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
	HAL092182	A. BUILDING: _____ B. WING _____	R 03/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(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 Section conducted an annual and follow-up survey on March 8-11, 2016, and March 14, 2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews for 2 of 7 residents sampled, the facility failed to notify the physician when blood pressure readings were outside ordered parameters (#3), failed to coordinate a physician consultation and a diagnostic procedure and failed to notify the healthcare provider during a facility visit for a resident's health complaints (#6). The findings are: 1. Review of Resident #6's current FL2 dated 12/01/16 revealed: -Resident #6's diagnoses included anemia, chronic airway obstruction, osteoporosis, hypertension, edema, anxiety states, glaucoma, and atherosclerosis. -Resident #6 was semi-ambulatory. -Resident #6 was dependent on continuous oxygen by nasal cannula. Review of Resident #6's Resident Register revealed an admission date of 11/19/10.	D 273	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action report; the Plan of Correction is soley prepared as a matter of compliance with State Law. Note: Facility has realigned structure, supervision & monitoring of daily operations, medication administration personnel as of 3/4/16. Monitoring will include, but not limited to: RN's, LPN's, Clinical Support Team, Quality Assurance Team, Regional Director of Operations & Senior Director of Operations & Clinical Services.	

POC reviewed & accepted.
Lynn Kulynych 6/21/16

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D 273	Continued From page 1 A. An interview with Resident #6 on 03/08/16 at 4:10pm revealed: -Resident #6 had lived at the facility "for some time". - Resident #6 enjoyed living at the facility. -Resident #6 had not felt well "for about a week" and complained of a cold with a sore throat and a headache which had resulted in a decrease level of activity compared to Resident #6's baseline activity. -Resident #6 had reported that she did not feel well "Having a cold" to the staff at the facility. -Resident #6 was aware that the facility's physician was on-site at the facility on this day and was told by a member of the staff that an antibiotic had been ordered for the cold. Observation during interview with Resident #6 at 4:10pm revealed the resident had a congested sounding cough. Interview with Resident #6 on 03/09/16 at 8:23am revealed: -Resident #6 did not see the physician yesterday. -Resident #6 was prescribed an antibiotic on 03/08/16. -Resident #6 ate breakfast in bed and ate "over half" of the meal. Observation on 03/09/16 at 4:50pm revealed: -A female resident speaking to Resident #6 from the hallway, asking "Are you still not feeling any better". -The female resident in the hall voiced concern aloud that Resident #6 "Has not been herself", "Staying in bed all day", "Has not been feeling well for a while now". An interview with a Medication Aide (MA) on	D 273	Chart audits conducted to ensure Health Care Referral & Follow up to include comparing physician orders, medication administration record, medications on hand and follow through on all orders. Audit was monitored by Registered Nurse. Physicians were notified of any discrepancies and facility followed through with any recommendations and orders. Completed 4/14/16 & ongoing Registered Nurse provided additional training/education on health care referral & follow up to include, but not limited to; -BP parameters & notifying physician -Shift report-communication log, review by SIC & Care Managers -Communication with the Executive Director on acute changes. Completed 4/14/16 & ongoing -Documentation Training	Target Date 4/28/16 Target Date 4/28/16

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D 273	Continued From page 2 03/09/16 at 5:45pm revealed: -The MA overheard Resident #6 tell another resident that Resident #6 had received a new order for an antibiotic. -The MA would check to see if the antibiotic was ordered. A follow up interview with the same MA on 03/09/16 at 6:00pm revealed: -When there are issues or any concerns with residents at the facility, the residents medical chart is placed in a "Hot Box" that alerted staff of any resident issues or concerns between shifts. The MA had checked and Resident #6's chart was not in the "Hot Box". -The MA looked in the facility's system for new orders and there was not an entry for a new antibiotic. -The MA would contact Resident #6's primary provider and report Resident #6's complaints during 2nd shift. Interview with the Administrator on 03/09/16 at 6:50pm revealed "follow up" would be done with Resident #6's primary provider regarding the resident not feeling well. Interview with Resident #6 on 03/10/16 at 8:30am revealed: - The resident received cough medication last night for coughing which helped some. -Resident #6 continued to have a headache, "I never have a headache" and "I may need to go to the hospital to get straight". -Resident #6 had eaten breakfast in bed and ate approximately "half "of the meal. Observation during interview with Resident #6 at 8:30am revealed a congested sounding cough.	D 273	Care Managers will review all Physician orders to include discharge summaries, emergency dept orders and licensed professional recommendations to ensure health care referral and follow up. Nurse consultants will continue to provide ongoing educational, training and monitoring during site vists.	Target Date 4/28/16 Target Date 4/28/16

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D 273	Continued From page 3 Review of Resident #6's care notes documented on 03/10/16 at 8:15am by the Administrator revealed: -Resident #6 reported "She didn't feel any better or worse but thought she wanted to go to hospital just to be checked out". - The MA was told that Resident #6 wanted to go the hospital, the MA would have the Aide get the resident ready for transport. Observation on 03/10/16 at 9:20am to 9:36am revealed: -Emergency Medical Services (EMS) arrived to transport Resident #6 to the emergency room. - The Resident Care Coordinator (RCC) was at Resident #6's room door. - The EMS workers placed Resident #6 on the stretcher and then into the ambulance. - Resident #6's oxygen saturation was checked by EMS and was at 83 percent on room air. Oxygen was applied by a nasal cannula by EMS and oxygen saturation increased to 94 percent. -Resident #6 was transported to a local emergency room of her choice. A telephone interview on 03/10/16 at 10:45am with Resident #6's Primary Care Provider (PCP) revealed: -The PCP made a facility visit to see residents on 03/08/16. - The PCP was not notified of any concerns related to Resident #6 not feeling well or having a cold on 03/08/16. -The only staff contact made regarding Resident #6 was a text message concerning a hospital bed on 03/08/16 which had already been ordered. -The PCP had not received an after hour call on 03/09/16 regarding Resident #6's complaints of not feeling well.	D 273		

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D 273	Continued From page 4 A telephone interview on 03/10/16 at 11:20am with a staff member at the PCP's office revealed an after hour call was received after business hours from the facility on 03/09/16 and the call was sent to another provider who was on call. Interview with the Resident Care Coordinator (RCC) on 03/10/16 at 11:30am revealed: -When residents are sent out for a medical evaluation to the emergency room, the facility contacts the resident's primary provider and the contact person listed in the resident's chart. -The RCC had not made any contact with Resident #6's primary physician nor with the contact person listed in the resident's record. -The MA should have made contact with Resident #6's primary physician and the contact person listed in the resident's record. Interview with a MA on 03/10/16 at 12:00 pm revealed: -The MA had not made contact with Resident #6's primary physician nor the contact person listed in the resident's record, but had planned to do so during the day shift. - The MA called and left a voice message for Resident #6's contact person during the interview. - Resident #6 had reported to her in the past week, "Her butt was sore" and this was the reason she had not transferred out of the bed. -Resident #6 had reported she had a "Cold". - The MA was not aware of an order for an antibiotic. Interview with the Administrator on 03/10/16 at 12:25pm revealed: -The Administrator was not aware on 03/08/16 that Resident #6 did not feel well. - The Administrator was aware that contact had been made with the Primary Care Provider on the	D 273		

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D 273	Continued From page 5 evening of 03/09/16 concerning Resident #6. -The facility was instructed to follow standard orders. There was no chest x-ray ordered. -The Administrator spoke with Resident #6 last evening (03/09/16) and at that time, Resident #6 did not want to be evaluated in the emergency room. -The resident would wait and see how she felt in the morning. Interview with a Personal Care Aide (PCA) on 03/10/16 at 2:05pm revealed the PCA was aware that Resident #6 was not feeling well with a cold on Tuesday, 03/08/16 and reported this to the MA. Interview with Resident #6's responsible person on 03/11/16 at 10:45am: -Resident #6 was admitted to acute care due to a touch of pneumonia. -Resident #6 was admitted to acute care for a few days to receive intravenous antibiotics and breathing treatments. Interview with the Senior Director of Operations and Clinical Services on 03/11/16 at 10:55am revealed: -Resident #6 was admitted with a diagnosis of Coronary pulmonary disease exacerbation. -Resident #6 was placed on an antibiotic. Interview with a resident on 03/11/16 revealed Resident #6 had not been feeling well with a cold for about week. Observation on 03/14/16 at 9:55am revealed Resident #6 was receiving a breathing treatment in her room from the Medication Aide. Interview with Resident #6 on 03/14/16 at	D 273		

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D 273	Continued From page 6 9:55am revealed that she returned to the facility on 03/11/16. Review of a hospital discharge summary for Resident #6 revealed: -The resident was admitted on 03/10/16 and discharged on 03/11/16. -The resident was admitted on 03/10/16 with a diagnosis of coronary pulmonary disease with acute exacerbation and dyspnea. B. Review of documentation from a local hospital emergency room visit dated 02/10/15 for Resident #6's revealed: -Resident #6 was seen at the emergency room on 02/10/15 and diagnosed with hip pain and Paget's disease (A disorder that interferes with a person's normal body process, involving abnormal bone destruction and regrowth, the bones become fragile). -There were instructions from the emergency room visit on 02/10/15 to follow up with an orthopedic clinic as soon as possible. Review of documents in Resident #6's record revealed no information related to a follow up with an orthopedic clinic. Interview with the Senior Director of Operations and Clinical Services and Senior Executive Director on 03/11/16 revealed it was unknown why Resident #6's follow up to an orthopedic clinic was not in the resident's chart. Interview with the Senior Director of Operations and Clinical Services on 03/14/16 at 10:20am revealed Resident #6's physician was contacted on 03/11/16 and made aware no orthopedic appointment was ever scheduled as ordered.	D 273		

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D 273	Continued From page 7 Review of a new order/notification/clarification dated 03/11/16 revealed a telephone order that the primary care physician was notified that the resident was to follow up with an orthopedic clinic and that no follow up was done as ordered. C. Review of Resident #6's physician orders revealed: -There were orders located under the plan section of the physician's assessment visit on 06/02/15 for a mobile EKG (Electrocardiogram also known as an ECG, is a test used to measure the electrical activity of the heart). - The EKG/ECG was ordered to rule out atrial flutter versus 2nd degree atrioventricular block. -There were no ECG/EKG reports found in Resident #6's chart. Interview with the Senior Director of Operations and Clinical Services and Senior Executive Director on 03/11/16 revealed it was unknown why Resident #6's order for an ECG/EKG ordered on 06/02/15 was not in the residents chart. Interview with the Senior Director of Operations and Clinical Services on 03/14/16 at 10:20am revealed: -Resident #6 did not have an ECG/EKG done as ordered on 06/02/15. -Resident #6's physician was contacted on 03/11/16 regarding the missed ECG/EKG. -There have been new orders received for Resident #6. Review of physician orders for Resident #6 revealed: -Resident #6's physician was contacted on 03/11/16 with an order received to discontinue current order for ECG/EKG.	D 273		

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D 273	Continued From page 8 -Reschedule ECG/EKG for next [word missing] with Mobile-X. - The diagnosis reason for ECG/EKG was atrial flutter. -Please send the order to Mobile x-ray so they can complete the x-ray. Review of a subsequent order dated 03/11/16 revealed an order to discontinue the ECG order given to the community on 03/11/16 due to an ECG completed on 03/10/16 while the resident was in the hospital and to discontinue the order for 2015. 2. Review of Resident #3's current FL-2 dated 08/11/2015 revealed diagnoses included alzheimer's dementa vascular, rheumatoid arthritis, peripheral vascular disease, anxiety, coronary artery disease, hypertension, and diabetes mellitus. Review of physician orders for Resident #3 revealed: -There was a physician's order dated 08/25/2015 for daily blood pressure (BP) for 7 days. Notify provider if BP greater than 170/90 or less than 100/50. -There was a subsequent order dated 01/13/2016 for daily blood pressure three times daily at 8am, 2pm, and 8pm. The order included instructions to notify provider if BP greater than 170/90 or less than 100/50. Review of the electronic Medication Administration Records (eMARs) for February 2016 for Resident #3 revealed: -On 02/06/2016 at 8:00pm, Resident #3's blood pressure was documented as 152/101. -On 02/18/2016 at 8:00pm, Resident #3's blood pressure was documented as 92/63.	D 273		

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D 273	Continued From page 9 -On 02/20/2016 at 8:00am, Resident #3's blood pressure was documented as 171/90. -On 02/26/2016 at 8:00am, Resident #'s blood pressure was documented as 189/62. -On 02/29/2016 at 2:00pm, Resident #3's blood pressure was documented as 135/109. Review of the electronic Medication Administration Records (eMARs) for March 2016 for Resident #3 revealed: -On 03/03/2016 at 8:00am, Resident #3's blood pressure was documented as 111/102. -On 03/04/2016 at 2:00pm, Resident #3's blood pressure was documented as 94/59. -On 03/06/2016 at 8:00am, Resident #3's blood pressure was documented as 174/80. Review of Resident #3's Care Notes revealed no documentation of provider contact regarding high or low blood pressure readings obtained by facility staff. Interview with a Medication Aide during the survey revealed: -The MA was aware of the blood pressure parameters for notifying Resident #3's physician. -The MA contacted the Supervisor when Resident #3's blood pressure was outside the physician ordered parameters for notification. -The MA was supposed to call the Provider when the blood pressure readings were outside the prescribed parameters and the Provider would give instructions as to what he wanted done. -The MA had rechecked Resident #3's blood pressure but did not think the rechecked blood pressure was documented. -The MA did not call the Provider because once the MA rechecked the blood pressure and found the blood pressure to be within the parameters, the MA did not call.	D 273		

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D 273	Continued From page 10 Interview with the Primary Care Provider (PCP) on 03/10/2016 at 10:45am revealed the PCP had not been notified when Resident #3's blood pressure was outside the PCP prescribed parameters for notification. Interview with Resident #3 on 03/14/2016 at 1:15pm revealed: -Resident #3's blood pressure was checked by staff. -Resident #3 sometimes had a headache. -Resident #3 would ask the MA for "a Tylenol or something" when she had a headache. -Resident #3 did not know what medications were administered to her by the medication aides. Review of the Plan of Protection dated 3/10/16 submitted by the facility revealed: -The facility nurse will educate the staff on reporting resident illness or acute changes to the supervisor-in-charge (SIC) who will record on the shift report. -Shift report will be reviewed by the care manager and the oncoming SIC daily. -Care manager and/or SIC will report any changes as necessary and follow any physician directives. -Care managers will update Executive Director with any acute changes. -Nurse consultants will continue to provide ongoing educational training and monitoring during onsite visits. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 28, 2016.	D 273		

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D 276	Continued From page 11	D 276		
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: Based on record reviews and interviews, the facility failed to implement orders for blood pressure (BP) checks prior to the administration of blood pressure medications for 1 of 7 sampled residents (Resident #5). The findings are: 1. Review of Resident #5's FL-2 dated 11/03/15 revealed: -Diagnoses included pain, constipation, vitamin D deficiency, hypertension, anemia, senile without psychosis. - The resident was not ambulatory. Review of Resident #5's Resident Register revealed an admission date of 05/31/11. Review of Resident #5's medication orders revealed: - There was an order from the physician assistant signed on 12/02/15 to increase Lisinopril from 20mg to 40 mg daily. -There was a signed order by the physician assistant for Hydrochlorothiazide 25 mg one tablet daily.	D 276	Registered Nurse provided education & training on, but not limited to; -proper medication administration -orders to include monitoring BP prior to administering blood pressure medications -physician ordered parameters to hold medication Training provided 3/7/16, 3/11/16 with continued onsite monitoring by licensed professional.	4/28/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(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 276	Continued From page 12 Review of a clarification request from the hospice provider faxed and dated 02/26/16 revealed: - The hospice nurse noted the resident's blood pressure was 70/40 after blood pressure medications given. -The hospice provider recommended to have blood pressures checked prior to blood pressure medications. - If residents blood pressure was less than 90 systolic (Top blood pressure number) to hold blood pressure medications: Hydrochlorothiazide 25 mg by mouth daily and Lisinopril 40 mg tablet daily. -The physician signature was dated 03/08/16. Review of Resident #5's January 2016 Medication Administration Record (MAR) revealed: -There was a computer generated entry for Hydrochlorothiazide, (A medication to control blood pressure) 25 mg daily, (check BP prior to administering, hold if systolic (top number of blood pressure) blood pressure less than 90). -There was a row to document the administration of Hydrochlorothiazide daily at 8:00am. -There was a row to record BP daily. -There was a computer generated entry for Lisinopril, (A medication to control blood pressure) 40mg daily, (Check BP prior administering, hold if systolic BP less than 90). -There was a row to document the administration of Lisinopril daily at 8:00am. -There was a row to record BP daily. -The Medication Aides (MA), documented administration of Hydrochlorothiazide daily from 01/01/16 through 01/31/16 -The space designated to record the blood pressure daily prior to the administration of Hydrochlorothiazide was blank from 01/01/16	D 276	Quick MAR (electronic medication adminstration record) will be reviewed daily by the medication aide to ensure medications are administered as ordered to include required monitoring and parameters to hold medications. Care Managers will review Quick Mar weekly for compliance. Any discrepancies found are followed up Care Manager and addressed accordingly per procedure. 4/28/16 LHPS nurse conducted medication administration refresher training and revalidated medication aides. Revalidation completed 3/18/16. 4/28/16	

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D 276	Continued From page 13 through 01/31/16. -The MA documented administration of Lisinopril daily from 01/01/16 through 01/31/16. - The space designated to record the blood pressure daily prior to the administration of Lisinopril was blank from 01/01/16 through 01/31/16. Review of Residents #5's February 2016 MAR revealed: -There was a computer generated entry for Hydrochlorothiazide 25 mg daily, (check BP daily prior to administering, hold if systolic blood pressure less than 90). -There was a row to document the administration of Hydrochlorothiazide daily at 8:00am. -There was a row to record BP daily. -There was a computer generated entry for Lisinopril 40 mg daily, (Check BP prior administering, hold if systolic BP less than 90). -There was a row to document the administration of Lisinopril daily at 8:00am -There was a row to record BP daily. -The MA documented administration of Hydrochlorothiazide daily from 02/01/16 through 02/29/16 -The space designated to record the blood pressure daily prior to the administration of Hydrochlorothiazide was blank from 02/01/16 through 02/29/16. -The MA documented administration of Lisinopril daily from 02/01/16 through 02/29/16. -The space designated to record the blood pressure daily prior to the administration of Lisinopril was blank from 02/01/16 through 02/29/16. Review of Residents #5's March 2016 MAR revealed: -There was a computer generated entry for	D 276		

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D 276	Continued From page 14 Hydrochlorothiazide 25 mg daily, (check BP prior to administering, hold if systolic blood pressure less than 90). -There was a row to document the administration of Hydrochlorothiazide daily at 8:00am. -There was a row to record BP daily. -There was a computer generated entry for Lisinopril 40 mg daily, (Check BP prior administering, hold if systolic BP less than 90). -There was a row to document the administration of Lisinopril daily at 8:00am -There was a row to record BP daily. -The MA documented administration of Hydrochlorothiazide daily from 03/01/16 through 03/11/16. -The space designated to record the blood pressure daily prior to the administration of Hydrochlorothiazide was blank from 03/01/16 through 03/08/16. -The MA documented administration of Lisinopril daily from 03/01/16 through 03/09/16. - The space designated to record the blood pressure daily prior to the administration of Lisinopril was blank from 03/01/16 through 03/08/16. -The B/P was documented as 93/62 on 03/09/16 in the row under Hydrochlorothiazide and Lisinopril administration. -The B/P was documented as 99/56 on 03/10/16 in the row under Lisinopril. - The B/P was documented as 90/60 on 03/11/16 in the row under Lisinopril. -Hydrochlorothiazide was discontinued on 03/09/16 at 10:00am. Interview on ---03/11/16 at 11:40 am with the Administrator revealed: -No prior B/P'S were recorded as obtained by the MA's assigned to Resident #5. -It was unknown how the systolic BP parameters	D 276		

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D 276	Continued From page 15 ordered for Resident #5 were missed.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 3 of 7 sampled residents (Residents #2, #5 and #7), including, administering an antipsychotic medication not ordered, a vitamin supplement, missed doses of medications not in the facility, and hypertension medication, and a 7% medication error rate during observation of the medication pass, 2 errors out of 27 (Resident #9's Omeprazole administered after a meal instead of before meals as ordered and a missed Gabepentin dose for Resident #1) The findings are: 1. Review of Resident #2's current FL-2 dated 11/02/15 revealed diagnoses of hypothyroidism, anemia, diabetes mellitus, hyperlipidemia, and hyperplasia of prostate. Review of laboratory (lab) results dated 10/30/15	D 358	Registered Nurse provided additional training/education on proper medication administration to include, but not limited to; -Blood Pressure parameters to hold or administer medications -reviewing & approving orders -FSBS -Insulin parameters -Medication before, after & during meals -One hour administration window -Use of PRN's, signs/symptoms & frequency -Diabetic Training to include signs & symptoms of hyper/hypoglycemia Training conducted on 3/7/16 & 3/11/16 and ongoing	Target Date 4/13/16

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D 358	Continued From page 16 revealed: -Lab results for a lipid panel, comprehensive metabolic panel, CBC, thyroid panel, and Valproic Acid level were in the resident ' s record. -The resident's Valproic Acid level was documented as 101.8, which was above therapeutic range (therapeutic range is 50.0 - 100.0mg/L). Review of Resident #2's October and November 2015 medication administration records (MAR) revealed Valproic Acid (Depakote) was not documented as administered on the MARS. Review of the facility's pharmacy medication review dated 12/16/16 revealed: -The 11/1/15 lab results listed Valproic Acid at the toxic range of 101.8. -Patient is not on VPA [Valproic Acid]?? Review of the facility's pharmacy consultant's "Note To Attending Physician/Prescriber" dated 12/21/15 revealed: -The 11/01/15 lab results for this patient (Resident #2) included a Valproic Acid level in the toxic range of 101.8. My records do not indicate this patient was taking Valproic Acid. Your thoughts? -The resident's primary provider's response was "No lab records for [Resident #2] in any system that indicate measurement of VPA. This appears to be a mix up". Review of documentation on Resident #2's MAR for the months of December 2015, January 2016, and February 2016 revealed: -On 12/17/15, Depakote 125mg was started with direction to take 2 capsules (250mg) by mouth twice a day (8:00am and 8:00pm) for agitation (The medication was documented as	D 358	Medication pass observations are being condcuted weekly by LPN or qualified designee. Monitored by Clinical Support and Quality Assurance Team during onsite visits. Initiated on 3/6/16. LHPS Nurse conducted medication administration refresher training and revalidated medication aides. Completed 3/18/16. Medication carts are checked weekly by LPN or qualified desginee to ensure medications are available for administration. Initiated 3/18/16 New medication order process & procedure implemented to include "New Order Tracking", which includes a designated color coded system. Care Managers are responsible for reviewing and approving all orders. Registered Nurse provided training on the medication order processing & procedures. Initiated 3/10/16 & ongoing.	Target Date 4/13/16 Target Date 4/13/16 Target Date 4/13/16 Target Date 4/13/16

Division of Health Service Regulation

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D 358	Continued From page 17 administered at 12/17 (at 8:00pm) and from 12/18/15 through 12/31/15 at 8:00am and 8:00pm). -From 01/01/16 through 01/31/16, Depakote 250mg was documented as administered at 8:00am and 8:00pm. -From 02/01/16 through 02/02/02/16, Depakote 250mg was documented as administered at 8:00am and 8:00pm (the medication was discontinued on 02/02/16). Interview with a representative from the facility's pharmacy on 03/09/16 at 2:35pm revealed: -Depakote 125mg capsules, 29 tablets were dispensed on 12/17/16. -The order for the medication was not available and the pharmacy director would return telephone call. -The representative did not know how many capsules/pills were dispensed in January 2016 or February 2016. Interview with Resident #2's primary medical provider on 03/10/16 at 10:28am revealed: -He became aware Resident #2 was being administered Depakote 250mg, 2 times a day in February, 2016. -He did not know who ordered the Depakote on 12/17/15 or who discontinued the medication on 02/02/17. -He did not know why the resident was started on the Depakote, because the resident did not have dementia, was not agitated, had no other psychiatric diagnosis and did not have seizures. -He did not know where the order came from and must have been a pharmacy error. -He ordered a lab for VPA level on 02/19/16 and the VPA level was low, even though some of the medication remained in the resident's blood. -The facility did not contact him to verify or clarify	D 358	Pharmacy will communicate any pharmacy errors detected by the pharmacy staff to the facility. Facility will implement the medication error reporting procedure upon notification from the pharmacy of such errors. Initiated 3/10/16 & ongoing. Facility requested a Quality Assurance program from the pharamcy on reporting errors. Pharmacy will conduct an internal investigation of any pharmacy errors using a quality tracking log and will be available to clinical & corporate personnel. Initated 3/14/16 & ongoing.	Target Date 4/13/16 Target Date 4/13/16

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D 358	Continued From page 18 the medication order. Review of the lab report dated 02/20/16 revealed: -Resident #2 had a Valproic Level of less than 12.5. -The resident's primary medical provider handwrote on 2/23/16 that "Depakote [discontinued] on 2/2/16". -The lab order was received and collected on 02/19/16. Review of a letter from the facility's pharmacy dated 03/09/16 revealed: -[The facility's pharmacy] received prescriptions on 12/16/15 for a [Resident #2]. -The prescription was as follows: Increase Depakote to (2) 125mg tabs (250mg) po BID for agitation. Dispense 120. -There is more than one [Resident #2] in our system. The prescription was entered into EMAR (electronic medication administration record) inadvertently by [the facility's pharmacy] on [Resident #2's] profile. -The issue was identified by the facility's clinical support staff during a chart audit on 03/09/16 at which time the facility notified the pharmacy. -One of our certified pharmacy technicians, when trying to discontinue the Depakote, inadvertently changed the stop date to 02/02/16 instead of discontinuing the medication as intended [on 12/18/15]. Interview with the facility's Senior Director of Operations and Clinical Services on 3/09/16 at 6:00pm revealed: -The facility became aware of the medication error last week while performing record audits. -The facility's pharmacy dispensed 120 Depakote pills on 12/17/15. -Because the pharmacy entered a stop	D 358		

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D 358	Continued From page 19 medication date of 02/02/16, the resident received Depakote 2 times a day from 12/17/15 until 02/02/16. -The facility did not have an order to administer the Depakote to Resident #2. The Depakote should have been dispensed to a resident in another facility. -The facility's pharmacy was responsible for putting new orders in the facility electronic MAR system. -The facility's RCC was responsible for approving any new medication on the electronic MAR before the medication was administered to the residents. -The facility had no system/policy to check the accuracy of MAR's at the end of the month or the beginning of the new month. -The facility did not become aware of the medication error before the medication was automatically stopped on 02/02/16. -A medication error report was completed and sent to the resident's primary medical provider on 03/09/16. Interview with a 1st shift personal care aide (PCA) on 3/9/16 at 2:15pm revealed: -In December 2015, January 2016 and the 1st part of February 2016, Resident #2 was weak and slept a lot. -The resident ate his meals in bed and the staff had to assist him with his baths, dressing and transferring out of bed. -The resident has started back doing his own care and transferring himself to wheel chair in February 2016. Interview with a 1st shift Medication Aide (MA) on 3/10/16 at 9:10pm revealed: -Resident #2 was started on Depakote 250mg, 2 times a day, in December 2015 near the same time he started radiation treatments for lung	D 358		

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D 358	Continued From page 20 cancer. -The resident did not move around a lot, he was weak, his appetite was poor and he slept a lot. -The resident was in bed most of the time and the staff had to bring his meals to him. -The resident provided his own care before starting the Depakote/radiation treatments, but the staff had to assist the resident with his baths, getting dressed and transferring from bed to wheelchair while on the Depakote. -The resident finished the Depakote on 02/02/16 and continued the radiation treatments until about 2 weeks ago, but when the Depakote was stopped, there was a big difference; the resident was able to transfer himself out of bed to his wheelchair, eat meals in the dining room, bathe and dress himself. -The facility's RCC was responsible for approving all new medication/treatment orders on the EMAR. New medication orders were flagged (in green) and the RCC check the EMAR with the order in the facility and then approve the order. The MA's did not administer any medications until approved in the EMAR. Interview with the facility's Resident Care Coordinator (RCC) on 3/10/16 at 3:35pm revealed: -The RCC was responsible for making sure medication orders were in the EMAR system correct before the MA's administered the medication. -The RCC compare the EMAR with the written physician orders and if correct, the EMAR was approved and the MA's started administering the new medication. -The Depakote which Resident #2 received from 12/17/15 to 02/02/16 was approved by the former RCC.	D 358		

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D 358	Continued From page 21 -An order for the Depakote was not found in the resident's records. -While the resident was receiving Depakote, the resident was weak and slept most of the time. The PCA's assisted the resident with his baths, dressing and transferring. -Since Depakote was discontinued, the resident does his own care and transfers himself. Interview with the facility's Pharmacy Consultant on 3/09/16 revealed: -A pharmacy review for Resident #2 had been done on 12/16/15 and did not remember if the Depakote was on the resident's EMAR. -After reviewing the lab report for the Valproic Acid level, there should have been an order for Valproic Acid in the resident's record or there was a mix up. There was no Valproic Acid in the medication cart for the resident. Interview with Resident #2 on 3/14/16 at 10:40am revealed: -The resident was on "a pill" but did not know what the pill was for. -The resident was not getting the pill now, it was stopped last month. -While receiving the pill, the resident was sleepy and the staff helped him with his baths, dressing and getting out of bed. -The resident was very weak and sleepy, but was not weak or sleepy after the pill was stopped. -The resident did not ask the MA why he was getting the pill; he thought it was because he was receiving radiation for lung cancer. -Currently, the resident does his own care and transfers himself from bed to wheelchair. 2. Review of Resident #5's FL-2 dated 11/03/15	D 358		

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D 358	Continued From page 22 revealed: -Diagnoses included pain, constipation, vitamin D deficiency, hypertension, anemia, senile without psychosis. - The resident was not ambulatory. Review of Resident #5's Resident Register revealed an admission date of 05/31/11. Review of a physician order for Resident #5's revealed an order dated 03/06/16 to add Vitamin D 1000 units by mouth daily written on a lab order dated 02/16/16. Review of Resident #5's March, 2016 Medication Administration Record (MAR) revealed there was no entry for Vitamin D 1000 units. Interview on 03/11/16 at 11:40am with the Pharmacist who performs the facility's quarterly medication reviews: - Resident #5's March 2016 MAR had been reviewed. -On 02/02/16 Resident #5's vitamin D level was borderline low at 30 and the pharmacist made a suggestion to decrease vitamin D to a maintenance dose at next quarterly review. Interview with Corporate Nurse on 03/11/16 revealed it was unknown why the order for Vitamin D 1000units by mouth was not added to the March 2016 MAR but would review. Interview on 03/14/16 with the facility's pharmacy provider revealed no prescription dated 03/06/16 for Vitamin D 1000 units by mouth daily had been received for Resident #5. 3. Review of Resident #7's current FL2 dated 9/24/15 revealed diagnoses included lithium	D 358		

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D 358	Continued From page 23 toxicity, bipolar mood disorder, and hypertension. Review of medication orders on the FL2 dated 9/24/15 revealed: -Artificial Tears, one drop into each eye twice daily. (Artificial tears are lubricant eye drops used to treat dryness and irritation.) -Aspirin 81mg, one tablet daily. (Aspirin is used to treat pain, fever, and headache, and also reduces the risk of heart attack.) -Lithium Carbonate 300mg, one tablet three times daily. (Lithium Carbonate is used to treat manic episodes of bipolar disorder). -Quetiapine 400mg, one tablet daily. (Quetiapine is used to treat bipolar disorder and depression.) -Tamsulosin 0.4mg, one tablet daily after the same meal. (Tamsulosin is used to treat enlarged prostate.) -Xarelto 20mg, one tablet daily with the evening meal. (Xarelto is a blood thinner used to treat and prevent blood clots.) A. Review of Resident #7's Electronic Medication Administration Record (E-MAR) for March 2016 revealed: -There was an entry for Artificial Tears, instill one drop in both eyes twice daily at 8:00am and 8:00pm. -On 3/4/16, the afternoon/evening doses had the initials of the Medication Aide (MA) circled and documentation in the notes section on the E-MAR revealed that Resident #7 had refused Artificial Tears. Review of Resident #7's E-MAR for February 2016 revealed: -There was an entry for Artificial Tears, instill one drop in both eyes twice daily with administration times at 8:00am and 8:00pm. -From 2/1/16-2/29/16, there were ten	D 358		

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D 358	Continued From page 24 occurrences when the MA's initials were circled by the Artificial Tears entry. -There was documentation in the notes section that Resident #7 had refused Artificial Tears nine times. -On 2/18/16 at 7:23am, the MA documented in the notes section, that the Artificial Tears was not in the facility. -Artificial Tears was documented as administered on 2/17/16 and 2/18/16 at 8:00pm. Review of Resident #7's January 2016 E-MAR revealed: -There was an entry for Artificial Tears, instill one drop in both eyes twice daily at 8:00am and 8:00pm. -From 1/1/16-1/31/16, there were eleven occurrences when the MA's initials were circled by the Artificial Tears entry. -There was documentation in the notes section that Artificial Tears was not in the facility on four occasions and Resident #7 refused the medication on six occasions. -On 1/16/16, the documentation revealed that Resident #7 had received the Artificial Tears "given by home health." -Documentation revealed that Resident #7 was administered the 8:00am dose of Artificial Tears for the month of January. -Documentation revealed the 8:00pm dose was not administered on 1/13/16 and 1/14/16 and 1/17/16 and 1/19/16 due to the medication not being in the facility. -Documentation revealed that the 8:00pm dose was not administered on 1/20/16, 1/21/16, 1/26/16, 1/27/16, 1/28/16, and 1/31/16 due to Resident #7 refused. B. Review of Resident #7's Electronic Medication Administration Record (E-MAR) for March 2016	D 358		

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	HAL092182	A. BUILDING: _____ B. WING _____	R 03/14/2016

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D 368	Continued From page 25 revealed: -There was an entry for Lithium 300mg, take one capsule by mouth three times daily at 8:00am, 12:00pm, and 4:00pm. -On 3/4/16, the afternoon/evening doses had the initials of the MA circled and documentation in the notes section on the E-MAR revealed that Resident #7 had refused Lithium. Review of Resident #7's E-MAR for February 2016 revealed: -There was an entry for Lithium 300mg, take one capsule by mouth three times daily at 8:00am, 12:00pm, and 4:00pm. -From 2/1/16-2/29/16, there were nine occurrences when the MA's initials were circled by the Lithium entry. -There was documentation in the notes section that Lithium was not in the facility eight times, and on 2/10/16, Resident #7 was out of the facility. -Documentation revealed that Resident #7 received the first two doses of Lithium on 2/15/16, and documentation revealed it was not in the facility for the third dose. -On 2/16/16, documentation revealed that Resident #7 received the first and third dose of Lithium, but not the second dose. -On 2/17/16, documentation revealed that Resident #7 received the first and second doses of Lithium, but did not receive another Lithium dose until 2/19/16 when he was administered the third scheduled dose. C. Review of Resident #7's Electronic Medication Administration Record (E-MAR) for March 2016 revealed: -There was an entry for Xarelto 200mg, take one tablet daily with evening meal at 12:00pm. -On 3/4/16, the afternoon/evening doses had the initials of the MA circled and documentation in the notes section on the E-MAR revealed that	D 368		

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D 358	Continued From page 26 Resident #7 had refused Xarelto. D. Review of Resident #7's E-MAR for February 2016 revealed: -There was an entry for Aspirin 81mg, chew and swallow one tablet by mouth at 8:00am. -On 2/18/16, the MA's initials were circled and the notes in the documentation section revealed the Aspirin was not in the facility. -Aspirin was documented as administered all other days in February. E. Review of Resident #7's E-MAR for February 2016 revealed: -There was an entry for Quetiapine 400mg, take one tablet by mouth daily at 12:00pm. -From 2/1/16-2/29/16, there were five occurrences when the MA's initials were circled by the Quetiapine entry. -There was documentation in the notes section that Quetiapine was not in the facility four times, and on 2/10/16, Resident #7 was out of the facility. -Documentation revealed that Resident #7 did not receive the Quetiapine 2/18/16, 2/19/16, 2/20/16, or 2/23/16. F. Review of Resident #7's E-MAR for February 2016 revealed: -There was an entry for Tamsulosin 0.4mg, take one capsule by mouth daily 30 minutes after the same meal each day with administration time at 8:30am. -From 2/1/16-2/29/16, there were two occurrences when the MA's initials were circled by the Tamsulosin entry. -There was documentation in the notes section that Tamsulosin was not in the facility on both dates, 2/18/16 and 2/19/16.	D 358		

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D 358	Continued From page 27 Review of Resident #7's Nurse Notes revealed: -There was no documentation that the physician had been notified in January or February 2016 of the missed doses of medications. -There was no documentation that the physician had been notified that Resident #7 refused the Artificial Tears. -Review of communication signed by the physician on 3/5/16 revealed there was a communication in Resident #7's record that, "Attached are the MARS for Jan Feb, and March 2016. Please review and note any medications that were missed, refused, medications not given due to resident out of facility or documentation error. Please alert community of any action needed." Observation of Resident #7's medications on hand on 3/11/16 at 4:00pm revealed: -There was no Artificial Tears on the medication cart for Resident #7. -Tamsulosin, 30 tablets, were dispensed by the pharmacy on 2/19/16; 14 capsules were on hand. -Aspirin, 90 tablets, were dispensed by the pharmacy on 2/19/16; 12 tablets were on hand. -Quetiapine, 30 tablets, were dispensed by the pharmacy on 2/23/16; 17 tablets were on hand. -Xarelto, 30 tablets, were dispensed by the pharmacy on 2/5/16; 13 tablets were on hand. -Lithium, 90 tablets were dispensed by the pharmacy on 2/19/16; 45 tablets were on hand. Interview with a Medication Aide (MA) on 3/11/16 at 11:35am revealed: -On the medication package, there was a reminder around the fifth or sixth last dose to reorder the medication. -When the MA noticed that there were five or six doses remaining, the MA was prompted to reorder the medication.	D 358		

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D 358	Continued From page 28 -When the medication was reordered, the pharmacy usually delivered the medication by the next day. -All reorders were done in the computer system. Interview with a second MA on 3/11/16 at 4:15pm revealed: -The MA had never had an issue with Resident #7 refusing medications. -The facility policy was that after the third time a resident refused medications, the physician was notified. -If a resident refused insulin, the physician was notified after the first refusal. -On the medication packages, there was a section in blue that alerted the MA when the medication was getting low and needed reordering. -The pharmacy was called when and medication need to be reordered, and if there was a refill for the medication, the pharmacy would send the medication. -If there was no refill, the pharmacy would need a new prescription, so we would fax the prescription to the pharmacy or contact the physician for a new prescription. Interview with the Administrator on 3/11/16 at 12:10pm revealed: -The Administrator thought Resident #7 went to the hospital on Sunday, 3/6/16, because he was working that day. -Resident #7 was in the hall and said he "felt funny" and that his legs were weak. -Resident #7 sat in the chair, so 911 was contacted. -The Administrator had received a phone call from the hospital on 3/11/16 saying that Resident #7 had a stent placed and was going to rehab for 2 days to receive physical therapy.	D 358		

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D 358	Continued From page 29 -The Administrator was not aware that Resident #7 had refused medications or that his medications had not been in the facility. -The MA should be contacting the physician any time a resident was refusing medications or if there was an issue with the residents not receiving medications because the medications were not being sent from the pharmacy. Attempted interview with Resident #7 's responsible party and Resident #7's physician was not successful upon exit. 4. Review of the current FL-2 for Resident #3 dated 08/11/2015 revealed diagnoses included alzheimer's dementia vascular, rheumatoid arthritis, peripheral vascular disease, anxiety, coronary artery disease, hypertension, and diabetes mellitus. a. Review of physician orders dated 08/25/2015 revealed: -There was a physicians order for Humalog Insulin (used to lower blood sugar levels in diabetics) inject 5 units three times a day after each meal. -There was a physicians order for finger stick blood sugar (FSBS) three times a day before meals; FSBS less than 40 - call emergency medical service and notify provider; if FSBS 40-60, hold insulin and give one cup of juice; if FSBS 61-80, hold insulin and give ½ cup of juice; if FSBS 81-125, hold insulin and do not give juice; if FSBS greater than 451, notify provider. -There were no subsequent orders for insulin administration. Review of the electronic Medication Administration Records (eMARs) for January 2016 for Resident #3 revealed: -On 01/02/2016 at 1:00pm, there was	D 358		

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D 358	Continued From page 30 documentation of administration for 5 units of Humalog Insulin for a FSBS of 100 obtained before lunch at 11:00am. No insulin was required for a FSBS of 100 according to the physician's order. -On 01/09/2016 at 8:00am, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 106 obtained before breakfast at 7:00am. No insulin was required for a FSBS of 106 according to the physician's order. -On 01/15/2016 at 8:00am, there was documentation of administration for 5 units of Humalog Insulin for a FSBS of 107 obtained before lunch at 11:00am. No insulin was required for a FSBS of 107 according to the physician's order. -On 01/16/2016 at 1:00pm, there was documentation of administration for 5 units of Humalog Insulin for a FSBS of 98 obtained before breakfast at 7:00am. No insulin was required for a FSBS of 98 according to the physician's order. -On 01/17/2016 at 6:00pm, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 124 obtained before dinner at 6:00pm. No insulin was required for a FSBS of 124 according to the physician's order. -On 01/22/2016 at 1:00pm, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 88 obtained before lunch at 11:00am. No insulin was required for a FSBS of 88 according to the physician's order. -On 01/27/2016 at 8:00am, there was documentation of administration for 5 units of Humalog Insulin for a FSBS of 82 obtained before breakfast at 7:00am. No insulin was required for a FSBS of 82 according to the physician's order. Review of the electronic Medication	D 358		

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D 358	Continued From page 31 Administration Records (eMARs) for February 2016 for Resident #3 revealed: -On 02/05/2016 at 8:00am, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 58 obtained before breakfast at 7:00am. No insulin was required for a FSBS of 58 according to the physician's order. -On 02/07/2016 at 6:00pm, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 103 obtained before dinner at 4:00pm. No insulin was required for a FSBS of 103 according to the physician's order. -On 02/08/2016 at 8:00am, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 83 obtained before breakfast at 8:00am. No insulin was required for a FSBS of 83 according to the physician's order. -On 02/08/2016 at 1:00pm, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 81 obtained before lunch at 11:00am. No insulin was required for a FSBS of 81 according to the physician's order. -On 02/13/2016 at 1:00pm, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 120 obtained before lunch at 11:00am. No insulin was required for a FSBS of 120 according to the physician's order. -On 02/14/2016 at 1:00pm, there was documentation of administration for 5 units of Humalog insulin for a FSBS of 107 obtained before lunch at 11:00am. No insulin was required for a FSBS of 107 according to the physician's order. Interview with a Medication Aide (MA) on 03/10/2016 at 12:10pm revealed: -The MA was aware of the parameters for Resident #3's insulin administration.	D 358		

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D 358	Continued From page 32 -The MA usually did not administer insulin to Resident #3 if the resident's FSBS was within the physician ordered parameters to hold the insulin. -Resident #3's FSBS runs low sometimes, especially in the morning. -The MA did not know why the eMARs revealed documentation of administration for the Humalog insulin on dates and times when Resident #3's FSBS was within the parameters set by the physician for no insulin to be administered. -The MA thought she may have "documented wrong" on the eMARs. -The MAs used to document on the eMAR when insulin was not administered, but now document in the resident care notes when insulin not administered. -There was no place else where there would be documentation about the resident's medication administration. Interview with the Primary Care Provider (PCP) on 03/10/2016 at 10:45am revealed: -The PCP last saw Resident #3 on 02/23/2016 after the resident was seen at the hospital for hypoglycemia (low blood sugar). -Almost 10% of Resident #3's FSBS reading were less than 100. -The PCP was not aware Resident #3's insulin had been administered when it was not supposed to have been administered according to the PCP's ordered parameters to hold insulin. b. Review of physician orders dated 08/22/2015 revealed a physician's order for Clonidine HCL (generic name for Catapres which is used to treat high blood pressure) 0.1mg tablet every 8 hours as needed for a systolic blood pressure (top number) greater than 170 or diastolic blood pressure (bottom number) greater than 100.	D 358		

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D 358	Continued From page 33 Review of the electronic Medication Administration Records (eMARs) for February 2016 and March 2016 for Resident #3 revealed: -On 02/06/2016 at 8:00pm, Resident #3's blood pressure was documented as 152/101. There was no documentation for administration of Clonidine as ordered for a diastolic blood pressure greater than 100. -On 02/20/2016 at 8:00am, Resident #3's blood pressure was documented as 171/90. There was no documentation for administration of Clonidine as ordered for a systolic blood pressure greater than 170. -On 02/26/2016 at 8:00am, Resident #3's blood pressure was documented as 189/62. There was no documentation for administration of Clonidine as ordered for a systolic blood pressure greater than 170. -On 03/06/2016 at 8:00am, Resident #3's blood pressure was documented as 174/80. There was no documentation for administration of Clonidine as ordered for a systolic blood pressure greater than 170. Interview with a Medication Aide (MA) on 03/14/2016 at 11:25am revealed: -The MA was aware of the blood pressure parameters for administering Clonidine to Resident #3. -The MA could not recall having administered Resident #3 any Clonidine for an elevated blood pressure. -The MA contacted the Supervisor when Resident #3's blood pressure was outside the physician ordered parameters for administering Clonidine. -The MA had rechecked Resident #3's blood pressure but did not think the rechecked blood pressure was documented. Interview with the Primary Care Provider (PCP)	D 358		

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D 358	Continued From page 34 on 03/10/2016 at 10:45am revealed the PCP had not been notified when Resident #3's blood pressure was outside the PCP prescribed parameters. Interview with Resident #3 on 03/14/2016 at 1:15pm revealed: -Resident #3's blood pressure was checked by staff. -Resident #3 sometimes had a headache. -Resident #3 would ask the MA for something for pain when she had a headache. -Resident #3 did not know what medications were administered to her by the medication aides. 5. The medication error rate was 7% as evidenced by 2 errors out of 27 opportunities during the 12:00pm medication pass on 03/08/2016, the 8:00am medication pass on 03/09/2016, and the 5:00pm medication pass on 03/09/2016. A. Review of Resident #9's current FL-2 dated 06/16/2015 revealed diagnoses included diabetes mellitus, depression, chronic obstructive pulmonary disease, and hyperlipidemia. Review of a physician's order dated 03/05/2016 revealed an order for Omeprazole (generic for Prilosec used to treat digestion disorders) 40mg capsules twice a day before meals. Observation of the medication pass on 03/09/2016 at 8:28am revealed: -The MA administered seven oral medications to Resident #9 in the resident's bedroom. -The medications prepared for Resident #9 included Omeprazole 40mg one capsule. -The resident was offered a cup of water to swallow after the resident took the medications.	D 358		

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D 358	Continued From page 35 Review of Resident #9's electronic Medication Administration Records (eMARs) for March 2016 revealed: -Omeprazole 40mg cap take one capsule twice a day before meals was printed on the eMAR. -The Omeprazole was scheduled for administration at 7:30am and 4:30pm daily. Interview with Resident #9 on 03/10/2016 at 10:05am revealed: -Resident #9 ate breakfast every day at about 7:30am. -Resident #9 was administered medications in the morning, at night, and when needed. -The physician had prescribed Prilosec for Resident #9 "for gastritis, main problem is food and smelling food, the smell of food makes me vomit sometimes, no certain food - it's anything on any given day, felt like that this morning but didn't throw up". -Resident #9 denied having heartburn or upset stomach. -Resident #9 usually took the Prilosec medication before breakfast. -Resident #9 did not know if she had taken the Prilosec before breakfast on 03/09/2016. Interview with the Medication Aide (MA) on 03/10/2016 at 11:40am revealed: -The MA "usually" gave Resident #9 Prilosec with the morning medications at about 7 or 7:30am. -The MA was running late with the medication pass on 03/09/2016 because she had to do accuchecks and had to find residents and take them to their rooms to do accuchecks. -The Prilosec always showed up on the eMARs for administration with the 8:00am medications. -The MA did not administer the Prilosec before breakfast on 03/09/2016.	D 358		

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D 358	Continued From page 36 B. Review of Resident #1's hospital generated FL-2 dated 02/01/2016 revealed "See DC Summary" was printed in the diagnoses and medications section of the FL-2. Review of the Hospital Discharge Summary dated 02/01/2016 for Resident #1 revealed: -Diagnoses included sepsis associated hypotension, chronic diabetes mellitus, chronic asthma, chronic obstructive pulmonary disease, and abscess of left buttock. -Discharge medications included Gabapentin (generic for Neurontin and used to treat pain) 300mg capsule three times a day. Observation of the medication pass on 03/09/2016 at 4:57pm revealed: -The MA administered one pill (Metformin 1000mg tablet) to Resident #1 in the hallway outside the dining room. -The resident was offered a cup of water to swallow after the resident took the medication. -Resident #1 went into the dining room and made himself a cup of coffee. -Resident #1 was observed seated in the dining room at 5:08pm drinking the coffee, and eating at 5:20pm. Review of Resident #1's electronic Medication Administration Records (eMARs) for March 2016 revealed: -Metformin (used to treat diabetes mellitus) 1000mg take one tablet twice a day with meals was printed on the eMAR and scheduled for administration at 8:00am and 6:00pm. -Gabapentin 300mg capsule take one three times a day was printed on the eMAR and scheduled for administration at 8:00am, 12:00pm, and 4:00pm.	D 358		

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	HAL092192	A. BUILDING: _____ B. WING _____	R 03/14/2016

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OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(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 37 -There was no documentation for administration on the eMAR of Gabapentin 300mg capsule to Resident #1 on 03/09/2016 at 4:00pm. Interview with the Medication Aide (MA) on 03/10/2016 at 10:15am revealed: -The MA only had the scheduled 5:00pm medications high-lighted on the eMARs during the observed medication pass on 03/09/2016 which did not include Resident #1's Gabapentin. -The MA realized the 03/09/2016 4:00pm dose of Gabapentin had not been administered when she (MA) went back to double check the eMAR to ensure all resident scheduled medications had been administered. -The MA administered the Gabapentin to Resident #1 after supper which was around "5:15pm or 5:30pm". -According to the eMAR history for administration of Gabapentin, the medication was administered at 6:06pm on 03/09/2016. -The MA administered medications to residents based on what "popped up" on the eMAR. Review of the administration history for Resident #1's Gabapentin 4:00pm dose from 03/03/2016 to 03/09/2016 revealed the Gabapentin had been administered after 5:00pm on 4 of the 7 days. Review of a Standard Medication Administration Times document revealed: -Prescribed drug administration schedule used included the following unless otherwise prescribed: three times a day = 8:00am, noon, and 4:00pm. -"Before meals" med times are determined on each unit based on actual meal time for those patients. -"Before meals" meds should be given approximately 30 minutes prior to meal.	D 358		

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D 358	Continued From page 38 -The hours of administration are subject to change upon order of the physician or based on the action or interaction of the medication with other medications or foods, or to meet the special needs of a particular resident without a specific physician's order as long as the dosing intervals are not different than those defined above. -Routine medications may be given within one hour (before or after) of the time indicated on the Medication Administration Record. Review of the Plan of Protection dated 03/10/16 submitted by the facility revealed: -The facility's registered nurse (RN) will conduct additional training/education on proper medication administration to include but not limited to medications before, after and during meals, one hour administration window, FSBS, insulin parameters and administration. -Medication pass observations initiated on 03/06/16 and will continue weekly, documented and filed. -Medication pass observations wil be monitored by licensed professionals during site visits. -The RN will train and implement medication order process and procedure to include "New Order" tracking form, which includes designated color coded system. -Pharmacy will communicate to facility any medication errors detected by the pharmacy staff. -Pharmacy will communicate such errors to the facility at which time the facility will implement its medication error procedures. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 13, 2016.	D 358		

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D 410	Continued From page 39	D 410		
D 410	10A NCAC 13F .1010(c) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis. This Rule is not met as evidenced by: Type B Violation Based on record review and staff interview, the facility failed to assure the provision of pharmaceutical services to meet the needs of residents including procedures that assure the accurate ordering, receiving, and administering of all prescribed medications to 2 of 7 residents (#2, #6) sampled whose medications were not accurately transcribed to the Medication Administration Record as ordered (#6) and were received and administered without an order (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 11/02/15 revealed diagnoses included hypothyroidism, anemia, diabetes mellitus, hyperlipidemia, and hyperplasia of prostate. Review of Resident #2's October and November 2015 Medication Administration Records (MAR) revealed Valproic Acid (Depakote) was not documented on the MARS. Review of documentation on Resident #2's MAR for the months of December 2015, January 2016,	D 410	Facility requested a Quality Assurance program from the pharamcy on reporting errors. Pharmacy will conduct an internal investigation of any pharmacy errors using a quality tracking log and will be available to clinical & corporate personnel. Initated 3/14/16 & ongoing.	Target Date 4/28/16

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D 410	Continued From page 40 and February 2016 revealed: -There was an entry dated 12/17/15 for Depakote 125mg, 2 capsules (250mg) by mouth twice a day at 8:00am and 8:00pm for agitation. -Depakote 250mg was documented as administered on 12/17 at 8:00pm and from 12/18/15 through 12/31/15 at 8:00am and 8:00pm. -From 01/01/16 through 01/31/16, Depakote 250mg was documented as administered at 8:00am and 8:00pm. -From 02/01/16 through 02/02/16, Depakote 250mg was documented as administered at 8:00am and 8:00pm (the medication was discontinued on 02/02/16). Interview with a representative from the facility's pharmacy on 03/09/16 at 2:35pm revealed: -Depakote 125mg capsules, 29 tablets were dispensed on 12/17/16. -The order for the medication was not available and the pharmacy director would return telephone call. -The representative did not know how many capsules/pills were dispensed in 01/2016 or 02/2016. Interview with Resident #2's primary medical provider on 03/10/16 at 10:28am revealed: -He became aware Resident #2 was being administered Depakote 250mg, 2 times a day in February, 2016. -He did not know who ordered the Depakote on 12/17/15 or who discontinued the medication on 02/02/17. -He did not know why the resident was started on the Depakote, because the resident did not have dementia, was not agitated, had no other psychiatric diagnosis and did not have seizures. -He did not know where the order came from and	D 410	New medication order process & procedure implemented to include "New Order Tracking", which includes a designated color coded system. Care Managers are responsible for reviewing and approving all orders. Registered Nurse provided training on the medication order processing & procedures. Initiated 3/10/16 & ongoing. Compliance monitoring will be conducted by the facility's Licensed Practical Nurse or Qualified Designee, Registered Nurse, Executive Director, Regional Director of Operations & Clinical Support Staff.	Target Date 4/28/16 Target Date 4/28/16

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D 410	Continued From page 41 must have been a pharmacy error. Review of a letter from the facility's pharmacy dated 03/09/16 revealed: -[The facility's pharmacy] received prescriptions on 12/16/15 for a [Resident #2]. -The prescription was as follows: increase Depakote to (2) 125mg tabs (250mg) po BID for agitation. Dispense 120. -There is more than one [Resident #2] in our system. The prescription was entered into EMAR (electronic medication administration record) inadvertently by [the facility's pharmacy] on [Resident #2's] profile. -The issue was identified by the facility's clinical support staff during a chart audit on 03/09/16 at which time the facility notified the pharmacy. -One of our certified pharmacy technicians, when trying to discontinue the Depakote, inadvertently changed the stop date to 02/02/16 instead of discontinuing the medication as intended. Interview with the facility's Senior Director of Operations and Clinical Services on 3/09/16 at 6:00pm revealed: -The facility became aware of the medication error last week while performing record audits. -The facility's pharmacy dispensed 120 Depakote pills on 12/17/15. -Because the pharmacy entered a stop medication date of 02/02/16, the resident received Depakote 2 times a day from 12/17/15 until 02/02/16. -The facility did not have an order to administer the Depakote to Resident #2. The Depakote should have been dispensed to a resident in another facility. -The facility's pharmacy was responsible for putting new orders in the facility electronic MAR system.	D 410		

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D 410	Continued From page 42 Interview with a 1st shift Medication Aide (MA) on 3/10/16 at 9:10pm revealed: -Resident #2 was started on Depakote 250mg, 2 times a day, in December 2015 near the same time he started radiation treatments for lung cancer. -The resident did not move around a lot, he was weak, his appetite was poor and he slept a lot. -The resident was in bed most of the time and the staff had to bring his meals to him. -The resident provided for his own care before starting the Depakote/radiation treatments, but the staff had to assist the resident with his baths, getting dressed and transferring from bed to wheelchair while on the Depakote. -The resident finished the Depakote on 02/02/16 and continued the radiation treatments until about 2 weeks ago. When the Depakote was stopped, there was a big difference; the resident was able to transfer himself out of bed to his wheelchair, eat meals in the dining room, bathe and dress himself. -The facility's RCC was responsible for approving all new medication/treatment orders on the EMAR. -New medication orders were flagged (in green) and the RCC check the EMAR with the order in the facility and then approve the order. -The MA's did not administer any medications until approved in the EMAR. Interview with the facility's Resident Care Coordinator (RCC) on 3/10/16 at 3:35pm revealed: -The facility's RCC was responsible for making sure medication orders were in the EMAR system correct before the MA's administered the medication. -The RCC compare EMAR with the written	D 410		

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D 410	Continued From page 43 physician orders and if correct, the EMAR was approved and the MA's started administering the new medication. -The Depakote which Resident #2 received from 12/17/15 to 02/02/16 was approved by the former RCC. -An order for the Depakote was not in the resident's records. -While the resident was receiving Depakote, the resident was weak and slept most of the time. The PCA's assisted the resident with his baths, dressing and transferring. -Since Depakote was discontinued, the resident does his own care and transfers himself. Interview with the facility's Pharmacy Consultant (PC) on 3/09/16 revealed: -A pharmacy review for Resident #2 was done on 12/16/15 and the PC did not remember if the Depakote was on the resident's EMAR. -After reviewing the lab report for the Valproic Acid level, " In my mind, I was thinking there should be an order for Valproic Acid in the resident's record or there's a mix up ". - The PC did not see Valproic Acid in the medication cart for the resident. Interview with Resident #2 on 3/14/16 at 10:40am revealed: -The resident was on "a pill" but do not know what the pill was for. -The resident was not getting the pill now, it was stopped last month. -While receiving the pill, the resident sleepy and the staff helped him with his baths, dressing and getting out of bed. -The resident was very weak and sleepy, but was not weak or sleepy after the pill was stopped. -Currently the resident does his own care and transfers self from bed to wheelchair.	D 410		

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D 410	Continued From page 44 2. Review of Resident #6's current FL2 dated 12/01/15 revealed: -Resident #6's diagnoses included anemia, chronic airway obstruction, osteoporosis, hypertension, edema, anxiety states, glaucoma, and atherosclerosis -Medication orders included Cyanocobalamin 1000 micrograms (An injectable medication used to treat low levels of vitamin B12) subcutaneous injection, inject 1 ml every month. Review of Resident #6's Medication Administration Record (MAR) for December 2015 revealed: -There was an entry for Cyanocobalamin 1000 mcg, inject 1ml intramuscularly every month on the 15th. -The Medication Aide (MA) documented the administration of Cyanocobalamin intramuscularly in the right on 12/15/15. Review of Resident #6's MAR for January 2016 revealed: -There was an entry for Cyanocobalamin 1000 mcg, inject 1ml intramuscularly every month on the 15th. -The MA documented the administration of Cyanocobalamin intramuscularly in the left deltoid on 01/15/16. Review of Resident #6's MAR for February 2016 revealed: -There was an entry for Cyanocobalamin 1000 mcg, inject 1ml intramuscularly every month on the 15th. -The MA documented the administration of Cyanocobalamin intramuscularly in the left arm on 02/15/16. Review of Resident #6's Medication	D 410		

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D 410	Continued From page 45 Administration Record (MAR) for December 2015, January 2016 and February 2016 revealed the order dated 12/1/15 to administer Cyanocobalamin 1000 micrograms suboutaneously had been entered on the MARs to administer intramuscularly. Interview and observation with a MA on 03/14/16 at 12:45pm revealed: -The Cyanocobalamin was administered by injection in the "fatty part" of the Resident #6's arm. -The MA demonstrated where the Cyanocobalamin was given by placing her hand over the posterior side of her upper arm. -The Cyanocobalamin was administered the same way that insulin was administered. -The MA used a ½ ml insulin syringe when Cyanocobalamin was administered. -After verifying the dose of the Cyanocobalamin was 1 ml, the MA retrieved a 1 ml insulin syringe out of a closet that was sealed inside an unopened box. -The 1 ml syringe was the syringe used to administer the Cyanocobalamin to Resident #6. Interview with the Administrator on 3/14/16 at 1:10pm revealed: -The Administrator was not aware that there was inconsistent orders regarding Resident #6's Cyanocobalamin. -The MAs should have gotten clarification from the physician regarding the route of administration before administering an injection they knew they were not certified to administer. Review of a physician's order that listed current medications dated March 5, 2016 and signed by the physician assistant for Resident #6 revealed an order for Cyanocobalamin 1000mcg inject 1ml	D 410		

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D 410	Continued From page 46 every month on the 15th, schedule on day 15. (No route was indicated.) Review of a clarification request to the physician revealed: -There was a clarification order dated 03/06/16. -The physician signed the order on 03/08/16. -"The B12 injection is 1ml every month, do you want it IM/SQ?" -The Physician documented on the clarification, "The B12 is intramuscular." Review of the facility's Plan of Protection dated 03/14/16 revealed: -The facility notified the pharmacy, the pharmacy consultant, the physician and the responsible party on 3/9/16. -The facility requested a quality assurance program on reporting errors from the pharmacy. -The facility implemented a physician order process and procedure (new order form) to be completed by the facility's care manager (RCC) and monitored by the facility's licensed professional. -Compliance monitoring will be conducted by the facility's licensed practical nurse, registered nurse, executive director, regional director of operations and clinical support staff. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 28, 2016.	D 410		
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	D912		

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D912	Continued From page 47 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 observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care, medication orders, medication administration, and pharmaceutical services. The findings are: 1. Based on observations, interviews, and record reviews for 2 of 7 residents sampled, the facility failed to notify the physician when blood pressure readings were outside ordered parameters (#3), failed to coordinate a physician consultation and a diagnostic procedure and failed to notify the healthcare provider during a facility visit for a resident's health complaints (#6). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 3 of 7 sampled residents (Residents #2, #5 and #7), including, administering an antipsychotic medication not ordered, a vitamin supplement, missed doses of medications not in the facility, and hypertension medication, and a 7% medication error rate during observation of the medication pass, 2 errors out of 27 (Resident #9's	D912	Resident Rights training provided on 3/7/16 & 3/13/16 conducted by Senior Executive Director & Registered Nurse. Ombudsman conducted Resident Rights training on 3/29/16 & 4/7/16. Refer to Plan of Correction for Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)	

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D912	Continued From page 48 Omeprazole administered after a meal instead of before meals as ordered and a missed Gabepentin dose for Resident #1 [Refer to TAG 0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on record review and staff interview, the facility failed to assure the provision of pharmaceutical services to meet the needs of residents including procedures that assure the accurate ordering, receiving, and administering of all prescribed medications to 2 of 7 residents (#2, #6) sampled whose medications were not accurately transcribed to the Medication Administration Record as ordered (#6) and were received and administered without an order (#2). [Refer to Tag 410, 10A NCAC 13F.1010(c) Pharmaceutical Services (Type B Violation)].	D912	Refer to Plan of Correction for Tag 0358, 10A NCAC 13F. 1004(a) Medication Administration (Type A Violation) Refer to Plan of Correction for Tag 410, 10A NCAC 13F .1010(c) Pharmaceutical Services (Type B Violation)	
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	D934		

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D934	Continued From page 49 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that 1 of 3 sampled Medication Aides (Staff F) completed the annual state medication aide infection control training. The findings are: Review of the personnel file for Staff F (Medication Aide) revealed: -There was no hire date in Staff F's personnel file. -Staff F had been working as a MA since 4/11/12. -There were certificates of completion that Staff F completed State Infection Control training on 12/6/13 and 12/29/14. Staff F was not available for interview prior to exit. Interview with the Administrator on 3/11/16 at 4:00pm revealed: -The staff had completed trainings that they might not have certificates for in the personnel files. -Infection Control training was required annually. -The Administrator verified on his computer that the last training Staff F completed for State Infection Control was on 12/29/14. Interview with the Corporate Nurse on 3/11/16 at 4:45pm revealed: -There should be certificates located for Staff F that showed State Infection Control training was completed in 2015 if Staff F attended the training. -She had just completed Infection Control training with all staff on 3/9/16.	D934	Employee files will be audited to ensure initial & annual required training has been completed. Any discrepancies found will be corrected as of 5/2/16. Compliance will be monitored by the Business Office Manager, Executive Director and the Quality Assurance Team. 5/2/16 Infection Control training conducted by Registered Nurse for all staff on 3/13/16 & ongoing. Care Managers will monitor infection control training for medication aides and ensure initial & annual training is conducted. Compliance will be monitored bythe Executive Director. 5/2/16	