in the evening. -An entry for Jantoven 8 mg every Tuesday, Thursday, Saturday and Sunday in the evening. -Jantoven 4mg was documented as administered every Monday, Wednesday and Friday in the evening, and Jantoven 8 mg was documented as administered every Tuesday, Thursday, Saturday and Sunday in the evening from 1/01/16 to 1/31/16. Review of Resident #5's February 2016 eMAR revealed:	D 400		

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-An entry for Jantoven 4 mg was to be administered every Monday, Wednesday and Friday at 8:00 pm.
-An entry for Jantoven 8 mg was to be administered every Tuesday, Thursday, Saturday and Sunday at 8:00 pm.
-Jantoven 4mg was documented as administered every Monday, Wednesday and Friday in the evening, and Jantoven 8 mg was documented as administered every Tuesday, Thursday, Saturday and Sunday in the evening from 2/01/16 to 2/29/16.
-Jantoven 4mg was documented as administered every Monday, Wednesday and Friday in the evening, and Jantoven 8 mg was documented as administered every Tuesday, Thursday, Saturday and Sunday in the evening correctly from 2/24/16 to 2/29/16.

Review of Resident #5's March 2016 and April 2016 eMARs revealed:
-Jantoven was documented as administered as ordered from 3/01/16 to 4/27/16.

Review of a pharmacy review dated 1/19/16 revealed:
-Laboratory results were noted, and no recommendations were made.
-The Coumadin order entry on the January eMAR was not documented as being the wrong dose on the wrong days.
-There was no mention about clarifying that Jantoven was to be administered in place of Coumadin.

Interviews 4/27/16 at 1:40 pm and 4/28/16 at 10:00 am with the Administrator revealed:
-The facility had changed to eMARs on 10/2015 with a new phone/internet system at the same time.

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D 400	Continued From page 49 -She reviewed new orders and verified they were entered correctly on the eMAR. -She had not noticed the Coumadin entry was wrong for which dose was to be administered on which days on the January and February 2016 MARs. -There was no clarification performed with the physician that Jantoven was to be administered in place of Coumadin. Interview on 4/27/16 at 3:30 pm with the facility's contract pharmacy representative revealed: -The pharmacy entered medication orders into the eMAR system. -The pharmacy system showed an order dated 12/11/15 for Jantoven 4 mg at bedtime. -The pharmacy system showed an order dated 12/30/15 for Jantoven 8 mg every Monday, Wednesday and Friday, and Jantoven 4 mg every Tuesday, Thursday, Saturday and Sunday. -The pharmacy system showed an order dated 2/24/16 for Jantoven 4 mg every Monday, Wednesday and Friday, and Jantoven 8 mg every Tuesday, Thursday, Saturday and Sunday. -The January and February order entries looked correct on the Pharmacy side, but they were not correct on the eMAR side. "There was a glitch when some order entries carried over into the eMAR. It was not caught by the facility's Administrator or staff". -The pharmacy had swapped to the eMAR system when the facility did, so "it had been a learning curve for everyone". -The facility was to double check orders entered into the eMARs for accuracy and notify the pharmacy or physician as necessary. Interview on 4/28/16 at 1:55 pm with the contracted Pharmacist revealed: -She was in the facility to perform the pharmacy	D 400		

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D 400	Continued From page 50 review of resident records. She had started the other day, but had not finished going through her notes to complete her reviews. -When she reviewed Resident #5's record, if she did not find a current INR, she would contact the physician. She could not remember without looking at her notes if she had noticed the lack of INR results and orders on Resident #5's records. -She had not noticed a discrepancy in the Coumadin orders and the eMAR entries.	D 400		
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 every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Health Care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure physician and pharmacy notification for 2 of 5 sampled residents (Residents #2 and #5) regarding orders for International Normalized Ratio (INR) laboratory results and medication orders for high blood pressure, enlarged prostate, anxiety,	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053027	A. BUILDING: _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 51 seizure, blood thinner, and cholesterol medications. [Refer to Tag 273, 10A NCAC 13 F .0902 (b) (Type B Violation).]	D912		