Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	R 05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 and the Cabarrus County Department of Social Services conducted a follow-up survey on May 3-5, 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: FOLLOW-UP TO Type B VIOLATION The previous Type B Violation was not abated. Based on observation, record reviews, and interviews, the facility failed to ensure physician notification for 2 of 8 sampled residents (Residents #1 and #6) with physician's orders for thromboembolism-deterrent (TED) hose and weights. The findings are: Review of Resident #1's current FL2 dated 6/04/15 revealed: -Diagnoses included lumbar 3 end plate infarction, chronic kidney disease, hyponatremia, hypertension, congestive heart failure, irritable bowel syndrome, history of pulmonary embolism and insomnia. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 8/17/15. 1. Review of Resident #1's record revealed a	{D 273}	See attached POC dated 6.14.16	

Reviewed and accepted 6/16/16 JW

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{D 273}	Continued From page 1 physician's order dated 4/15/16 for velcro compression hose - place support hose on daily while awake and remove at bedtime. Observation of Resident #1 during initial tour on 05/03/16 at 9:19 am of Resident #1 revealed: -The resident was sitting in a reclining chair. -The reclining chair lifted the resident's feet off the floor. -The resident was not wearing TED hose or velcro compression stockings. -The resident was wearing socks that were pulled to mid calve and the top of each sock was cut in several places. -Moderate edema was present in both lower extremities. Review of Resident #1's Medication Administration Records (MAR) for April and May 2016 revealed there were no entries for Velcro Compression stockings. Review of Resident #1's May 2016 Treatment Administration Records (TAR) revealed: -Daily documentation of Resident #1 refusing TED hose. -There was no entry for velcro compression stockings. Second observation on 5/04/16 at 11:45 am of Resident #1 revealed: -The resident was sitting in a reclining chair. -The reclining chair lifted the resident's feet off the floor. -The resident was not wearing TED hose or velcro compression stockings. -The resident was wearing socks that were pulled to mid calve and the top of each sock was cut in several places. -Moderate edema was present in both lower	{D 273}	See attached POC dated 6.14.16	

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{D 273}	Continued From page 2 extremities. Interview with Resident #1 on 5/04/16 at 11:45 am revealed: -She always tried to elevate her feet to reduce the edema. -She cut the tops of her socks so they would not cause compression rings. -She went to her physician about her lower extremity edema and the physician ordered a one time, elevated dose of Furosemide (a medication used to reduce fluid retention) and a new kind of compression stocking. -She did not like wearing TED hose because they hurt her feet and legs when they were applied and removed. -The TED hose left compression rings around her ankles and right below her knees. -Her physician said that the velcro compression stockings would not hurt her legs during the application and removal. -Her physician also told Resident #1 that the velcro compression stocking were less likely to leave compression rings. -She wanted to try the new stockings because they were likely to reduce her edema without causing her pain. -She would wear the new velcro compression stockings if they did not hurt when they were applied. -She was never measured for the new compression stockings. -She never received or even saw the velcro compression stockings. Interview with a Medication Aide on 5/05/16 at 11:15 am revealed: -She knew that Resident #1 had a history of refusing her TED hose. -She did not apply the TED hose, the PCAs did.	{D 273}	See attached POC dated 6.14.16	

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{D 273}	Continued From page 3 -She never knew there was an order for velcro compression stockings. -The velcro compression stockings were not on her MAR but may be on the TAR. Interview with a Personal Care Aide (PCA) on 5/05/16 at 11:30 am revealed: -Resident #1 did have a few pair of TED hose but she refused to wear them because they were too tight. -Resident #1 complained when she applied the TED hose and would remove them by herself. -She documented in the TAR when Resident #1 refused -She did not remember the last time she tried to apply the TED hose on Resident #1. -She never saw the new pair of velcro compression stockings. Interview with the first floor Quality Control Aide (QCA) on 5/05/16 at 10:20 am revealed: -The Quality Control Aide was a Medication Aide and Supervisor. -She did not process the velcro compression stockings order and did not know who filed the order in the chart. -She expected the pharmacy to call the facility and report that they could not supply the velcro compression stockings. -She had never seen or applied the velcro compression stockings. Interview with a representative from the contracted pharmacy on 5/05/16 at 9:25 am revealed: -The pharmacy never received an order for velcro compression stockings. -She was not sure if they supplied them but could most likely order them.	{D 273}	DC attached POC dated 6.14.16	

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{D 273}	Continued From page 4 Interview with the Administrator on 5/05/16 at 11:27 am revealed: -She had never heard of velcro compression stockings. -She did not know of the order dated 4/15/16 for velcro compression stockings. -She did not know if they were in the facility or not. -She expected the MAs or Supervisors were responsible to assure the velcro compression stockings were received and applied. Interview with the Nurse at Resident #1's primary care physician's office on 5/05/16 at 12:15 pm revealed: -The facility never called the physician's office to clarify the velcro compression stocking order or to report that Resident #1 was not wearing the velcro compression stockings. -The physician expected that an order that was issued should be initiated as soon as possible and if they had issues obtaining the velcro compression stockings they would call and inquire where to obtain the stockings. B. Review of Resident #6's current FL2 dated 4/27/15 revealed: -Diagnoses included orthopedic aftercare, history of falls, lack of coordination, muscle weakness, generalized anxiety, depressive disorder, atrial fibrillation and osteoporosis. -Resident #6 was intermittently disoriented. Review of Resident #6's record revealed: -A physician's order dated 2/18/16 for daily weights and physician was to be notified for weight gain of 3 pounds in 1 day or 5 pounds in 1	{D 273}	See attached POC dated 6.14.16	

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{D 273}	Continued From page 5 week. -A physician's order dated 3/08/16 for daily weights and physician was to be notified for weight gain of 3 pounds in 1 day or 5 pounds in 1 week. Review of Resident #6's February 2016 Treatment Record revealed: -An entry for "Weigh daily. Call MD for weight gain of 3 pounds in 1 day or 5 pounds in 1 week". The weight check was scheduled for 6:00 am. -Daily weights were documented 21 of 29 days in February. -Resident #6 was documented as having refused to be weighed on 6 days: 2/06/16, 2/07/16, 2/12/16, 2/17/16, 2/20/16 and 2/26/16). -Weights ranged from 165 to 169.4 pounds. -There was no weight results documented for 2/14/16 and 2/29/16, and no documentation why the weights were not obtained. -There was no documentation the physician was notified of Resident #6's refusals to be weighed in February. Review of Resident #6's March 2016 Treatment Record revealed: -An entry for "Weigh daily. Call MD for weight gain of 3 pounds in 1 day or 3 pounds in 1 week." The weight check was scheduled for 6:00 am. -There were no weights documented for 22 out of 31 days. Resident refused to be weighed on 3/8/16 otherwise there was no documentation why the weights were not obtained. -The following weights were documented for the month of March: -On 3/2/16-213.8 -On 3/3/16-213 -On 3/4/16-213 -On 3/5/16-166.6 -On 3/9/16-168.2	{D 273}	See attached POC dated 6.14.16	

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{D 273}	Continued From page 6 -On 3/12/16-167 -On 3/19/16-168.2 -On 3/24/16-161.6 -There was no documentation that Resident#6's physician was notified of Resident #6's fluctuation in weight from 3/2/16 to 3/5/16 and 3/19/16 to 3/24/16. Review of Resident #6's April 2016 Treatment Record revealed: -An entry for "Weigh daily. Call MD for weight gain of 3 pounds in 1 day or 5 pounds in 1 week." The weight check was scheduled for 6:00 am. -No weight information was documented for 23 out of 31 days. -Resident #6 refused to be weighed 6 out of 31 days on 4/3/16, 4/8/16, 4/11/16, 4/15/16, 4/16/16 and 4/29/16. -There was one weight of 166 recorded on 4/23/16. -There was no documentation the physician was notified of Resident #6's refusals to be weighed in April. Review of Resident #6's May 2016 Treatment Record on 5/05/16 revealed: -An entry for "Weigh daily. Call MD for weight gain of 3 pounds in 1 day or 3 pounds in 1 week". The weight check was scheduled for 6:00 am. -No weight information was documented from 5/01/16 to 5/05/16. Review of Resident #6's most current FL 2 dated 5/03/16 revealed: -Blood pressure (BP) and pulse checks were to be checked monthly and as needed (PRN). -There was no physician's order on the FL 2 dated 5/03/16 for daily weights. Observation of a stand-up scale in the facility	{D 273}	See Attached POC 6-14-16	

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{D 273}	Continued From page 7 revealed: -It was a digital scale and had a calibration button. -It was unknown how often the scale was calibrated. (Staff were not asked and there was no calibration log next to the scale). -Staff was not observed weighing a resident. Interview on 5/03/16 at 3:50 pm with a Quality Control Aide (QCA) revealed: -Monthly weights were documented in a notebook located at the nursing station. -Documentation of weights to be done more frequently than monthly were documented on the resident's individual Treatment Record by the Personal Care Aides (PCA). -Physician's orders for weights were entered on the Treatment Record for the PCAs to follow. Interview on 5/03/16 at 4:20 pm with the Administrator revealed: -Monthly weights were documented in a notebook located at the nursing station. -Documentation of all other orders (i.e.: weekly, daily, etc.) were documented on the resident's individual Treatment Record. -The PCAs on the third shift checked weights based on the orders entered on the treatment records. A second interview with the Administrator on 5/4/16 at 9:00 am revealed: -She and QCA staff were to review treatment records to assure weights were done as ordered. -The facility's policy was to contact the resident's physician after 3 refusals of a treatment ordered, including weights. -The staff were to document refusals. -The Administrator clarified she "did not speak with staff specifically about Resident #6, but she	{D 273}	See attached POC dated 6.14.16	

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{D 273}	Continued From page 8 just reminded them to document refusals". -She had not been reviewing Treatment Records to check behind staff. -The MD had not been notified of Resident #6's refusals for weight. A second interview on 5/04/16 at 9:20 am with the QCA revealed: -PCAs were responsible for weighing residents. -The QCA and the Administrator were to check behind staff to assure the tasks were done. They were to check the Treatment Record to assure staff documented weights and resident refusals, but had no set schedule for monitoring this. -The QCA had not been checking behind staff and monitoring Treatment Record to assure documentation of weights, BP and vital signs (VS). She was unable to give a reason as to why the Treatment Records were not being monitored. -She had not notified the physician when Resident #6 refused to be weighed. Interview on 5/04/16 at 2:45 pm with a PCA revealed: -She worked first shift most of the time but had been helping out on the other shifts due to recent staffing issues. -PCAs were responsible for weighing residents. The results were to be logged into the black notebook on the treatment cart. -She checked the notebook at the start of her shift as orders were entered on the Treatment Record for what needed to be done for residents including BP, VS and weight checks. -She documented information on the Treatment Record including refusals, and also reported to the MA if a resident refused. -Resident #6 was weighed on third shift and she refused frequently. She had notified the MA when Resident #6 refused to be weighed. She was not	{D 273}	See attached POC dated 6.14.16	

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{D 273}	Continued From page 9 sure what the MA did when she reported refusals. Interview on 5/04/16 at 4:00 pm with Resident #6 revealed: -She was weighed once a month. -She did not recall ever being weighed daily. -She did have issues with swelling and bloating at times and that she was currently swollen and bloated. Observation on 5/04/16 at 4:00 pm revealed Resident #6's legs were swollen and socks left indentions when Resident #6 pulled the socks back. Interview on 5/05/16 at 9:00 am with Resident #6's Nurse Practitioner revealed: -She had not been notified that Resident #6 had been refusing to have his weight obtained. -She had not been notified of fluctuations in weight. -She expected weights to be obtained as ordered. A Plan of Protection was provided by the facility on May 5, 2016: -Effective immediately the staff were to be retrained on the appropriate procedures for referral and follow-up and implementation of orders. -The Executive Director and/or the Quality Control Staff will review residents' records to ensure that the referral and follow-up is documented to meet the routine and acute health care needs of the residents. -The Executive Director and/or the Quality Control Staff shall randomly audit residents' records to ensure documention reflects referral and follow-up weekly for 4 weeks, then monthly there after. -Any staff found not following procedure will	{D 273}	See attached POC dated 6.14.16	

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{D 273}	Continued From page 10 receive discipline actions to include retraining, write-up and/or termination. CORRECTION DATE FOR THE UNABATED TYPE B VIOLATION SHALL NOT EXCEED June 4, 2016.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure physician's orders were implemented for 3 of 8 sampled residents (Residents #3, #6, and #7) regarding weights and vital signs. The findings are: A. Review of Resident #3's current FL 2 dated 8/26/15 revealed: -Diagnoses included orthostatic hypotension, hypertension, congestive heart failure (CHF), muscle weakness, and osteoarthros. Review of Resident #3's Resident Register	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 11 revealed and admission date of 8/21/15. 1. Review of Resident #3's Record revealed an order dated 3/22/16 for daily weights, but no parameters to notify the physician for weight loss or gain was specified. Review of Resident #3's March 2016 Treatment Administration Record (TAR) revealed weight results were recorded as ordered from 3/22/16 to 3/31/16. Review of Resident #3's April 2016 TAR revealed: -An entry for daily weights scheduled at 6:00 am. -Weights were not obtained 22 of 30 days from 4/01/16 to 4/30/16. -There was no documentation why weights were not obtained on these dates. Review of Resident #3's May 2016 TAR revealed: -Weight results were recorded daily at 6:00 am as ordered from 5/01/16 to 5/04/16 except for 5/02/16. -There was no documentation why Resident #3's weight was not obtained on 5/02/16. Interview on 5/03/16 at 9:45 am with Resident #3 revealed the facility staff weighed him several times per week. He was not aware how often his physician ordered him to be weighed. Interview on 5/04/16 at 9:50 am with a Personal Care Aide (PCA) revealed weights and VS (BP and pulse) were obtained by the PCA and documented on the TAR. Abnormal results were reported immediately to the Medication Aides (MAs). Interview on 5/05/16 at 8:55 am with Resident #3's Nurse Practitioner (NP) revealed:	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 12 -The facility did not report when VS or weights were missed. -She looked at Resident #3's record when she visited the facility and stated that Resident's weights had "stabilized out". -Resident #3 had a history of CHF, and monitoring weights was important. -She expected her orders to be followed. -She did not specify if she planned to change Resident #3's daily weight order. Interview on 5/05/16 at 11:15 am with the Administrator revealed: -Weights were usually obtained by the 3rd shift PCA. They were documented on the TAR. -She expected staff to obtain weights as ordered. -The Quality Control Aides (QCA) should be looking at the VS and Weight logs and reporting to the physician or NP if there was a 3 pound in one day (or 5 pound in 3 days) weight gain or loss per facility policy. 2. Review of Resident #3's record revealed an order dated 12/04/15 for daily Vital Signs (VS), but no order for parameters for notifying the physician specified. Review of Resident #3's February 2016 Treatment Administration Record (TAR) revealed: -A pre-printed entry for "obtain ortho stats (Vitals) sitting, standing, and lying" daily and scheduled for 6:00 am. The printed entries listed were for blood pressure (BP) and pulse rate checks. -BP and pulse results were recorded daily at 6:00 am except for 7 days on 2/01, 2/16, 2/07, 2/13, 2/14, 2/20 and 2/23/16. There was no documentation why the BP and pulse checks were not obtained on these dates. -Resident #3's BP ranged from 100/60 to 150/70. -Resident #3's pulse ranged from 60-82.	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 13 Review of Resident #3's March 2016 TAR revealed: -A pre-printed entry for "obtain ortho stats (Vitals) sitting, standing, and lying" daily and scheduled for 6:00 am. The printed entries listed were for BP and pulse rate checks. -BP and pulse results were recorded daily at 6:00 am from 3/01 to 3/05/16, and from 3/11 to 3/12, 3/14, 3/16, and from 3/18 to 3/20/16. -There were x's marked in the boxes for 3/06, 3/07, and 3/13/16. (An x was to be used to reflect a resident refused- per the legend on the bottom of the treatment record form). -There were no BP and pulse results recorded in March for 19 days including from 3/05 to 3/10, 3/13, 3/15, 3/17, and from 3/21 to 3/31/16. -Pulse rates were recorded on 3/23 and 3/30 but no blood pressures (BP). -Resident #3's BP ranged from 100/58 to 168/72. -Resident #3's pulse ranged from 60-82. -There was no documentation why BP and pulse checks were not recorded daily as ordered. Review of Resident #3's April 2016 TAR revealed: -Separate handwritten entries for "orthostatics sitting", "orthostatics while standing", and "orthostatics lying" and all scheduled daily at 6:00 am. -BP and pulse results were documented on 9 days in April on 4/02, 4/04, 4/06, 4/10, 4/11, 4/13, 4/14, 4/18, and 4/23. -There were no BP and pulse results recorded in April for 15 days including 4/01, 4/03, 4/05, 4/7, 4/8, 4/9, 4/12, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, 4/22, and from 4/24 to 4/30/16. -A Pulse rate but no BP was recorded on 4/25/16. -Resident #3's BP ranged from 95/63 to 119/72. -Resident #3's pulse ranged from 70-99. -There was no documentation why BP and pulse	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 14 checks were not done daily as ordered. Review of Resident #3's May 2016 TAR on 5/03/16 revealed: -Separate handwritten entries for "orthostatics sitting", "orthostatics while standing", and "orthostatics lying" and all scheduled daily at 6:30 am. The entries were specific for BP and pulse results. -BP and pulse results were documented on 5/01 and 5/03/16. -BP and pulse results were not documented on 5/02/16. -There was no documentation why BP and pulse checks were not done daily as ordered. Interview on 5/03/16 at 9:45 am with Resident #3 revealed: -The facility staff took his BP and pulse lying, sitting and standing several times per week. He was not aware how often his physician ordered his BP and pulse to be checked. Interview on 5/04/16 at 9:50 am with a Personal Care Aide (PCA) revealed: -Weights and vital signs were obtained by the PCA and documented on the TAR. Abnormal results were reported immediately to the Medication Aides (MAs). Interview on 5/05/16 at 8:55 am with Resident #3's Nurse Practitioner (NP) revealed: -The facility did not report when VS or weights were missed. -She looked at Resident #3's record when she visited the facility and stated that Resident's BP had "stabilized out". -She expected her orders to be followed. -She did not specify if she planned to change Resident #3's order for VS checks.	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 15 Interview on 5/05/16 at 11:15 am with the Administrator revealed: -Weights were usually obtained by the 3rd shift PCA. They were documented on the TAR. -VS were usually obtained on the 1st or 2nd shift, and occasionally on the 3rd shift. They were documented on the TAR. -She expected staff to obtain VS and weights as ordered. -The Quality Control Aides (QCA) should be looking at the VS and weight logs and reporting to the physician or NP if there was a 3 pound in one day (or 5 pound in 3 days) weight gain or loss per facility policy. B. Review of Resident #7's current FL 2 dated 3/01/16 revealed: -Diagnoses included Coronary Artery Disease, diabetes, and hypertension. Review of Resident #7's Resident Register revealed an admission date of 3/08/16. 1. Review of Resident #7's record revealed: -A Nurse Practitioner's (NP) order signed and dated 3/10/16 daily weights in the morning prior to breakfast. Review of Resident #7's March Medication Administration Record (MAR) from 3/11/16 to 3/31/16 revealed: -A handwritten entry for daily weights in the morning prior to breakfast and scheduled for 6:00 am and marked to start 3/11/16. -Initialed entries were recorded on 3/11/16 and 3/23/16, but no weight values were recorded. -Daily weights were not recorded in March for Resident #7 from 3/11/16 to 3/31/16.	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 16 Review of the March 2016 monthly Vital Sign log sheet revealed: -The log sheet had a handwritten "March 2016" entry on the top, but no specific date was recorded. -The log sheet was a listing of all residents residing on the 2nd floor, and had entries for weight, temperature, pulse and BP to be recorded. -Resident #7's weights were not recorded. Review of Resident #7's April MAR revealed: -A pre-printed entry for daily weight check in the mornings prior to breakfasts. This entry had a line crossed through it and "TMAR" (Treatment Administration Record [TAR]) marked in the entry box. No documentation was recorded on this line. -A handwritten entry on another page in the MAR for daily weight check in the mornings prior to breakfast and scheduled for 6:00 am. -Only one weight, 347 pounds on 4/11/16, was recorded from 4/01/16 to 4/30/16. -There was no documentation why daily weights were not obtained. Review of the April 2016 monthly Vital Sign log sheet revealed: -The log sheet had a handwritten "April 2016" entry on the top, but no specific date was recorded. -The log sheet was a listing of all residents residing on the 2nd floor, and had entries for weight, temperature, pulse and BP to be recorded. -Resident #7's weight was recorded and did not match the weight documented on the April MAR on 4/11/6. Interview on 5/03/16 at 9:52 am with Resident #7 revealed:	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 17 -He had lost 269 pounds before admission to the facility, but had been gaining it back because at home he was watching what he ate. He ate more vegetables at home than he was at the facility. Interview on 5/04/16 at 9:50 am with a Personal Care Aide (PCA) revealed: -Weights and VS were obtained by the PCA and documented on the TAR. Abnormal results were reported immediately to the Medication Aides (MAs). -The physician's orders were entered on the TAR for the PCAs to follow. This would alert the PCA if a BP or weight was to be obtained more frequently than monthly. Interview on 5/05/16 at 8:55 am with Resident #7's NP revealed: -The facility had not reported weights not being done as ordered. They had not reported any abnormal values. -She expected the weights to be obtained and documented as ordered. -She usually requested a weight to be documented on the MAR on the days she visited. -The staff was not always consistent with transferring the information to the MAR. Interview on 5/05/16 at 10:05 am with a Quality Control Aide (QCA) revealed: -Resident weights were obtained monthly unless ordered more frequently by the physician. -The PCA obtained the weights and documented them on the TAR. They were to report abnormal results to the MA. -There was no order for parameters to notify Resident #7's physician for weights results. Interview on 5/05/16 at 11:15 am with the Administrator revealed:	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 18 -Weights were usually obtained by the 3rd shift PCA. They were documented on the TAR. -She expected staff to obtain weights as ordered. -The QCA should be looking at the VS and Weight logs and reporting to the physician or NP if there was a 3 pound in one day (or 5 pound in 3 days) weight gain or loss as per the facility's policy. -Resident #7 had been admitted to the local hospital on 5/04/16, but she was not aware why. Further interviews with Resident #7 were not available as he was admitted to the hospital on 5/04/16 for atypical chest pain. An attempted telephone interview on 5/05/16 at 12:15 pm with Resident #7's family member was not available. A Second interview on 5/05/16 at 12:25 pm with Resident #7's NP revealed Resident #7's hospital admission was not a CHF "flare-up" and was not related to VS and weights not being done or reported. 2. Review of Resident #7's record revealed: -A Nurse Practitioner's (NP) order signed and dated 3/10/16 for blood pressure (BP) and pulse checks every other day with a large cuff. Review of Resident #7's March Medication Administration Record (MAR) from 3/11/16 to 3/31/16 revealed: -A handwritten entry dated 3/10/16 for BP every other day with large cuff and scheduled for 8:00 am and marked to start 3/11/16. There were x's on the even days on the entries. -A handwritten entry dated 3/10/16 for pulse check every other day and scheduled for 8:00 am and marked to start 3/11/16. There were x's every	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 19 other day on the entries. -BP and pulse results were documented every other day as ordered from 3/15/16 to 3/31/16 except for no result documented on 3/17/16. -There was no documentation why no results were documented for 3/11/16, 3/13/16 and 3/17/16. -Resident #7's BP ranged from 158/66 to 164/70. -Resident #7's pulse ranged from 67 to 71. Review of Resident #7's April MAR revealed: -A pre-printed entry to "check BP and pulse every other day, use large cuff". This entry had a line crossed through it and "TMAR" (Treatment Administration Record [TAR]) marked in the entry box. No documentation was recorded on this line. -A handwritten entry on another page in the MAR to "check BP and pulse every other day, use large cuff" and scheduled for 6:00 am. There were x's on the even days on the entries. -Only one BP of 130/90 and pulse of 69 was documented from 4/01/16 to 4/30/16, on 4/07/16. -There was no documentation why VS were not obtained every other day. Review of the April 2016 monthly Vital Sign (VS) log sheet revealed: -The log sheet had a handwritten "April 2016" entry on the top, but no specific date was recorded. -The VS sheet was a listing of all residents residing on the 2nd floor, and had entries for weight, temperature, pulse and BP to be recorded. -Resident #7's BP and pulse results were recorded and did not match the results documented on his April MAR on 4/07/16. Interview on 5/04/16 at 9:50 am with a Personal Care Aide (PCA) revealed:	D 276	See Attached POC dated 6-14-16	

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D 276	Continued From page 20 -Weights and VS were obtained by the PCA and documented on the TAR. Abnormal results were reported immediately to the Medication Aides (MAs). -The physician's orders were entered on the TAR for the PCAs to follow. This would alert the PCA if a BP or weight was to be obtained more frequently than monthly. Interview on 5/05/16 at 8:55 am with Resident #7's NP revealed: -The facility had not reported VS not being done as ordered. They had not reported any abnormal values. -She expected the VS to be obtained and documented as ordered. -She usually requested a BP to be documented on the MAR on the days she visited. -The staff was not always consistent with transferring the information to the MAR. Interview on 5/05/16 at 10:05 am with a Quality Control Aide (QCA) revealed: -Resident BP and pulse were obtained monthly unless ordered more frequently by the physician. -The PCA obtained the weights and VS and documented them on the TAR. They were to report abnormal results to the MA. -There was no order for parameters to notify Resident #7's physician for weights or BP results. Interview on 5/05/16 at 11:15 am with the Administrator revealed: -VS were usually obtained on the 1st or 2nd shift, and occasionally on the 3rd shift. They were documented on the TAR. -She expected staff to obtain VS as ordered. -Resident #7 had been admitted to the local hospital on 5/04/16, but she was not aware why.	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 21 Further interviews with Resident #7 were not available as he was admitted to the hospital on 5/04/16 for atypical chest pain. An attempted telephone interview on 5/05/16 at 12:15 pm with Resident #7's family member was unsuccessful. A Second interview on 5/05/16 at 12:25 pm with Resident #7's NP revealed Resident #7's hospital admission was not a CHF "flare-up" and was not related to VS and weights not being done or reported. C. Review of Resident #6's current FL2 dated 4/27/15 revealed: -Diagnoses included Orthopedic Aftercare, history of falls, lack of coordination, muscle weakness, generalized anxiety, depressive disorder, atrial fibrillation and osteoporosis. -Resident #6 was intermittently disoriented. -A physician's order for blood pressure (BP) and vital signs (VS) to be checked weekly. Review of Resident #6's record revealed: -A physician's order dated 2/18/16 for BP and VS to be checked weekly and scheduled for 4:00 pm. -A physician's order dated 3/08/16 for BP and VS to be checked weekly and scheduled for 4:00 pm.. Review of Resident #6's March 2016 Treatment Administration Record (TAR) revealed: -An entry to "take BP and vitals weekly on Wednesday at 4:00 pm", and specified BP and pulse checks. -There was no documentation of pulse or BP checks for the month of March. -There was no documentation why BP and pulse	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 22 were not obtained. -There was no documentation that Resident #6's physician was notified BP and pulse checks were not obtained. Review of Resident #6's April 2016 TAR revealed: -An entry to "check BP weekly" and "check VS weekly", and scheduled to be checked at 4:00 pm on 4/06/16, 4/13/16, 4/20/16 and 4/27/16. BP and pulse checks were specified. -A BP result of 132/58 and pulse of 76 were recorded on 4/20/16. -There were no BP or VS results recorded for 4/6/16, 4/13/16 or 4/27/16. -There was no documentation why BP and pulse checks were not obtained on these dates. -There was no documentation that Resident #6's physician was notified BP and pulse checks were not obtained. Review of Resident #6's May 2016 TAR revealed: -An entry to "check BP weekly" and scheduled for Wednesdays at 4:00 pm. -The order for "weekly VS checks" was not transcribed onto the May TAR. -Resident #6's BP was scheduled to be checked on 5/04/16 but no results were recorded, and there was no documentation why the BP was not obtained. Interview on 5/03/16 at 3:50 pm with the Quality Control Aide (QCA) revealed: -Monthly BP and pulse checks were documented in a notebook located at the nursing station. -Documentation of BP and pulse checks to be done more frequently than monthly were documented on the resident's individual TAR. Review of a Vital Sign log book kept at the nursing station revealed monthly Vital Sign sheets	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 23 with resident names and columns for documenting weights, BP and pulse results. Interview on 5/03/16 at 4:20 pm with the Administrator revealed: -Monthly BP and pulse checks were documented in a notebook located at the nursing station. -Documentation of all other orders (i.e.: weekly, daily, etc.) were documented on the resident's individual TAR. -The Personal Care Aides (PCA) checked VS and weights. Third shift staff were responsible for weighing residents and second shift staff checked VS. A second interview with the Administrator on 5/4/16 at 9:00 am revealed: -She and QCA staff were to review TARs to assure weights and VS checks were done as ordered. -The facility's policy was to contact the resident's physician after 3 refusals of treatment. -The staff were to document refusals in the resident's record. -The Administrator clarified she "did not speak with staff specifically about Resident #6, but she just reminded them to document refusals". -She had not been reviewing TARs to check behind staff. Interview on 5/04/16 at 9:20 am with a Quality Control Aide (QCA) revealed: -PCA's were responsible for weighing residents and checking vitals. -The QCA and the Administrator were to check behind staff to assure the tasks were done. They were to check the TAR to assure staff documented weights, BP and pulse results and resident refusals. -The QCA had not been checking behind staff	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 24 and monitoring TAR to assure documentation of weights, BP and pulse checks. She was unable to give a reason as to why the TARs were not being audited. -She had not notified the physician when Resident #6 refused to be weighed. Interview on 5/04/16 at 2:45 pm with a PCA revealed: -She worked first shift most of the time, but had been helping out on the other shifts due to recent staffing issues. -PCA's were responsible for weighing residents and checking their BP and pulse. The results were to be logged into the black notebook (the TAR) on the treatment cart. -She checked the notebook (the TAR) at the start of her shift to see what resident orders were to be performed that shift. -She documented information on the TAR including refusals, and also reported to the MA if a resident refused. Interview on 5/04/16 at 4:00 pm with Resident #6 revealed: -Staff occasionally checked her blood pressure and pulse, but did not check her BP weekly or monthly. Interview on 5/5/16 at 9:00 am with Resident #6's NP revealed: -She had not been notified that Resident #6's BP checks were not being obtained as ordered. -She had asked for weekly BP and pulse checks so she could review them when she visited the facility. -There were "issues with no documentation of weights and BP" in several residents' records. A Plan of Protection was provided by the facility	D 276	See attached POC dated 6.14.16	

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D 276	Continued From page 25 on May 5, 2016: -Effective immediately the staff were to be retrained on the appropriate procedures for referral and follow-up and implementation of orders. -The Executive Director and/or the Quality Control Staff will review residents' records to ensure that the referral and follow-up is documented to meet the routine and acute health care needs of the residents. -The Executive Director and/or the Quality Control Staff shall randomly audit residents' records to ensure documention reflects referral and follow-up weekly for 4 weeks, then monthly there after. -Any staff found not following procedure will receive discipline actions to include retraining, write-up and/or termination. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 19, 2016.	D 276	See attached POC dated 6.14.16	
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	D 344		

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	HAL013044	A. BUILDING: _____ B. WING _____	R 05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 344	Continued From page 26 record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure orders were accurate for 1 of 3 residents observed during the medication pass (Resident #10) regarding medications on the FL2. The findings are: Review of Resident #10's current FL2 dated 3/29/16 revealed: -Diagnoses included cardiomyopathy, atrial fibrillation, depression, urinary retention and hypothyroidism. -Medication orders including citalopram 20mg 1 tablet twice daily (a medication used to treat depression), Oxybutynin 5mg 1 tablet twice daily (used to treat bladder spasms). A. Observation of the medication pass on 5/04/15 at 7:25 am revealed Resident #10 received duloxetine 30mg (a medication used to treat depression), Myrebetriq 25mg (used to treat bladder spasms), Spironolactone 25mg (a diuretic used to treat hypertension) and calcium with vitamin D 600/400mg (a vitamin supplement used to maintain bone density). Review of medications on hand revealed: -One bubble pack of duloxetine 30mg with instructions to give one capsule twice daily. -One bubble pack of Myrebetriq 25mg with instructions to give one tablet daily. -One bubble pack of Spironolactone 25mg with instructions to give one tablet three times daily. -One bubble pack of calcium with D 600/400mg with instructions to give one tablet twice daily.	D 344	DLL attached POC dated 6.14.16	

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D 344	Continued From page 27 Review of Resident #10's record revealed: -A physician's order dated 3/21/16 for calcium with D 600/400 1 tablet twice daily. -A physician's order dated 3/29/16 for Myrebetriq 25mg 1 tablet daily. -A physician's order dated 3/21/16 to discontinue citalopram and start duloxetine 20mg 1 capsule twice daily. -Subsequent physician orders dated 3/01/16 which included Spironolactone 25mg 1 tablet three times daily and Oxybutynin 5mg was discontinued 2/19/16 however the FL2 dated 3/29/16 included both Spironolactone and Oxybutynin. The March 2016 Medication Administration Record (MAR) revealed all order were transcribed and documented as administered as ordered. Review of the April 2016 Medication Administration Record (MAR)revealed: -An entry for calcium with D 600/400mg one tablet twice daily and documented as administered at 8:00 am and 8:00 pm from 4/01 through 4/30/16. -An entry for Myrebetriq 25mg one tablet once daily and documented as administered at 8:00 am from 4/01 through 4/30/16. -An entry for duloxetine 20mg one tablet twice daily and documented as administered at 8:00 am and 8:00 pm from 4/01 through 4/28/16. -An entry for duloxetine 30mg one tablet twice daily and documented as administered at 8:00 am and 8:00 pm from 4/29 through 4/30/16. -An entry for Spironolactone 25mg one tablet three times daily and documented as administered at 8:00 am, 2:00 pm and 8:00 pm from 4/01 through 4/30/16.	D 344	See attached POC dated 6-14-16	

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D 344	Continued From page 28 Review of the May 2016 MAR revealed: -An entry for calcium with D 600/400mg one tablet twice daily and documented as administered at 8:00 am and 8:00 pm from 5/01 through 5/04/16. -An entry for Myrebetriq 25mg one tablet once daily and documented as administered at 8:00 am from 5/01 through 5/01/16. -An entry for duloxetine 30mg one tablet twice daily and documented as administered at 8:00 am and 8:00 pm from 5/01 through 5/04/16. -An entry for Spironolactone 25mg one tablet three times daily and documented as administered at 8:00 am, 2:00 pm and 8:00 pm from 5/01 through 5/04/16. Interview with the Quality Control Aide (QCA) on 5/04/16 at 10:33 am revealed: -She usually faxed signed FL2s to the pharmacy to update the medications list. -She did not fax the FL2 dated 3/29/16 but did not know why. -She was not aware that the physician orders on the FL2 were the most up to date medication orders. -She did not prepare the FL2s, but knew that the FL2s were prepared and would sit in a file until the Nurse Practitioner (NP) came to the facility to sign them. -She did not review the FL2 the day the NP signed them to ensure accuracy of the FL2 compared with the most current orders. Interview with the QCA responsible for the FL2s on 5/04/16 at 4:09 pm revealed: -She prepared the FL2s as they became due and put them in files so they could be signed by the NP during the next visit. -She prepared the FL2s before the NP's visit according to what was listed on the current MARs	D 344	See attached POC dated 6.14.16	

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D 344	Continued From page 29 on the day she prepared them. -She did not go back and ensure any new orders were added, changes were made or discontinued medications were removed from the FL2 that was prepared in advanced. -She was unaware there were discrepancies on Resident #10's current May 2016 MAR as compared with the most current FL2. -She was unaware that she omitted the Spironolactone and the calcium with D from the new FL2 and thought she must have just over looked them. Interview with the Administrator on 5/04/16 at 10:39 revealed: -She was not aware there were discrepancies on the most current FL2 dated 3/29/16 as compared with the most current MAR. -She knew that the most recent FL2 must be accurate as it served as the most current medication list. -She expected that MAs would check for accuracy so the medications were correct and the medications listed on the FL2 were inclusive. Interview with the NP on 5/04/16 at 10:12 am revealed: -She intended for Resident #10 to be taking Spironolactone 25mg three times daily. -She intended for Resident #10 to be taking calcium with D 600/400 mg once daily. -She intended for Resident #10 to be taking duloxetine 30mg twice daily. -She was unsure about the Myrebetriq order. -She expected the facility staff check the current orders and the MARs to assure the FL2s were accurate. Interview with Resident #10's Urologist on 5/05/16 at 10:12 am revealed the urologist	D 344	See attached POC dated 6.14.16	

Amended

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D 344	Continued From page 30 intended for Resident #10 to be taking Myrebetriq 25mg daily and confirmed Resident #10 should not be taking Oxybutynin.	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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 8 sampled residents (Residents #2, #7 and #8) related to medications including Symbicort, ipratropium, coenzyme Q10, Amitiza, edecrin, Miralax, tramadol, lidoderm patch, multivitamin, potassium, Imdur and Tylenol not on hand or not ordered. The findings are:	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 31 A. Review of Resident #8's current FL2 dated 10/20/15 revealed: -The diagnosis included chronic obstructive pulmonary disease, dementia, schizo-affective disorder, hypertension, hypothyroidism, gastroesophageal reflux disease, osteoarthritis and constipation. -The medication orders included azithromycin 250mg 1 every 48 hours (an antibiotic used to treat and inhibit bacterial infections), albuterol/ipratropium 2.5-0.5mg/3ml solution 1 vial every 4 hours as needed for wheezing or shortness of breath and Symbicort 160/4.5 mcg/actuation - 2 puffs twice daily (a medication used to treat asthma). Review of Resident #8's Resident Register revealed an admission date of 8/25/14. 1. Review of the February 2016 Medication Administration Record (MAR) revealed: -An entry for Symbicort - use two puffs twice daily scheduled for 6:00 am and 8:00 pm. -The Symbicort was documented as administered every morning from 2/01-2/27/16 and every evening from 2/01-2/25/16. -The Symbicort was documented as "Med Not Given" at 6:00 am on 2/27/16 and 8:00 pm 2/26, 2/27, 2/28 and 2/29/26. Review of the March 2016 MAR revealed: -An entry for Symbicort 160-4.5mcg/act aerosol - use two puffs twice daily scheduled for 6:00 am and 8:00 pm. -The Symbicort was documented as "Med Not Given" at 6:00 am on 3/01/16 and 8:00 pm 3/01/16. -The Symbicort was documented as administered every morning and every evening from 3/02-3/31/16.	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 32 Interview with Resident #8's Responsible Party (RP) on 5/03/16 at 10:55 am revealed: -The RP was talking to Resident #8 on the phone and she heard Resident #8 wheezing and coughing over the phone on 2/29/16 and Resident #8 told the RP she was experiencing shortness of breath. -The RP asked Resident #8 if she was getting her Symbicort and Resident #8 told the RP she had not had the Symbicort inhaler for several days. -The RP inquired about the Symbicort inhaler with the Medication Aide (MA) on duty the morning of March 1, 2016 and the RP was told they had ordered it but it had not come in. -The RP was not informed that Resident #8 did not have Symbicort available. -The RP took Resident #8 to a local acute care clinic and Resident #8 was prescribed an antibiotic, an increase in prednisone and benzonatate capsules (a cough suppressant) on March 1, 2016. Interview with a MA on 5/3/16 at 4:30 pm revealed: -It was their policy to call the pharmacy if they ran out of medications and the pharmacy would call the back up pharmacy to supply them with any medications that they did not have. -They have had difficulty ordering and receiving medications since the facility switched to a new pharmacy. -It had been difficult to obtain the Symbicort inhaler for Resident #8 and thought that it may have been because the medication was expensive. Interview with the Quality Control Aide (QCA) on 5/03/16 at 4:38 pm revealed: -It was their policy to call the pharmacy if they ran	{D 358}	DOC attached POC dated 6.14.16	

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{D 358}	Continued From page 33 out of medications and the pharmacy would call the back up pharmacy to supply them with any medications that they did not have. -The MAs were all responsible for ordering medications when the supply got low. -The bubble packs have a row that is colored blue and when the medications get to the blue strip the MAs are to re-order the medications. -There was not a specific person or shift assigned to re-order medications. -If a medication did not come in, all the MAs were responsible to call the pharmacy and make sure that the medication was called in to the back up pharmacy. -She did remember when Resident #8 was out of Symbicort and did not know why it was not in the facility (whether the Symbicort was misplaced or if it ran out). -She did order it on 2/25/16, but was informed that it was too early for it to be refilled. -On 2/28/16 she did notify the Nurse Practitioner who visited the facility weekly that the facility could not obtain Symbicort due to insurance and was told Resident #8 should be "ok as long as she had the albuterol/ipratropium and is asymptomatic." -She did not write a discontinue or hold order for the Symbicort. -She did not notify the RP that Resident #8 was not receiving the Symbicort. -She would have called the RP if Resident #8 fell or 911 was called but would not call her if she had a cold or ran out of medication. -When she notified the Nurse Practitioner Resident #8 was not complaining of respiratory symptoms. Review of packing slips from the previously contracted pharmacy dated 2/15/16 revealed one Symbicort inhaler was sent to the facility on	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 34 2/15/16 which contained 120 doses which should have lasted one month. Interview with the Administrator on 5/04/16 at 1:27 pm revealed: -She was not aware that Resident #8 went several days without her Symbicort. -After having discussed it with the QCA the morning of 5/04/16 she understood that as long as Resident #8 had the albuterol/ipratropium available she would be ok. -She understood that Resident #8 did not have symptoms in late February/March 2016. -She expected the MAs would contact the NP if a resident was presenting with shortness of breath, wheezing or cough. -As a Registered Nurse she understood the difference between albuterol/ipratropium and Symbicort and knew one could not be substituted for the other. Interview with the facility's contracted Nurse Practitioner on 5/05/16 at 12:35 pm revealed: -She was aware the facility could not obtain the Symbicort but did not know why. -She was not told Resident #8 was presenting with shortness of breath, wheezing or cough. -She did instruct the facility to use the prn albuterol/ipratropium nebulizer if Resident #8 needed it, but did not intend this was to be used as a substitute for Symbicort. -She was not aware Resident #8 went to a local acute care clinic because she was experiencing shortness of breath, wheezing and cough. -She expected facility staff work with the RP to obtain the Symbicort. -She expected facility staff to notify her if Resident #8 was presenting with respiratory distress and she was not made aware or notified.	{D 358}	DOC Attached POC dated 6.14.16	

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{D 358}	Continued From page 35 Review of the February 2016 MAR revealed there were no administrations of the "as needed" albuterol/ipratropium nebulizer treatments. Review of the Physician's Progress Notes from an office visit with Resident #8's Pulmonologist dated 3/08/16 revealed: -"Her medical history is notable for rhinitis, mild bronchiectasis and more importantly a history of severe chronic persistent asthma which has intermittently required corticosteroid therapy at high doses." -Resident #8 was seen 3/08/16 because on 3/01/16 Resident #8 experienced an exacerbation of her asthma according to available medical records. -Resident #8 was out of her Symbicort for 5 days and "this lapse of steroid and long-acting bronchodilator coincided with the onset of a sinusitis-like infection". -Resident #8 was treated with an increase in prednisone and Levaquin. -Resident #8 had improved over the last week but still has a wheeze. -"Certainly the absence of her most needed asthma medication at the onset of illness only contributed to the severity of the episode." Review of Resident #8's record revealed: -Resident #8 had a follow-up visit with her pulmonologist on 3/22/16 and the benzonatate was refilled. -Resident #8 had a follow-up with her pulmonologist on 4/19/16. -A physician's order dated 4/19/16 for azithromycin 250mg 1 tablet everyday for 30 days (an increase from every other day to every day). -A physicians order dated 4/19/16 for ipratropium .02% nebulizer solution - take 2.5 mls by nebulizer four times a day.	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 36 -A physicians order dated 4/19/16 for prednisone 10mg one tablet daily for 30 days (a continued increase from 5mg to 10mg). Review of medications on hand on 5/03/16 at 11:11 am revealed: -One multidose inhaler of dispensed 4/04/16 with no doses remaining per the gauge on the container. -No azithromycin on medication cart. -There were two unopened packs of ipratropium .02% nebulizer solution dispensed 4/19/16 (a total of 60 vials) available on the medication cart. -One bubble pack of prednisone 10mg 1 tablet daily dispensed 4/20/16. -One unopened box of albuterol/ipratropium dispensed 4/19/16. -One unopened pack containing 5 vials of albuterol/ipratropium dispensed 4/18/16. Interview with Resident #8's Pulmonologist on 5/05/16 revealed: -Resident #8 had "pretty bad" asthma and in her case she required the Symbicort. -The Symbicort was the foundation of her pulmonary care. -In her case going 5 days without the Symbicort could have exacerbated her asthma symptoms. -She was taking azithromycin, prednisone, montelukast and Symbicort with the Symbicort being the number one priority. Telephone interview with Resident #8's RP on 5/04/16 at 2:53 pm revealed: -The facility never informed her that they could not obtain the Symbicort because it was too early per the insurance. -She expected the facility would call her if they could not obtain the Symbicort because she would have paid for the medication to assure that	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 37 Resident #8 took her Symbicort. -The albuterol/ipratropium can not be substituted for Symbicort. -The facility said they were getting the Symbicort but no one ever followed up with me and Resident #8 continued to decline. Interview with Resident #8 on 5/04/16 at 2:41 pm revealed: -The last of February 2016 Resident #8 was without Symbicort for approximately 5 days. -Over the last weekend of February 2016 her wheezing started to become worse, she started coughing more and Resident #8 found it difficult to breathe. -Resident #8's RP took her to a local acute care clinic and she was prescribed several medications. -Resident #8 did have albuterol/ipratropium via nebulizer that could be administered as needed but when Resident #8 was feeling sick she did not think to ask for it. -The facility staff knew that Resident #8 was coughing and wheezing badly, but no one offered her the prn nebulizer treatments. -She had not felt good and even now did not feel as good as she had before this sickness which started in late February 2016. 2. Review of Resident #8's Record revealed a physicians order dated 4/19/16 for ipratropium .02% nebulizer solution - take 2.5 mls by nebulizer four times a day. Review of the April 2016 Medication Administration Record (MAR) revealed there was no entry for ipratropium .02% nebulizer solution - take 2.5 mls by nebulizer four times a day. Review of the May 2016 MAR revealed there was	{D 358}	See attached POC dated 6-14-16	

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(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 358}	Continued From page 38 no entry for ipratropium .02% nebulizer solution - take 2.5 mls by nebulizer four times a day. Observation of medications on hand 5/05/16 revealed: -There were two unopened packs ipratropium .02% nebulizer solution dispensed on 4/19/16 (a total of 60 vials) available on the medication cart. Interview with a Medication Aide (MA) on 5/05/16 at 11:43 am revealed: -She knew that Resident #8 had albuterol/ipratropium nebulizer treatments ordered as needed. -She did not know there was an order for ipratropium to be given four times a day. -She did not know if there was a difference between albuterol/ipratropium nebulizer treatments and ipratropium nebulizer treatments. -She did know that "PRN" meant as needed and "QID" meant a medication was to be given four times a day. -She did not process the ipratropium nebulizer treatments order. -She did observe Resident #8 with a cough and congestion but did not report to the NP, did report the cough to the QCA (Quality Control Aide). Interview with QCA on 5/05/16 at 11:50 am revealed: -She knew that Resident #8 had albuterol/ipratropium nebulizer treatments ordered as needed. -She did not know there was an order for ipratropium to be given four times a day. -She did not know if there was a difference between albuterol/ipratropium nebulizer treatments and ipratropium nebulizer treatments. -She did know that "PRN" meant as needed and "QID" meant a medication was to be given four	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 39 times a day. -She did not process the ipratropium nebulizer treatments order. -She did not know who processed the order but staff had to have faxed it to the pharmacy because the medication was in the building. -She knew that the two medications had similar ingredients and had she known about the order for ipratropium to be given four times a day she would have called the physician for clarification. Interview with Resident #8's Pulmonologist on 5/05/16 at 1:20 pm revealed: -He wanted Resident #8 on nebulizer treatments four times a day along with the increase in prednisone and increase in frequency of the azithromycin to get her through this tough period. -If there was a discrepancy with a preexisting order and an order he wrote at an in office visit he expected the facility to call for clarification. -The facility did not call for clarification. Interview with Resident #8 on 5/04/16 at 2:41 pm revealed: -She had not had nebulizer treatments four times a day routinely. -There was a nebulizer on her small table next to her recliner. -She thought the nebulizer treatments were three times a day but did not know if they were supposed to be albuterol/ipratropium or ipratropium. -She had not felt good and even now did not feel as good as she had before this sickness which started in late February 2016. B. Review of Resident #2's current FL 2 dated 4/03/15 revealed: -Diagnoses included cerebral infarction with right	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 40 hemiparesis, diabetes, irritable bowel syndrome, hypertension, osteoarthritis and anxiety. -Medications included Coenzyme Q 10 50 mg daily (a vitamin supplement beneficial for heart health), Amitiza 24 mcg at bedtime (a laxative), Edecrin 50 mg every morning (a diuretic), Miralax 17 gm twice daily (a laxative), and Tramadol 50 mg every 4 hours as needed (prn) for pain (used to treat moderate to severe pain). Review of Resident #2's Resident Register revealed an admission date of 6/17/15. Review of Resident #2's record revealed: -Subsequent pre-printed physician's orders signed and dated 3/08/16 for Coenzyme Q10 50 mg daily, Amitiza 24 mcg twice daily, Miralax 17 gm twice daily, and Tramadol 50 mg every 4 hours prn for pain. -A physician's order dated 3/03/16 for Edecrin 50 mg every morning. -A new FL 2 signed and dated 5/05/16 for Coenzyme Q10 50 mg daily, Amitiza 24 mcg twice daily, Edecrin 50 mg every morning, Miralax 17 gm daily, and Tramadol 50 mg every 4 hours prn for pain. Review of Resident #2's February 2016 Medication Administration Record (MAR) revealed: -An entry for Coenzyme Q10 50 mg daily scheduled at 7:00 pm. It was documented as administered daily except for 5 days on 2/04, 2/05, 2/07, 2/08, and 2/10/16. The legend at the bottom of the MAR stated "med not given" but did not document the reason. -An entry for Amitiza 24 mcg twice daily scheduled at 8:00 am and 7:00 pm and documented as administered as ordered at 8:00 am and 7:00 pm from 2/01/16 to 2/29/16.	{D 358}	DEL attached POC dated 6.14.16	

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{D 358}	Continued From page 41 -An entry for Edecrin 50 mg every morning scheduled for 8:00 am and documented as administered as ordered at 8:00 am from 2/01/16 to 2/29/16. -An entry for Miralax 17 gm daily scheduled for 8:00 am and documented as administered daily except for 2 days on 2/18/16 and 2/20/16. The legend at the bottom of the MAR stated "med not given" but did not document the reason. -An entry for Tramadol 50 mg every 4 hours prn for pain. Tramadol 50 mg was documented as administered on 2/25/16 at 1:22 pm. Tramadol 150 mg (3 tablets) was documented as administered on 2/03/16 7:16 pm (and instead of initials, it had a # which the legend at the bottom of the MAR stated "see prn report". No documentation was visible on the "prn report".) Review of Resident #2's March 2016 MAR revealed: -An entry for Coenzyme Q10 50 mg daily scheduled at 7:00 pm and documented as administered daily from 3/01/16 to 3/31/16 except for 1 day on 3/07/16. There was no documentation why the medication was not administered. -An entry for Amitiza 24 mcg twice daily scheduled at 8:00 am and 7:00 pm and documented as administered as ordered at 8:00 am and 7:00 pm from 3/01/16 to 3/31/16 except for 2 days on 3/07/16 at 8:00 pm and 3/27/16 at 8 pm. There was no documentation why the medication was not administered. -An entry for Edecrin 50 mg every morning scheduled for 8:00 am and documented as administered as ordered at 8:00 am from 3/01/16 to 3/31/16. -An entry for Miralax 17 gm daily scheduled for 8:00 am and documented as administered daily from 3/01/16 to 3/31/16.	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 42 -An entry for Tramadol 50 mg every 4 hours pm for pain. Tramadol 50 mg was documented as administered on 3/16/16 at 7:00 am. Review of Resident #2's April 2016 MAR revealed: -An entry for Coenzyme Q10 50 mg daily scheduled at 7:00 pm and documented as administered daily from 4/01/16 to 4/30/16 except for 1 day on 4/09/16. There was no documentation why the medication was not administered. -An entry for Amitiza 24 mcg twice daily scheduled at 8:00 am and 7:00 pm and documented as administered as ordered at 8:00 am and 7:00 pm from 4/01/16 to 4/30/16 except for 1 days on 4/09/16 at 8:00 pm. There was no documentation why the medication was not administered. -A handwritten entry for Edecrin 50 mg every morning scheduled for 8:00 am and documented as administered daily at 8:00 am from 3/01/16 to 3/31/16 except for 4 days on 4/04/16, 4/10/16, 4/20/16 and 4/29/16. There was no documentation why the medication was not administered. -An entry for Miralax 17 gm daily and scheduled for 8:00 am. It was documented as administered daily from 4/01/16 to 4/31/16 except on 4/20/16 with no reason documented why the medication was not administered. There were 2 days with circled initials on 4/04/16 and 4/09/10 but no documentation medication was not administered. -An entry for Tramadol 50 mg every 4 hours prn for pain. Tramadol 50 mg was documented as administered on 4/02/16 but no time was specified. Review of Resident #2's May 2016 MAR on 5/03/16 revealed:	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 43 -An entry for Coenzyme Q10 50 mg daily scheduled at 7:00 pm and documented as administered on 5/01/16. There was no documentation why the medication was not administered on 5/02/16. -An entry for Amitiza 24 mcg twice daily scheduled at 8:00 am and 7:00 pm and documented as administered as ordered at 8:00 am and 7:00 pm from 5/01/16 to 5/03/16 except for 1 days on 5/02/16 at 8:00 pm. There was no documentation why the medication was not administered. -A handwritten entry for Edecrin 50 mg every morning scheduled for 8:00 am and documented as administered daily at 8:00 am from 5/01/16 to 5/03/16. -An entry for Miralax 17 gm daily scheduled for 8:00 am and documented as administered daily from 5/01/16 to 5/03/16. -An entry for Tramadol 50 mg every 4 hours prn for pain. There was no documented entries that Tramadol was administered from 5/01/16 to 5/03/16. Review of medications on hand for Resident #2 on 5/03/16 at 3:30 pm revealed: -Amitiza 24 mcg was not available for administration. -Tramadol 50 mg was not available for administration. There were no controlled medication count sheets on the cart for Tramadol for Resident #2. -All other scheduled medications for Resident #2 were available to be administered as ordered. Interview on 5/03/16 at 9:05 am with Resident #2 revealed: -The facility ran out of her medications "sometimes", but she had never experienced any problems from missing a dose. "It never last	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 44 long." -She expected the facility to administer her medications as ordered by her physician. Interview on 5/03/16 at 3:30 pm with a Medication Aide (MA) revealed: -When a medication ran out, the MAs were to call the resident's pharmacy. There was more than one pharmacy who supplied medications to the facility. -Normally medications were reordered when the medication card "order now" area was reached. -She "distinctly remembered (Resident #2's) Tramadol order was changed after a recent dental procedure so I did not reorder the medication". (The order was not changed). -We were to document on the back of the MARs when medications were not given. -She would contact the pharmacy for the Amitiza and Tramadol for Resident #2. -Resident #2's Edecrin was dispensed by a mail order company. Interview on 5/04/16 at 11:50 am with Resident #2's physician's office RN revealed: -There was no record in the office files that the facility had contacted Resident #2's physician regarding missed doses of any medications, especially Edecrin (4 doses in April) and Coenzyme Q10 (5 doses missed in February). -There was no documentation that the physician had been notified that Resident #2 received or needed Tramadol 150 mg on 2/03/16. -Resident #2 was last seen by the physician 4/01/16 and there was no documentation that any medications were changed. -The physician expected his orders to be followed. Interview on 5/04/16 at 12:15 pm with Resident	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 45 #2's pharmacy representative revealed: -Tramadol 50 mg was dispensed on 2/02/16 for 12 tablets. It was an active order in their system, but would need a "hard script" to refill it. -Coenzyme Q10 50 mg was dispensed on 2/04/16 for 30 tablets, and on 3/12/16 for 30 tablets. -Amitiza 24 mcg was dispensed on 3/30/16 for 60 tablets, and 5/03/16 for 60 tablets. -Edecrin 50 mg had not been dispensed by the pharmacy since 5/2014. Review on 5/05/16 at 10:20 am of Resident #2's Edecrin 50 mg bottle revealed it was a mail order medication dispensed on 3/09/16. Interview on 5/05/16 at 11:15 am with the Administrator revealed: -The Quality Control Aides (QCA) or the MAs were to process medication orders and medication refill requests. -The QCA or the MAs were to call the pharmacy to see when a medication would be delivered if there was the possibility it would need to come from the back-up pharmacy. -There was no process in place to check if a MA gave medications as ordered. -The MA should document on the backs of the MARs any time a medication was not administered. C. Review of Resident #7's current FL2 dated 3/01/16 revealed: -Diagnoses included coronary artery disease, dyslipidemia, diabetes, hypertension, chronic pain, depression, and benign prostatic hyperplasia. -Medications included Lidoderm patch (a pain patch), Multivitamin one daily (a vitamin supplement), KCL 20 meq twice daily (used to	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 46 treat or replace low potassium), Imdur 30 mg daily (used to prevent angina attacks), and Tylenol 500 mg three times daily (used to treat mild pain). Review of Resident #7's Resident Register revealed an admission date of 3/08/16. Review of Resident #7's record revealed: -A physician's office visit order dated 3/14/16 to "d/c (discontinue) Imdur 30 mg daily and start Imdur 60 mg daily". -A physician's order dated 3/18/61 to change Tylenol 500 mg to twice daily. -A Nurse Practitioner's (NP) order dated 3/22/16 for Lidoderm patch "on 12/off 12 hours". -A NP's order dated 3/22/16 for Doxycycline 100 mg twice daily after food for 10 days (an antibiotic used to treat infections). -A NP's order dated 3/22/16 "after antibiotic completion, begin Probiotic 1 capsule twice daily for 30 days". -A NP's order dated 4/27/16 to clarify Probiotic 1 capsule twice daily for 30 days. Review of Resident #7's physician's orders signed by the NP on 3/24/16 revealed: -A handwritten entry for Doxycyline 100 mg twice daily with food for 10 days. It was scheduled to start 3/24/16 and be administered at 6:30 am and 4:30 pm. -A handwritten entry for Probiotic capsule twice daily for 30 days after the antibiotic. It was scheduled to start 4/01/16 and be administered at 6:30 am and 4:30 pm. -A handwritten entry for Lidoderm patch on 12 hours and off 12 hours and scheduled for 6:00 am and 6:00 pm. No detail for which time was the application and which was the removal time.	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 47 Review of Resident #7's March 2016 Medication Administration Record (MAR) from 3/08/16 to 3/31/16 revealed: -A handwritten entry dated 3/10/16 for Tylenol 500 mg three times daily and scheduled for 8:00 am, 2:00 pm and 9:00 pm and marked to start 3/11/16. It was administered three times daily from 3/11/16 at 8:00 am until 3/16/16 except for 3 doses on 3/14/16 at 2:00 pm, 3/16/16 at 2:00 pm and 9:00 pm. There was no documentation why the doses were not administered as scheduled or ordered. -A handwritten entry for Tylenol 500 mg twice daily to start 3/18/16 scheduled for 6:00 am and 8:00 pm and documented as administered as ordered from 3/18/16 to 3/31/16. -A handwritten entry for multivitamin daily scheduled for 6:00 am and documented as administered daily from 3/17/16 to 3/31/16 except for circled initials on 3/17/16, 3/18/16, and 3/23/16. There were also circled initials on 3/09/16, 3/11/16, and 3/14/16. It was not documented as administered on 3/10/16, 3/12/16, 3/15/16 and 3/16/16. There was no documentation why the doses were not administered as scheduled. -A handwritten entry for KCL 20 meq twice daily scheduled for 8:00 am and 8:00 pm and documented as administered as ordered from 3/08/16 to 3/31/16 except for one missed 8:00 pm dose on 3/18/16, and 8 missed 8:00 am doses on 3/22/16, 3/24/16, 3/25/16, 3/26/16, and from 3/28/16 to 3/31/16. There was no documentation why the doses were not administered as scheduled. -A handwritten entry for Imdur 30 mg daily scheduled for 6:00 am and documented as administered daily from 3/08/16 to 3/31/16. There was no documentation that the Imdur order had been changed on 3/14/16.	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 48 -There was no entry for Imdur 60 mg daily starting after the 3/14/16 order. -A handwritten entry for Lidoderm patch on 12/off 12 hours and scheduled to start 3/23/16. It was scheduled to be applied at 6:00 am and removed at 6:00 pm. It was documented as applied and removed as ordered from 3/23/16 to 3/31/16. -A second handwritten entry for Lidoderm patch on 12/off 12 hours and scheduled for 6:00 am and 6:00 pm. It was not specified which of the 6:00 am and 6:00 pm times the medication was to be applied or removed. There were initialed entries at 6:00 am on 3/24/16, 3/25/16, and 3/27/16, and at 6:00 pm daily from 3/24/16 to 3/31/16. -Comparing the Lidoderm patch entries, Resident #7 received his patches as ordered from 3/24/16 to 3/31/16. -A handwritten entry for Doxycycline 100 mg after food for 10 days to start 3/23/16 scheduled at 6:00 am and 8:00 pm and documented as administered daily at 8:00 pm from 3/25/16 to 3/31/16. There was a circled initial on 3/23/16 at the 6:00 am dose, but no other entries (9 missed doses) from 3/24/16 to 3/31/16. -A second handwritten entry for Doxycycline 100 mg twice daily with food for 10 days to start 3/24/16 scheduled for 6:30 am and 4:30 pm and documented as administered daily at the 8:00 pm dose from 3/24/16 to 3/31/16. There were no 6:30 am doses (8 doses missed) documented as administered, and no documentation as to why they were not administered as ordered. -Comparing the two Doxycyline 100 mg entries, Resident #7 received the medication only daily in the evening from 3/23/16 to 3/31/16. -A handwritten entry for Probiotic capsule for 30 days twice daily after antibiotic, and scheduled to start on 4/02/16 and be administered at 6:00 am and 8:00 pm. It had lines through the entry with a	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 49 note to start on 4/2/16. -A second handwritten entry for Probiotic capsule for 30 days twice daily after antibiotic, scheduled to start on 4/01/16 and be administered at 6:30 am and 8:30 pm. It was documented as administered at 6:30 am on 3/24/16, 3/27/16 and at 4:30 pm on 3/25/16, 3/30/16, and 3/31/16. -Comparing the 2 Probiotic capsule entries, the medication was not to be started until the April 1, 2016 MAR. Review of Resident #7's April 2016 MAR revealed: -A pre-printed entry for Multivitamin one daily and scheduled for 6:00 am. It was documented as administered daily from 4/01/16 to 4/30/16 except for 2 missed doses on 4/10/16 and 4/24/16. There was no documentation for why the doses were not administered. -A pre-printed entry for KCL 20 meq twice a day scheduled for 6:00 am and 8:00 pm and documented as administered twice a day except for 1 missed 6:00 am dose on 4/24/16 and 3 missed 8:00 pm doses on 4/22/16, 4/23/16 and 4/24/16. There was no documentation for why the doses were not administered. -An handwritten entry for Lidoderm patch scheduled to be applied at 6:00 am and removed at 6:00 pm and documented as applied daily from 4/01/16 to 4/30/16 at 6:00 am except for 1 day on 4/04/16. It was documented as removed daily at 8:00 pm from 4/01/16 to 4/30/16 except for 5 days on 4/02/16, 4/03/16, 4/07/16, 4/15/16, and 4/20/16. There was no documentation for why the patch was not applied or removed as ordered. -There was no entry for Doxycycline 100 mg twice daily with food x 10 days which should end 4/02/16. It could not be determined if the medication was administered as ordered. -There was no entry for Probiotic capsule for 30	{D 358}	See attached POC dated 6.14.16	

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{D 358}	Continued From page 50 days twice daily after antibiotic, and scheduled to start on 4/01/16 or 4/02/16. It could not be determined if the medication was administered as ordered. -A pre-printed entry for Tylenol 500 mg twice daily and scheduled for 6:00 am and 8:00 pm. It was documented as administered as scheduled from 4/01/16 to 4/30/16 except for 1 missed 6:00 am dose on 4/24/16 and 3 missed 8:00 pm doses on 4/22/16, 4/23/16, and 4/24/16. There was no documentation for why the doses were not administered. Review of Resident #7's May 2016 MAR from 5/01/16 to 5/04/16 revealed: -A pre-printed entry for Imdur 30 mg daily and scheduled for 6:00 am. It had a line marked through the entry with a "d/c" (discontinued) handwritten on the MAR. It was documented as administered daily from 5/01/16 to 5/04/16 and the initials were marked through for the 5/01/16, 5/02/16, and 5/03/16 doses. -A handwritten entry for Imdur 60 mg daily and scheduled for 6:00 am. It was documented as administered as scheduled from 5/01/16 to 5/04/16. -A pre-printed entry for multivitamin daily and scheduled for 6:00 am. It was documented as administered as scheduled from 5/01/16 to 5/04/16. -A pre-printed entry for KCL 20 meq twice daily scheduled for administration at 6:00 am and 8:00 pm and documented as administered as scheduled from 5/01/16 to 5/04/16. -A handwritten entry for Lidoderm patch daily on for 12 hours and off for 12 hours scheduled to be applied at 6:00 am and removed at 6:00 pm. It was documented as administered as scheduled from 5/01/16 to 5/04/16. -A handwritten entry for Probiotic capsule twice	{D 358}	DLL attached POC dated 6-14-16	

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{D 358}	Continued From page 51 daily for 30 days to start 5/01/16 scheduled for 6:00 am and 8:00 pm and documented as administered as scheduled from 5/01/16 to 5/04/16. -A pre-printed entry for Tylenol 500 mg twice daily scheduled for 6:00 am and 8:00 pm and documented as administered as scheduled from 5/01/16 to 5/04/16. Review of medications on hand for Resident #7 on 5/04/16 at 4:05 pm revealed: -There was no Doxycycline on the cart (order expired 4/02/16). -All other scheduled medications for Resident #2 were available to be administered as ordered Interview on 5/04/16 at 9:52 am with Resident #7 revealed: -He was treated well by staff and thought they administered his medications as ordered by his physician. -He thought he had missed some doses of his Lasix, as he had swelling, but he really was not sure. (No doses were found to be missed after record review). Interview on 5/05/16 at 8:55 am with Resident #7's NP revealed: -She was not aware that Doxycyline had only been administered daily, and that the Probiotic was not administered as ordered after the antibiotic was completed. She had ordered the antibiotic twice a day as Resident #7 was a large man. She was aware the staff contacted her to clarify the Probiotic order. -Resident #7 needed his medications as they were ordered. -The facility staff did not notify her when medications were missed. -She was not aware the Imdur dose had been	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 52 changed, and thought it was probably changed by the cardiologist. -She expected orders to be followed as written. -She had suggested tothe facility administration a "second pair of eyes to look over orders" to ensure accuracy. Interview on 5/05/16 at 9:40 am with Resident #7's pharmacy representative revealed: -The Imdur order on file with the pharmacy was dated 3/08/16 for 30 mg daily. They did not have an order for a change in dose. Interview on 5/05/16 at 10:05 am with a Quality Control Aide (QCA) revealed: -The QCA and the MA reviewed and verified old and new MARS for accuracy. -The QCA and the MA reviewed orders when they came in. -She did not know why the Doxycycline was not administered twice daily as ordered. Interview on 5/05/16 at 10:20 am with a MA revealed: -When MARs were changed from one month to the next, the QCA or the Resident Care Coordinator (RCC) and the MA reviewed them for accuracy. Interview on 5/05/16 at 11:15 am with the Administrator revealed: -If the QCA was not available, the MA was to process medication orders. -The MA should look at old MARs to make sure the new MARs were correct. -There was no system in place to check if the MAs were administering medications as ordered. -If a medication was not given, the MA should document the reason on the back of the MAR.	{D 358}	See attached POC dated 6-14-16	

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{D 358}	Continued From page 53 Attempted interview on 5/05/16 at 12:15 pm with Resident #7's family member was not available. Resident #7 was admitted to the hospital on 5/04/16 and was unavailable for interview. The facility provided a Plan of Protection on 5/03/16: -Immediately, the Adminsitrator and Quality Control Aides will audit residents records to ensure residents are receiving medications as ordered by their physician. -Immediate staff training on medication administration regarding administering medications as ordered. -The Administrator and Quality Control Aides will audit random sampling of Medication Administration Records weekly for 4 weeks then monthly thereafter to ensure medications are being administered as ordered by the physicians. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED May 12, 2016.	{D 358}	See attached POC dated 6-14-16	
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; (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	D 367		

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D 367	Continued From page 54 A. Review of Resident #2's current FL 2 dated 4/03/15 revealed: -Diagnoses included cerebral infarction, diabetes, diverticulitis, osteo-arthritis, anxiety and irritable bowel syndrome. -Medications included Vitamin D2 50,000 units every month on the 15th (a supplement used for Vitamin D deficiency and to promote bone health). Review of Resident #2's Resident Register revealed an admission date of 6/17/15. Review of Resident #2's record revealed physician's orders signed and dated 3/08/16 for Vitamin D 50,000 units once a month. Review of Resident #2's March 2016 Medication Administration Record(MAR) revealed: -An entry for Vitamin D2 50,000 units every month and scheduled for 8:00 am. There were initialed entries dated 3/01, 3/02, 3/03, 3/04, and 3/05 that had been crossed out. There were lines across the documentation boxes for the dates from 3/06 to 3/09 and from 3/11 to 3/27. The boxes for 3/28, 3/29, 3/30, and 3/31 were blank. -Vitamin D2 50,000 units was documented as administered on 3/10/16 at 8:00 am. Review of Resident #2's April 2016 MAR revealed: -An entry for Vitamin D2 50,000 units every month and scheduled for 8:00 am. There were lines across the documentation boxes for the dates 4/01, from 4/08 to 4/14, and from 4/16 to 4/30. -Vitamin D2 50,000 units was documented as administered at 8:00 am on 4/02, 4/03, 4/05, 4/06, 4/07, and 4/15. The initialed entry on 4/04	D 367	See attached POC dated 6-14-16	

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D 367	Continued From page 55 was circled as not given, however there was no documentation on the back of the MAR for the reason the medication was not given. There were lines across the documentation boxes for the dates from 4/08 to 4/14 and from 4/16 to 4/30. Review of Resident #2's May 2016 MAR on 5/03/16 at 3:15 pm revealed: -An entry for Vitamin D2 50,000 units every month and scheduled for 8:00 am. A box was handwritten around the 5/15/16 date. -Vitamin D2 50,000 units was documented as administered daily at 8:00 am on 5/01, 5/02, and 5/03/16. Review of Resident #2's May 2016 MAR on 5/03/16 at 3:30 pm revealed: -The Vitamin D2 50,000 units initialed entries at 8:00 am on 5/01, 5/02, and 5/03 had been crossed out with a line. There were also 2 long lines across the dates from 5/01/06 to 5/14/16 and from 5/16/16 to 5/31/16, allowing for a 5/15/16 scheduled dose. Interview on 5/03/16 at 3:30 pm with a Medication Aide (MA) revealed: -She had not administered the Vitamin D2 to Resident #2 this week as it was a monthly medication. -The initialed entries on Resident #2's MAR for Vitamin D2 for 5/01, 5/02, and 5/03 were made by her. She had not looked closely at the MAR when signing the medications she had administered. -Resident #2's Vitamin D2 was scheduled to be administered on 5/15/16 at 8:00 am. -"We were told not to circle items that we initialed in error, but to cross or mark through our initials." -Staff were to document on the back of the MARs when an error was made in signing out medication administration.	D 367	See attached POC dated 6.14.16	

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D 367	Continued From page 56 Interview on 5/04/16 at 1:00 pm with Resident #2 revealed: -She knew what medications she was ordered to receive. -She was administered Vitamin D2 once a month on various days, "but usually in the middle of the month". -She expected the staff to administer her medications as ordered by her physician. Interview of 5/05/16 at 10:00 am with the facility's contract pharmacy representative revealed: -The MARs were printed by the contract pharmacy for the facility. -The pharmacy entered medication orders onto the MARs for the facility. -The pharmacy did not know what day of the month that Resident #2 was to be administered Vitamin D2 50,000 units, so they did not mark the MAR for one specific date. The facility should contact the pharmacy if a specific date was selected for administration. -The pharmacy only dispensed one Vitamin D2 dose per month for Resident #2. Refer to interview on 5/05/16 at 11:15 am with the Executive Director. B. Review of Resident #3's current FL 2 dated 8/26/15 revealed: -Diagnoses included osteoarthros (osteoarthritis), congestive heart failure, muscle weakness, and hypertension. -Medications included Methotrexate 20 mg every Thursday (used to treat rheumatoid arthritis). Review of Resident #3's Resident Register revealed an admission date of 8/21/15.	D 367	See attached POC dated 6-14-16	

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D 367	Continued From page 57 Review of Resident #3's March 2016 Medication Administration Record (MAR) revealed: -An entry for Methotrexate 20 mg every week at 8:00 am on Thursday. -Methotrexate 20 mg was documented as administered daily from 3/01 to 3/09, then weekly on Thursdays on 3/10, 3/17, 3/24, and 3/31/16. There were initialed entries on 3/04 and 3/07 that had a line crossed through the initials, but there was no documention of the reason. There were boxes with x's on days that were not Thursdays from 3/11 to 3/30/16. -Methotrexate 20 mg was documented as administered on Thursdays in March on 3/03, 3/10, 3/17, 3/24, and 3/31/16. Review of Resident #3's April 2016 MAR revealed: -An entry for Methotrexate 20 mg every week at 8:00 am on Thursday. -Methotrexate 20 mg was documented as administered as ordered on Thursdays at 8:00 am on 4/07, 4/14, 4/21, and 4/28/16. Review of Resident #3's May 2016 MAR on 5/04/16 revealed: -An entry for Methotrexate 20 mg every week at 8:00 am on Thursday. -Methotrexate 20mg had not been documented as administered this month as the dose was not due until 5/05/16. Interview on 5/03/16 at 9:45 am with Resident #3 revealed: -He was "not sure exactly" what medications he was ordered by his physician but expected the facility to administer his medications as ordered. Interview on 5/03/16 with Resident #3's Nurse Practitioner (NP) revealed:	D 367	See attached POC dated 6/14/16	

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D 367	Continued From page 58 -She expected orders to be followed as written. -She "had suggested" to the facility administration "that a second pair of eyes look over the MARs" to ensure accuracy, as she was seeing errors. Interview of 5/05/16 at 10:00 am with the facility's contract pharmacy representative revealed: -The MARs were printed by the contract pharmacy for the facility. -The pharmacy entered medication orders onto the MARs for the facility. -Resident #3's physician's order for Methotrexate 20 mg every week at 8:00 am on Thursday was dispensed as ordered. -The facility had not requested Methotrexate refills earlier than when it was due. Interview on 5/05/16 with Resident #3's family was not available. Refer to interview on 5/05/16 at 11:15 am with the Executive Director. C. 1. Review of Resident #5's FL2 dated 03/18/16 revealed: -Diagnoses included Parkinson's disease, sciatica, hypothyroid, and benign prostatic hyperplasia. -No indication that Resident #5 was confused. -Medication orders included Gabapentin 200mg three times a day (used to treat seizures and pain). Review of Resident #5's Resident Register revealed an admission date of 04/07/16. Review of a hospital discharge summary dated 05/02/16 revealed an order for Gabapentin 300mg take one capsule at noon and two capsules at 7:00pm.	D 367	See attached POC dated 6.14.16	

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D 367	Continued From page 59 Review of Resident #5's May 2016 MAR revealed: -A handwritten entry for Gabapentin 300mg take 1 at noon only. -Times written for Gabapentin to be administered were at 12:00pm and 7:00pm. -There were initials on 05/03/16 that Gabapentin had been administered at 12:00pm and 7:00pm. Review on 05/04/16 of medications available for Resident #5 revealed Gabapentin 300mg was available for 12:00 pm and 7:00 pm doses, packaged by the pharmacy with a label for directions to administer one tablet at 12:00 pm and 2 tablets at 7:00 pm. Interview with a Medication Aide (MA) on 05/05/16 at 8:55am revealed: -She referred to the MARs when administering medications. -She administered the Gabapentin to Resident #5 on 05/03/16 at 7:00pm. -She was unaware the entry transcribed on the May 2016 MAR did not have an entry for administering the Gabapentin at 7:00pm. -The Quality Control Aide (QCA) had completed the May 2016 MAR when Resident #5 returned from the hospital on 05/02/16. Interview with the QCA on 05/04/16 at 1:35pm revealed: -She transcribed orders to the May 2016 MAR upon Resident #3's return to the facility on 05/02/16. -She was unaware she had not completed the entry on the May 2016 MAR for the Gabapentin 300mg two tablets to be administered at 7:00pm. -She knew Resident #3 received Gabapentin 300mg one pill at 12:00 pm and two pills at 7:00pm prior to his hospitalization.	D 367	See attached POC dated 6.14.16	

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D 367	Continued From page 60 -"I should have made a separate entry for the 7:00pm dose." Interview with a Nurse Practitioner on 05/05/16 at 10:45 am revealed: -Today was the first time she had seen Resident #5. -It was very important for Resident #5 to take his medications appropriately and on time due to the Parkinson's disease symptoms. -Resident #5 had informed her this morning that he was having a lot of pain and needed his pain medications. Interview with the Executive Director on 05/05/16 at 11:35 am revealed: -The MAs were responsible for transcribing new medication orders onto residents' MARs. -She was unaware the transcribing of the order for Resident #5's Gabapentin on 05/02/16 was incomplete. -The facility did not have a policy of having two persons to review medications transcribed for MARs. Refer to interview on 5/05/16 at 11:15 am with the Executive Director. 2. Review of Resident #5's FL2 dated 03/18/16 revealed an order for Hydrocodone/APAP 7.5/325 one every 8 hours as needed (used for pain). Review of Resident #5's May 2016 MAR on 05/04/16 revealed: -An entry for Hydrocodone 7.5mg-325mg take one by mouth every 4 hours prn (as needed). -There were three sets of staff initials on 05/03/16 that Hydrocodone had been administered. -One of the entries included a time of 4:54pm. -There were no entries on the nurse's medication	D 367	DEL attached POC dated 6.14.16	

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D 367	Continued From page 61 notes for May 2016 of the hydrocodone being administered, the reason, and the results/response. Review of Resident #5's May 2016 MARs on 05/05/16 revealed: -Staff initials that Hydrocodone 7.5-325mg take one by mouth every 4 hours prn (as needed) had been administered four times on 05/03/16, four times on 05/04/16, and 4 times on 05/05/16. -Entries on the nurse's medication notes for May 2016 of the hydrocodone being administered, the reason (pain), and the results/response were documented for 05/04/16 at 12:25pm, 05/03/16 at 9:00pm, 05/04/16 at 6:00am, 05/04/16 at 8:30pm, 05/05/16 at 1:45pm, and 05/05/16 at 6:00am, -All of the entries, except the first one, were entered by the same MA. -The resident's responses to all entries were documented as "good". Interview with a MA on 05/05/16 at 9:45 am revealed: -Resident #5 requested pain medication frequently. -It was important the times be documented so the next staff person would know when Resident #5 had pain medication. -The MAs were to document with their initials on the front of the MAR when administering a medication ordered as needed. -They were to then document on the Nurse's Medication Notes section of the MAR the medication that was administered, the time, why the resident received the medication, or the results. Interview with the MA on 05/05/16 at 11:43 am revealed: -She observed on 05/05/16 Resident #5's May	D 367	See attached POC dated 6.14.16	

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D 367	Continued From page 62 2016 MAR had no documentation on the Nurse's Medication Notes section as to the reason, times, and effects of the hydrocodone administered by the MAs. -She was unaware documentation had been entered after 05/04/16 for 05/03/16 and 05/04/16. -The MA may have entered the documentation after the Executive Director had a meeting on 05/04/16 with all of the MA's about documentation. Interview with the Executive Director on 05/05/16 at 11:40 am revealed: -The MAs were to document on the MAR at the time medication was administered. -If a medication was administered that was ordered as needed, they were to document on the back page of the MAR what they administered, the time administered, why they gave it, and then go back within an hour and document the effects of the medication. -She had a meeting on 05/04/16 with all of the MAs and told them to be sure to document on the back of the MAR. -Staff were to refer to the MAR to see when medications administered as needed are given so they will know when they may give the next dose, if requested by the resident. Refer to interview on 5/05/16 at 11:15 am with the Executive Director. Interview on 5/05/16 at 11:15 am with the Executive Director revealed: -The was no system in place to check that MA's were administering and documenting medications as ordered. -The MAs were to circle their initials on the MARs if they errored and signed a medication as administered that they did not administer. The	D 367	See attached POC dated 6.14.16	

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D 367	Continued From page 63 MAs were to document the reason for circling their initials on the backs of the MARs.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to assure proper procedures for self-administration of medications for 2 of 3 sampled residents related to properly labeled medications for self-administration and competency assessment by the facility to self-administer medications (Resident #5), and failure to obtain a physician's order for self-administration of medications (Resident #8). The findings are: A. Review of Resident #5's FL2 dated 03/18/16 revealed:	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 64 -Diagnoses included Parkinson's disease, sciatica, hypothyroid, and benign prostatic hyperplasia. -No indication that Resident #5 was confused. -Medication orders included: -Alprazolam 0.5mg twice a day (used to treat anxiety and panic disorder). -Carbidopa Levopylendo 325/150/200 six times a day at 2:00 am, 5:00 am, 8:00 am, 11:00 am, 2:00 pm, and 5:00 pm (used to treat Parkinson's disease symptoms), including encephalitis (swelling of the brain, tremors, and stiffness). -Diclofenac 100mg daily (used to treat pain). -Gabapentin 200mg three times a day (used to treat seizures and pain). -Hydrocodone/APAP 7.5/325 one every 8 hours as needed (used for pain). -Ropinirole 1mg four times a day (used to treat Parkinson's disease). -Sertraline 100mg at bedtime (used to treat depression and anxiety disorders). Review of Resident #5's Resident Register revealed an admission date of 04/07/16. Review of Resident #5's record revealed: -There was an unsigned physician's letter dated 03/29/16 that stated resident "is able to self administer his own medications. Please contact me with any questions or concerns." -There was no assessment documented by the facility that Resident #5 had been assessed for his ability to self-administer medications. -Resident #5 was seen by the facility's physician on 04/21/16. -There was a physician's order dated 04/21/16 to "Please administer patient's meds (Discontinue order for patient to self admin)." Review of a physician's visit summary dated	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 65 4/21/16 revealed: -The resident's advanced Parkinson's disease was maintained on multi-day-dosing, short-acting Sinemet (Carbidopa/Levapylendo) and Requip (Ropinirole). -The resident experienced multiple episodes of prominent dyskinesia (difficulty in performing voluntary movements) and Akathesia (restlessness and being in constant motion) during the day. -The physician ordered a Duragesic patch 25mg per hour for long-acting pain control. -Hydrocodone/APAP 7.5/325 was to continue 4 times a day (scheduled) with instructions to hold if the patient became drowsy. Review of a staff progress note dated 04/25/16 revealed: -Resident #5 was found in his room "in a catatonic state, not talking (light whisper)". -Resident #5 was transferred to the hospital for evaluation. Review of a hospital discharge summary revealed: -Resident #5 was admitted to the hospital on 04/25/16 and returned to the facility on 05/02/16. -Resident #5 was admitted secondary to acute encephalopathy, likely from recent initiation of a Fentanyl patch. -The encephalopathy resolved fairly quickly. -"With the patient's Parkinson's, too high dosing of narcotics have easily caused altered mental status." Interview with Resident #5 on 05/04/16 at 3:35 pm revealed: -When he was admitted, he wanted to self-administer his medications because he was concerned he would not receive his medications	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 66 on time if the facility administered his medications. -His family member had been preparing his medications for him for the past two years. -"My medicine has to be taken on time." -His family member lived 2 hours away and would provide him with "several weeks" of medication to keep in his locked closet. -When he was admitted, his family member was getting his medications filled and packaged the medications in plastic bags with the day and time the medication was to be taken. -All tablets that were to be taken at the same time were in the same plastic bag. -When he saw the doctor at the facility, it was recommended that he let staff give his medications so they would know how his medications were being administered. -He found a bag of medications in his closet when he returned from the hospital a few days ago. -The bag he found was "my backup bag" that my family member kept for me at home in case I ran out of a medicine. -"Do you want to see them?" Observation on 05/04/16 at 3:40 pm revealed: -Resident #5 unlocked his closet located beside his bed with a key, removed a briefcase from the closet, entered a combination to unlock the briefcase, and showed the surveyor a large plastic bag with medications packaged as follows: -A large plastic sealable bag with 5 smaller plastic sealable bags labeled Monday, Tuesday, Wednesday, Thursday, and a second bag labeled Thursday. -Each bag labeled with a day of the week had with seven smaller individual bags labeled 4:30 am, 7:00am, 9:30 am, 12:00 pm, 2:30 pm, 5:00 pm, and 7:00 pm. -The bags labeled Monday, Tuesday,	D 375	DOC attached POC dated 6.14.16	

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D 375	Continued From page 67 Wednesday, and Thursday each contained 6 oval rose colored tablets, 4 oblong white tablets, 1 round pink tablets, 3 round pink tablets, 1 yellow oval tablets, 2 small pink oval tablets, 3 oval yellow capsules, 1 round white tablet, and 1 green/yellow capsule. -A second bag labeled Thursday contained one rose colored tablet and one round pink tablet . -The medications were not labeled with the name of the resident, the name of the medications, nor instructions for administering the medications. Further interview with Resident #5 on 05/04/16 at 3:43 pm revealed: -"I guess I should give these to the staff. I just found them this week." -Resident #3 stated he took his medications on the days and times written on the bags when he was self-administering his medications. -He denied taking any additional pain medication when he was self-administering his medications. Observation on 05/04/16 at 3:47 pm of Resident #5 speaking to a MA revealed: -Resident #5 gave the bags of medication to a MA at the nurses station on 3rd floor. -"I found these in my room a few days ago after I got back from the hospital." Observation on 05/05/16 at 9:15 am revealed: -Resident #5 was administered medication by a MA. -Resident #5 told the MA he sometimes had problems swallowing and needed to take his medications with lukewarm water instead of cold water to help with his swallowing. -He requested the MA make a notation on his record to alert staff to give his medications with lukewarm water.	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 68 Interview with a family member on 05/05/16 at 1:05 pm revealed: -Resident #5 had been self-administering his medications prior to admission to the facility with the assistance of the family member. -The family member packaged Resident #5's medications in plastic bags by day and time that the medication was to be taken. -The family member had concerns about Resident #5 self-administering his medications because of his shaking and he would, at times, not get all of his medication because he would drop the tablets. -The resident had insisted on self-administering his medications when he was admitted to the facility because he was concerned he would not get his medications on time. -The resident was used to the regimented times to take his medications. -The family member provided Resident #5 with three weeks supply of medications on 04/21/16. -The family member preferred the facility administer Resident #5's medications, but the adjustment was difficult for Resident #5. -He was unaware Resident #5 still had medications locked in his room. -"He should not have medications in his room now." -Resident #5 experienced "tremendous amounts of pain, including back pain." -"His pain is real and his need for pain medication is real." -Resident #5 previously saw a pain specialist and he would like to discuss this with the physician. Interview with a Quality Control Supervisor (QCS) on 05/04/16 at 8:45 am revealed: -She was the QCS for the 3rd floor unit. -Resident #5's family member had been "setting up" Resident #5's medications prior to admission	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 69 for the resident to take at scheduled times during the day. -The family member, upon admission on 04/07/16, provided to the facility a list of medications and times the resident self-administered them. -The listed medications and times to be taken included Stalevo (4:30am, 7:00am, 9:30am, 12:00pm, 2:30pm, and 5:00pm), Diclofenac 100mg (4:30am), Zoloft 100mg (7:00am), Ropinerole (7:00am, 12:00pm, 5:00pm), Gabapentin 300mg take 1 at 12pm and 2 at 7pm, Flomax (7:00pm), Norco 7.5mg scheduled (4:30am, 9:30am, 2:30pm, 7:00pm), Amitiza (9:30am and 2:30pm), Oxybutynin 5mg (7pm). -The family member had medications in plastic bags for each day with individual tablets in smaller packets with the times they were to be taken. -When Resident #5 was admitted, the MCS discussed with the family member and resident that staff could administer his medication. -"The family member and the resident kept going back and forth, changing their mind about him giving his own meds or having us give it." -Resident #5 kept the medications in a locked closet in his room. -Staff had not been monitoring if he had been taking his medications as prescribed when he was self-medicating. -She thought he may have not been taking his medications as prescribed. Second interview with the QCS on 05/04/16 at 1:35 pm revealed: -Resident #5 was admitted with an order from his physician that he could self-medicate. -Resident #5 wanted to self-medicate and the family member did not want him to. -There was no assessment done by staff to see if	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 70 he could self-medicate "because he had all of his medications with him and his family member had already prepared them." -She discussed with the family member what medications the resident was taking and referred to the "schedule" provided by the family member. -On 04/21/16, the facility's physician assessed Resident #5 and ordered for staff to administer his medications. -The physician "readjusted" his medications, including adding a Fentanyl patch for pain management. -On 04/21/16, she asked the resident to give her any medications he had in his room and he told her "he was done with all of his medicines." -Resident #5 kept the medications in a locked closet in a locked box, but refused to let staff check his closet for medications. -When Resident #5 was discharged to the hospital on 4/25/16, she requested the key to his closet to check for medications and he refused. Interview with a Nurse Practitioner on 05/05/16 at 10:45 am revealed: -Today was the first time she had seen Resident #5. -She discussed with the resident the medications he returned to the staff on 05/04/16. -Resident #5 stated he took his medications at the times indicated and did not take additional pain medication when he was self-medicating. -It was very important for Resident #5 to take his medications appropriately and on time due to the Parkinson's disease symptoms. -Resident #5 needed to be sitting up to take his medications due to swallowing difficulties. -She could not determine if his hospitalization was impacted by the fact that he was self-administering his medications, because additional pain medication had been ordered on	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 71 04/21/16. Interview with Administrator on 05/04/16 at 10:05 am revealed: -She was unaware there had not been a self-administer medications assessment completed by the facility at the time Resident #5 was admitted. -The facility's policy was all medications were to be labeled with the resident's name, name of the medication, and instructions for taking the medications. -If medications were ordered from their pharmacy, they were labeled by the pharmacy. -She had discussed with the family member that the facility could administer Resident #5's medication, but the resident wanted to self-administer his medications. -She was unaware "until later" that Resident #5's medications were not labeled. Refer to interview with a MA on 05/05/16 at 3:00 pm. Refer to interview with Administrator on 05/04/16 at 10:05 am. B. Review of Resident #9's current FL2 dated 11/12/15 revealed: -Diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. -An order for Nexium 20mg DR take two daily (self-medicate). Review of Resident #9's Resident Register revealed an admission date of 11/26/14. Review of Resident #9's record revealed: -A prescription signed by the physician on	D 375	See attached POC dated 6.14.16	

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D 375	Continued From page 72 01/11/16 for an order "Patient may self medicate with Levothyroxine 75 mg take one po (by mouth) before breakfast". -A Monthly Compliance Checklist for Self-Administering Resident completed by the 3rd floor MA/SIC on 02/03/16 for Resident #9. -Resident #9 was assessed for self administration of Nexium 20mg take 2 daily and Synthroid (Levothyroxine) 75mg take 1 before breakfast. Interview with Resident #9 on 05/04/16 at 5:43 pm revealed: -"I am not taking Nexium right now. I'm taking Prilosec." -She took one tablet every morning. -Resident stated her physician gave her samples of Prilosec to take instead of Nexium. -Resident had boxes of individual samples of Prilosec 20. 6mg acid reducer tablets without a label or the resident's name on the box. -She usually asked the MA to order medications for her when she needed them. Review of Resident #9's current May 2016 Medication Administration Record (MAR) revealed there was no entry for Prilosec. Review of Resident #9's record revealed no physician's order for Prilosec. Interview with a MA on 05/05/16 at 2:55 pm revealed: -She was unaware Resident #9 was no longer taking Nexium. -The current MAR had listed Resident #9 was taking Nexium. -Resident #9 did not have a physician's order to take Prilosec. -She was unaware Resident #9 had Prilosec samples in her room.	D 375	All attached POC dated 6.14.16	

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D 375	Continued From page 73 -Resident #9 drove herself to her physician appointments and was to have taken a form from the facility for the physician to write any new medication orders for the facility. -She would re-educate Resident #9 about the need to inform the facility when she had a physician's appointment and when there were changes in her medications that she self-administered. Refer to interview with a MA on 05/05/16 at 3:00 pm. Refer to interview with Administrator on 05/04/16 at 10:05 am. Interview with a MA on 05/05/16 at 3:00 pm revealed: -The Quality Control Staff for third floor was responsible for completing the self-medication assessments for residents with orders to self-medicate. -She did not know how often the assessments were to be completed. -She did not know why Resident #8's had not been updated since 02/03/16. Interview with Administrator on 05/04/16 at 10:05 am revealed: -The QCS for third floor was responsible for completing monthly self-assessments for any resident in the facility that had an order to self-medicate. -The assessment was to be on admission, or at the time of the order, and monthly after the initial assessment. -The QCA was to review each medication with the resident and ensure the resident knew what the medication was, why they were taking it, and when they were to take it.	D 375	See attached POC dated 6.14.16	

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(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 375	Continued From page 74 The facility provided a Plan of Protection on 05/05/16: -The Executive Director or Medication Aide Supervisors will review all self-administration to ensure residents who self-administer medication have specific instructions for administration of prescription medications printed on medication labels and check the Individual Medication Administration Records (orders). -The Executive Director and Medication Aide Supervisors will re-educate residents to make sure staff know of changes to their medications. -During monthly compliance of self administration, the Executive Director or Quality Control staff will ensure residents have specific instructions for administration of prescription medications printed on a medication label. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2016.	D 375	See attached POC dated 6.14.16	
{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	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	R 05/05/2016

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(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
{D912}	Continued From page 75 federal and state laws and rules and regulations as they relate to medication administration and clarification of medication orders. The findings are: A. Based on observation, record reviews, and interviews, the facility failed to ensure physician notification for 2 of 8 sampled residents (Residents #1 and #6) with physician's orders for thromboembolism-deterrent (TED) hose and weights. [Refer to tag 273, 10 A NCAC 13 F .0902 (b) (Unabated Type B Violation).] B. Based on observations, record reviews and interviews, the facility failed to ensure physician's orders were implemented for 3 of 8 sampled residents (Residents #3, #6, and #7) regarding weights and vital signs. [Refer to Tag 276, 10 A NCAC 13 F .0902(c)(3-4) (Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 4 of 8 sampled residents (Residents #1, #2, #7 and #8) related to medications including Symbicort, ipratropium, Coenzyme Q10, Amitiza, Edecrin, Miralax, Tramadol, Lidoderm patch, multivitamin, KCL, Imdur and Tylenol not on hand or not ordered. [Refer to Tag 358, 10 A NCAC 13F .1004(a) (Type A2 Violation).] D. Based on observations, interviews, and record review, the facility failed to assure proper procedures for self-administration of medications for 2 of 3 sampled residents related to properly labeled medications for self-administration and competency assessment by the facility to self-administer medications (Resident #5), and	{D912}	See attached POC dated 6.14.16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	R 05/05/2016

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{D912}	Continued From page 76 failure to obtain a physician's order for self-administration of medications (Resident #8). [Refer to Tag 375, 10 A NCAC 13 F .1005(A) (Type B Violation).]	{D912}	See attached POC dated 6.14.16	

The Living Center of Concord
HAL-013-044
Plan of Correction
DHSR Survey 05/05/2016

10 NCAC 13F .0902 (b) Health Care

(a) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents

Plan of Correction

Staff retrained on following up on physician orders and documentation of implementation of orders.	06/01/2016
Application and Removal of Ted Hose were added to the treatment record for SIC/MA to document that residents are wearing ted hose per physician order.	05/06/2016
Resident #1 is wearing ted hose as ordered.	05/06/2016
Resident #6 is being weighed per order and documentation of weights reflect weights and follow up.	05/06/2016
A list of daily, weekly, monthly weights was made available for QC staff to assure staff are documenting and following up in weights.	06/01/2016

Monitoring System

Random chart audit monthly by the ED/ Quality Assurance/Designee to assure referral and follow up is done in a timely and accurate manner.	06/01/2016
QC/SIC Staff will initial daily that weights are being done and recorded per physician orders as well as documentation of follow up.	06/01/2016
Any staff identified as not following procedures for referral an follow up will receive disciplinary action to include, retraining, write up, suspension up to termination.	06/01/2016

The Living Center of Concord
HAL-013-044
Plan of Correction
DHSR Survey 05/05/2016

10 NCAC 13F .0902 (c)(3-4) Health Care

(a) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional ; (4) implementation of procedures, treatments, or orders specified in Subparagraph (c)(3) of this Rule.

Plan of Correction

Implementation of Weight and Vital Sign Notebook put in place for monthly vitals. Daily weight forms, daily vital forms, weekly weight forms, and weekly vitals put in place to ensure vitals and weights are done according to physicians' orders.	06/01/2016
Staff retrained on implementation and documentation of written procedures, treatments or orders from a physician or other licensed health professional .	06/01/2016
Orders reviewed to assure that parameters are in place in to notify the Physician.	05/06/2016
Vital signs were assigned to the Medication aides to obtain and document.	06/01/2016
Resident # 3 weights and vitals are being obtained, recorded and reported to physician as ordered.	05/06/2016
Resident #7 weights and vitals are being obtained, recorded and reported to physician as ordered.	05/06/2016
Resident #6 vitals are being obtained, recorded and reported to the physician as ordered.	05/06/2016

Monitoring System

Random chart audit monthly by the ED/ Quality Assurance/Designee to assure referral and follow up is done in a timely and accurate manner.	06/01/2016
QC/SIC Staff will initial daily that weights are being done and recorded per physician orders as well as documentation of follow up.	06/01/2016

Any staff identified as not following procedures for referral an follow up will receive disciplinary action to include, retraining, write up, suspension up to termination. 06/01/2016

10 NCAC 13F .1002(a) Medication Orders
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.

Plan of Correction

QC Staff/ SIC's were assigned the role of checking in all orders, documenting contact with physician and ensuring proper implementation of order. 06/01/2016

QC Staff/SIC' s were trained on clarification of orders, documentation of contact with physician and implementation of orders. 06/01/2016

Implementation of daily orders notebook that will be reviewed by QC's daily to ensure clarification on all orders has been obtained if needed. 06/01/2016

Resident # 10 is receiving medication as ordered. 05/06/2016

10 NCAC 13F .1004 (a) 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 facilities policies and procedures

Plan of Correction

The ED/QC staff audited records to assure ensure residents were receiving medications as ordered. 05/06/2016

Staff retrained on proper medication administration per physician orders and Procedure to follow when residents refuse medications/orders. 06/01/2016 & ongoing

QC Staff/ SIC's were assigned the role of checking in all orders, documenting contact with physician and ensuring proper implementation of order. 06/01/2016

Resident's #8, #1, #2, & #7 are receiving medications as ordered. 05/06/2016

Monitoring System

Executive Director/Quality Assurance Staff will randomly audit Medication administration records weekly x 4 weeks then monthly thereafter, to assure that medications are given per physician orders. 06/01/2016

Implementation of daily orders notebook that is reviewed by the QC to ensure that any orders received are clarified, implemented and documented on the MAR to ensure proper administration. 06/01/2016

Any staff found not following procedures will receive disciplinary action to include retraining, write up, and/or termination. 06/01/2016

10NCAC 13F. 1004(j)
(j) The resident's MAR shall be accurate and include the following: (1) resident's name; (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 and documenting the resulting effect on the resident; (6) date and time of administration;(7) documentation of any omission medications or treatments and the reason for the omission, including refusals; and, (8) the 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 MAR.

Plan of Correction

Implementation of daily orders notebook that is reviewed by the QC to ensure that any orders received are clarified, implemented and documented on the MAR to ensure proper administration	06/01/2016
Staff retrained on proper medication administration and MAR requirements.	06/01/2016
Residents #2, #3 and #5 MAR's reflect proper medication administration.	05/06/2016
QC/ED reviewed MAR's to assure that they reflect resident's orders as prescribed by the physician.	05/06/2016

Monitoring System

Executive Director/Quality Assurance Staff will randomly audit Medication administration records weekly x 4 weeks then monthly thereafter, to assure that medications are given and documented on the MAR per physician orders.	06/01/2016
Implementation of daily orders notebook that is reviewed by the QC to ensure that any orders received are clarified, implemented and documented on the MAR to ensure proper administration.	06/01/2016
Any staff found not following procedures will receive disciplinary action to include retraining, write up, and/or termination.	06/01/2016

10 NCAC 13F. 1005 Self- Administration of Medications

(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met.

(1) The self- administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.

Plan of Correction

Staff retrained on Self- Administration of Medications Policy. 06/17/2016

Policy reminder reviewed with residents and residents families. 06/17/2016

Self- Administration Policy reviewed at admission and quarterly thereafter with resident's and families. 06/17/2016

Residents #5 and #3 are following the self-administration policy. The Residents and their families were re-educated to the self-administration policy. 06/17/2016

Monitoring

Random resident audits monthly to assure that residents are in compliance with the self –administration policy. 06/17/2016

Random staff interviews monthly to assure that staff understand the Self-administration policy and are reporting residents who are not following the policy. 06/17/2016

During monthly compliance of self-administration, the ED/QC will ensure residents have specific instructions for administration of prescription medications printed on the label. 06/17/2016

G.S. 131D-21(2) 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.

See POC for Medication Administration, Self -Administration & Health Care. In addition the following monitoring will be in place:

Executive Director/Designee will randomly interview residents monthly to assure that their resident right is not violated in regards to receiving care and services which are adequate, appropriate in compliance with relevant federal and state laws and rules and regulations. 06/17/2016

Staff re-trained on residents rights and violations of residents.

Virginia Watson
Signature / Executive Director

6/14/16
Date