STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PEACHTREE MC	2814 PEACHTREE ROAD STATESVILLE, NC 28625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey December 28-30, 2016 with an exit conference via telephone on January 6, 2017.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to properly store milk and fortified milk on ice, while used during meal service, in 2 of 2 resident dining rooms, in the memory care unit. The findings are: Observations on 12/28/16 at 8:00am of the breakfast meal in the Resident Dining Room on the Peachtree hallway revealed: -Residents seated and awaiting breakfast to be served. -No residents had been served any milk. -A rectangular storage container on a cart contained a gallon of milk, a covered pitcher labeled fortified milk and waxed paper cartons of orange juice and other juices. -No ice in the storage container. Additional observations on 12/28/16 at 8:17am, 8:25am and 8:32am of the breakfast meal in the Resident Dining Room on the Peachtree hallway revealed: -Residents being served and eating breakfast.	D 283		

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D 283	Continued From page 1 -Residents with glasses of orange juice and apple juice at their place settings. -No residents with glasses of milk at their place settings. -A rectangular storage container on a cart contained a gallon of milk, a covered pitcher labeled fortified milk and waxed paper cartons of orange juice and other juices. -No ice in the storage container. Observation on 12/28/16 at 8:50am of the Dietary Aide in the hallway outside of the Kitchen revealed: -She was pushing a cart from the direction of the Resident Dining Room in the Hummingbird hallway. -A rectangular storage container on the cart contained a gallon of milk, a covered pitcher labeled fortified milk and waxed paper cartons of orange and apple juice. -No ice in the storage container. Interview on 12/28/16 at 8:52am of the Dietary Aide revealed: -The cart with the storage container holding milk and juice (observed coming back to the kitchen from the Resident Dining Room in the Hummingbird hallway) had been delivered there "about 8:30." -The cart with the storage container holding milk and juice from the Resident Dining Room in the Peachtree hallway had been delivered there "about 8:15," but she had already returned the beverages to the refrigerator. Observation on 12/28/16 at 8:55am of temperatures of milk from the Hummingbird Resident Dining Room cart revealed: -Milk was poured into a glass from the storage container on the cart.	D 283		

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-The first facility thermometer (described as being "accurate" by the Dietary Aide) placed into the glass of milk read 50 degrees Fahrenheit (F).
-The second facility thermometer placed into the glass of milk read 60 degrees F.
-The third facility thermometer (with digital read-out) placed into the glass of milk read 11.8 degrees Celsius (converted to 56.24 degrees F)
-The surveyor's glass bulb thermometer was placed in an ice water bath, read 32 degrees F and was determined as accurate.
-The surveyor's thermometer placed into the glass of milk read 52 degrees.

Interview on 12/28/16 at 9:00am of the Dietary Manager revealed:
-When milk was delivered to the facility, he refused to accept delivery if the temperature was higher than 50 degrees F.
-He expected milk products to be placed on ice before being delivered to the Resident Dining Rooms.
-He would discard the remaining unused milk products returned from both Resident Dining Rooms.

A second interview on 12/28/16 at 8:50am with the Dietary Aide revealed:
-She normally placed milk products on ice but could not explain why she did not do this for the observed breakfast service.
-When the fortified milk pitcher was delivered to the Hummingbird Resident Dining Room it was full, but upon return to the kitchen the pitcher was half full.
-She did not know if residents in the Hummingbird Resident Dining Room had been served fortified milk with breakfast.

Interview on 12/28/16 at 9:40am with two

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D 283	Continued From page 3 Personal Care Aides (PCAs) revealed: -The PCAs had assisted residents in the Resident Dining Room in the Peachtree hallway during breakfast on that same day. -No milk products were served during that meal service. Interview on 12/28/16 at 9:40am with third PCA revealed: -She had assisted residents in the Resident Dining Room in the Hummingbird hallway during breakfast on that same day. -Milk products were served to residents during that meal service, but she could not remember to whom.	D 283		
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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the administration of gabapentin 200mg at bedtime, was in accordance with orders by a licensed prescribing practitioner for 1 of 6 sampled residents (Resident #6) in the memory care unit.	D 358		

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D 358	Continued From page 4 The findings are: Review of Resident #6's current FL2 dated 12/30/16 revealed: -Diagnoses included Alzheimer's disease, diabetes mellitus, and chronic gout. -Medications which included gabapentin 250mg/5ml solution (used to treat neuropathic pain), 1ml (50mg) twice daily, and gabapentin 250mg/5ml, 4ml (200mg) at bedtime. Review of Resident #6's Resident Register revealed an admission date of 12/01/15. Record review for Resident #6 revealed a previous FL2 dated 11/30/15 which included additional diagnoses of peripheral vascular disease and degenerative joint disease. Review of physician orders for Resident #6 revealed: -An order dated 8/17/16 to change gabapentin to 50mg twice daily and 200mg at bedtime. -An order dated 10/18/16 to change gabapentin capsules to liquid. -An order received on 12/30/16 at 1:34pm for gabapentin 250mg/5ml take 1ml (50mg) twice daily and 4ml (200mg) at bedtime. -No order to discontinue gabapentin 200mg at bedtime. Review of Resident #6's electronic Medication Administration Record (eMAR) for August 2016 revealed: -An entry for gabapentin 300mg capsule, give one capsule at bedtime was discontinued on 8/17/16 at 4:24pm. -An entry dated 8/17/16 at 8:00pm, for gabapentin 100mg give 2 capsules (200mg) at	D 358		

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bedtime.
-An entry for gabapentin 100mg capsule, give one capsule twice daily was discontinued on 8/17/16 at 4:19pm.
-An entry dated 8/18/16 at 8:00am for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm (50mg dose only available as solution).

Review of Resident #6's electronic eMAR for September 2016 revealed:
-An entry for gabapentin 100mg give 2 capsules (200mg) at bedtime.
-An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm.

Review of Resident #6's electronic eMAR for October 2016 revealed:
-An entry for gabapentin 100mg, give 2 capsules at bedtime with a start date 8/17/16 and a discontinue date of 10/19/16 at 5:44pm.
-Gabapentin 200mg was documented as administered from 10/01/16 to 10/18/16 at bedtime.
-There was no documentation for gabapentin 200mg at bedtime from 10/19/16 to 10/31/16.
-An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm, was documented as administered from 10/1/16 to 10/31/16.

Review of Resident #6's eMAR for November 2016 revealed:
-There was no entry for gabapentin 200mg at bedtime.
-An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm, was documented as administered from 11/1/16 to 11/30/16.

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D 358	Continued From page 6 Review of Resident #6's eMAR for December 2016 revealed: -There was no entry for gabapentin 200mg at bedtime. -An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm, was documented as administered from 12/1/16 to 12/30/16. Interview with the first shift Medication Aide (MA) on 12/29/16 at 11:36am revealed: -The order for the gabapentin 200mg bedtime dose was not entered when it changed from capsule to liquid. -The bedtime dose was documented as discontinued by a MA on 10/19/16. -The MA that entered the stop date of 10/19/16 no longer worked in the facility. -When the MAs received a new or changed order the MAs entered it into the computer and then faxed it to the pharmacy. Interview with the Health and Wellness Director, Registered Nurse (HWD, RN) on 12/29/16 at 1:56pm revealed: -The MAs processed all orders. -MAs called the pharmacy, faxed the order to the pharmacy, and completed the New Order Tracking form. -MAs entered new orders into the eMAR, placed the order in a notebook for MAs/HWD/RCC to review, then the HWD reviewed the order with information that had been entered on the eMAR. -A copy of the order was stapled to the New Order Tracking form and the original order was filed in the chart. -New Order Tracking forms were shredded after one month. Telephone interview with the Pharmacy Manager	D 358		

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D 358	Continued From page 7 on 12/30/16 at 1:30pm revealed: -She had not received a discontinue order for the gabapentin 200mg at bedtime. -The gabapentin 250mg/5ml solution had been filled on 8/17/16 for quantity 180ml, 12/15/16 for quantity 90ml and 12/27/16 quantity 90ml. -She was unsure how the order for gabapentin 200mg at bedtime was discontinued on the eMAR. -The pharmacy only discontinued orders from the eMAR when they received a discontinue order from the Primary Care Provider (PCP). Interview on 12/30/16 at 1:45pm with the HWD, Licensed Practical Nurse (LPN) revealed: -For new admissions, she or the Resident Care Coordinator (RCC) would have the FL-2 available the day of admission and upload the orders into the electronic record. -MAs had the access to the eMAR to make any changes in orders. -A review was done at the end of each in preparation for the new month where the older eMAR was compared to the eMAR for the new month. -Any discrepancies between the eMARs were clarified with the PCP. -The most current order signed by the PCP was the order staff were expected to follow. -The review would be done by the HWD, LPN and the RCC with MA assistance as necessary. -Due to a staff shortage of Personal Care Aides (PCAs), MAs were moved to fill those gaps and as a result she had had to work as a MA for four days a week. -Orders were processed using a New Order Tracking form, which had step-by-step instructions, staff would sign off on, attach a copy of the order and file in a binder. -The binder was reviewed by her on a weekly	D 358		

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basis.
-The New Order Tracking form also required a signature of a second person who would perform "double checking."

Observation of Resident #6's medications on hand in the medication cart on 12/30/16 at 2:37pm revealed:
-All ordered medications were on the medication cart.
-A medication bottle for gabapentin 250mg/5ml solution, with a dispense date of 12/15/16, for quantity 90ml, take 1ml (50mg) by mouth twice daily and take 4ml (200mg) at bedtime.

A second interview on 12/30/16 at 2:42pm with the HWD, LPN revealed:
-The gabapentin order had not changed.
-The staff member who entered the discontinue date in the computer, for the bedtime dose of gabapentin, is no longer employed at the facility.
-The RCC, who would be responsible for confirming that orders were entered into the eMAR correctly, was no longer employed by the facility.

Review of the facility's Medication Administration policy revealed:
-Medication directions on the physician order and pharmacy label shall correlate with the medication directions on the eMAR.
-Medication administration must be in accordance with the prescriber's orders.

Based on observation and record review the resident was determined to not be interviewable.

Telephone interview with the Primary Care Provider (PCP) on 1/4/17 at 1:39pm revealed there was "no harm done" related to the missed

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D 358	Continued From page 9 doses of gabapentin 200mg at bedtime. Attempted telephone interview with Resident #6's Power of Attorney (POA) was unsuccessful on 1/5/17. The facility's failure to assure medications as ordered for 1 of 6 residents, resulted in Resident #6, with diagnoses of Alzheimer's disease, diabetes mellitus, and peripheral vascular disease, missing 71 doses of gabapentin (used to treat neuropathic pain), 200mg at bedtime, from 10/19/16 to 12/29/16. The failure of the facility to assure medications were administered as ordered, was detrimental to the health and safety of the resident, which constitutes a Type B Violation. The facility provided the following Plan of Protection on 1/6/17: -PCP will be faxed to notify of this incident and also to clarify if this order still stands. -Order received to take medication at night. -MA to complete New Order Tracking form on all new orders. -HWD/RCC/designee to check New Order Tracking form to ensure orders are accurate. -HWD/RCC/designee to audit any new orders. -Will have New Order Tracking form filled out and reviewed by HWD/RCC/designee daily when in community for the next thirty days and at least weekly thereafter. DATE OF CORRECTION FOR THIS TYPE B VIOLATION WILL BE FEBRUARY 20, 2017.	D 358		

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D 400	Continued From page 10	D 400		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION	D 400		

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D 400	Continued From page 11 Based on observations, record reviews, and interviews, the facility failed to assure quarterly on-site medication reviews, that identified and prevented medication related problems for 6 of 6 (#1, #2, #3, #4, #5, and #6) sampled residents, in the memory care unit. The findings are: A. Review of Resident #6's current FL2 dated 12/30/16 revealed: -Diagnoses included Alzheimer's dementia, diabetes mellitus, hypertension, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, chronic gout, hyperlipidemia, and muscle weakness. -Medications which included gabapentin 250mg/5ml solution (used to treat neuropathic pain), 1ml (50mg) twice daily, and gabapentin 250mg/5ml, 4ml (200mg) at bedtime; nitroglycerin (used to treat chest pain) 0.4mg/hour apply 1 patch daily and remove at bedtime; Lasix (used to treat edema), 20mg every morning; Max-Ox (used to treat low magnesium levels in the blood), 400mg every morning; allopurinol (used to treat gout), 300mg daily; Plavix (used to prevent blood clots), 75mg daily; aspirin (used to prevent blood clots), 81mg daily with food; chlorthalidone (used to treat edema and high blood pressure), 25mg daily; and trazodone (used to treat insomnia), 100mg at bedtime. -The resident had orders for many additional medications. Review of Resident #6's Resident Register revealed an admission date of 12/01/15. Record review for Resident #6 revealed a previous FL2 dated 11/30/15 which included	D 400		

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additional diagnoses of peripheral vascular disease and degenerative joint disease.

Review of physician orders for Resident #6 revealed:
-An order dated 6/13/16 to change aspirin to 81mg daily with food.
-An order dated 7/6/16 to change trazodone to 100mg at bedtime and to add fiber-laxative 0.52 grams twice daily.
-An order dated 7/8/16 to discontinue Celexa 20mg daily.
-An order dated 8/17/16 to change gabapentin to 50mg twice daily and 200mg at bedtime.
-An order dated 9/19/16 to discontinue spironolactone 25mg daily and potassium chloride 20meq three times daily.
-An order dated 10/18/16 to change gabapentin capsules to liquid.
-An order received on 12/30/16 at 1:34pm for gabapentin 250mg/5ml take 1ml (50mg) twice daily and 4ml (200mg) at bedtime.
-No order to discontinue gabapentin 200mg at bedtime.

Review of Resident #6's electronic Medication Administration Record (eMAR) for August 2016 revealed:
-An entry for gabapentin 300mg capsule, give one capsule at bedtime was discontinued on 8/17/16 at 4:24pm.
-An entry dated 8/17/16 at 8:00pm, for gabapentin 100mg give 2 capsules (200mg) at bedtime.
-An entry for gabapentin 100mg capsule, give one capsule twice daily was discontinued on 8/17/16 at 4:19pm.
-An entry dated 8/18/16 at 8:00am for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm (50mg dose only available as

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D 400	Continued From page 13 solution). Review of Resident #6's electronic eMAR for September 2016 revealed: -An entry for gabapentin 100mg give 2 capsules (200mg) at bedtime. -An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm. Review of Resident #6's electronic eMAR for October 2016 revealed: -An entry for gabapentin 100mg, give 2 capsules at bedtime, with a start date of 8/17/16 and a discontinue date of 10/19/16 at 5:44pm. -Gabapentin 200mg was documented as administered from 10/01/16 to 10/18/16 at bedtime. -There was no documentation for gabapentin 200mg at bedtime from 10/19/16 to 10/31/16. -An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm, was documented as administered from 10/01/16 to 10/31/16. Review of Resident #6's eMAR for November 2016 revealed: -There was no entry for gabapentin 200mg at bedtime. -An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm, was documented as administered from 11/01/16 to 11/30/16. Review of Resident #6's eMAR for December 2016 revealed: -There was no entry for gabapentin 200mg at bedtime. -An entry for gabapentin solution 250mg/5ml, give 1ml (50mg) twice daily at 8am and 2pm, was documented as administered from 12/01/16 to	D 400		

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D 400	Continued From page 14 12/30/16. Interview with the first shift Medication Aide (MA) on 12/29/16 at 11:36am revealed: -The order for the gabapentin 200mg bedtime dose was not entered when it changed from capsule to liquid. -The bedtime dose was documented as discontinued by a MA on 10/19/16. -The MA that entered the stop date of 10/19/16 no longer worked in the facility. -When the MAs received a new or changed order the MAs entered it into the computer and then faxed it to the pharmacy. Telephone interview with the Pharmacy Manager on 12/30/16 at 1:30pm revealed: -She had not received a discontinue order for the gabapentin 200mg at bedtime. -The gabapentin 250mg/5ml solution had been filled on 8/17/16 for quantity 180ml, 12/15/16 for quantity 90ml, and 12/27/16 quantity 90ml. -She was unsure how the order for gabapentin 200mg at bedtime was discontinued on the eMAR. -The pharmacy only discontinued orders from the eMAR when they received a discontinue order from the Primary Care Provider (PCP). Subsequent review of Resident #6's record revealed: -The most current quarterly pharmacy review had been completed on 5/26/16. -A recommendation to reduce the aspirin dose to 81mg daily. -Documentation was absent for quarterly pharmacy reviews in August and November 2016. Refer to interview on 12/29/16 at 11:05am with the facility's Health and Wellness Director,	D 400		

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D 400	Continued From page 15 Registered Nurse (HWD, RN). Refer to interview on 12/30/16 at 1:15pm with the contract pharmacy Pharmacist Reviewer. Refer to review of the Pharmacy Products and Services Agreement from the consulting pharmacy. B. Review of Resident #2's current FL2 dated 6/20/16 revealed: -Diagnoses included dementia, hypertension, deafness, type II diabetes, osteoporosis, schizophrenia, and allergic rhinitis. -Medications which included Geodon (used to treat schizophrenia), 20mg daily 1 hour prior to sleep, Norvasc (used to treat high blood pressure), 5mg daily, lisinopril (used to treat high blood pressure), 20mg daily, Besivance (used to treat conjunctivitis), 0.6% 1 drop in both eyes twice daily, glimepiride (used to treat high blood sugar), 2mg twice daily, metformin (used to treat high blood sugar) 500mg twice daily, Levemir (used to treat high blood sugar), 100units/1ml inject 8 units subcutaneously (SQ) twice daily. -The resident had orders for many additional medications. Review of Resident #2's Resident Register revealed an admission date of 7/13/09. Review of physician orders for Resident #2 revealed: -An order dated 7/12/16 to discontinue Besivance 0.6% 1 drop both eyes twice daily. -An order dated 8/9/16 to decrease Levemir injection to 2 units SQ twice daily. -An order dated 10/4/16 for ciprofloxacin 500mg 1 tablet every 12 hours for 7 days. -An order dated 10/4/16 for polymyxin B/	D 400		

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trimethroprim opthalmic 10,000 units/1mg/ml, 1 drop in both eyes every 3 hours for 10 days.
-An order dated 10/17/16 for ciprofloxacin 500mg 1 tablet every 12 hours for 10 days.

Subsequent review of Resident #2's record revealed:
-The most current quarterly pharmacy review had been completed on 5/26/16.
-Documentation was absent for quarterly pharmacy reviews in August and November 2016.

Refer to interview on 12/29/16 at 11:05am with the facility's HWD, RN.

Refer to interview on 12/30/16 at 1:15pm with the contract pharmacy Pharmacist Reviewer.

Refer to review of the Pharmacy Products and Services Agreement from the consulting pharmacy.

C. Review of Resident #3's current FL2 dated 1/27/16 revealed:
-Diagnoses included Alzheimer's disease, hypertension, depression, osteoporosis, and hypothyroidism.
-Medications which included Celexa (used to treat depression), 20mg daily; Lopressor (used to treat high blood pressure), 25mg daily; synthroid (used to treat hypothroidism), 25mcg daily; Namenda (used to treat dementia), 5mg twice daily; vitamin E oil apply to affected areas twice daily; lidocaine (a local anesthetic) 5% ointment apply to rectal tissue three times daily; granulated sugar (used to decrease inflammation of rectal prolapse) apply ¼ cup to rectum twice daily; and oxycodone (used to treat moderate to severe pain), 5mg ½ tablet every 6 hours for pain.
-The resident had orders for many additional

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medications.

Review of Resident #3's Resident Register revealed an admission date of 2/06/13.

Review of physician orders for Resident #3 revealed:
-An order dated 10/25/16 to discontinue Lopressor 25mg daily.
-An order dated 12/01/16 to discontinue vitamin E oil twice daily.
-An order dated 12/01/16 to change sugar to ¼ cup to rectum three times daily.

Subsequent review of Resident #3's record revealed:
-The most current quarterly pharmacy review had been completed on 5/26/16.
-Documentation was absent for quarterly pharmacy reviews in August and November 2016.

Refer to interview on 12/29/16 at 11:05am with the facility's HWD, RN.

Refer to interview on 12/30/16 at 1:15pm with the contract pharmacy Pharmacist Reviewer.

Refer to review of the Pharmacy Products and Services Agreement from the consulting pharmacy.

D. Review of Resident #1's current FL2 dated 02/02/16 revealed:
-Diagnoses included history of a left hip fracture and Alzheimer's dementia.
-Medications which included amlodipine (a medication used to treat high blood pressure), 5 mg, one tablet every day; trazodone (a medication used to treat depression), 50 mg, one tablet at bedtime; citalopram (a medication used

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D 400	Continued From page 18	D 400		

to treat depression), 20 mg, one tablet every day; and levetiracetam (a medication used to treat seizures), 100 mg/ml, 1 teaspoon (5 ml) twice a day.
-The resident had orders for many additional medications.

Review of Resident #1's Resident Register revealed an admission date of 01/06/15.

Review of physician orders for Resident #1 revealed:
-An order dated 6/15/16 to discontinue amlodipine.
-An order dated 09/28/16 for quetiapine (an antipsychotic medication used to treat depression, bipolar disorder and schizophrenia), 50 mg, one tablet twice a day.
-An order dated 09/28/16 for valproic acid (a medication used to treat seizures and also to treat impulse control behaviors), 125 mg, two capsules twice a day.
-An order dated 09/30/16 to decrease the dosage of quetiapine to 25 mg, twice a day.

Review of Resident #1's last completed quarterly pharmacy review revealed:
-A date of 5/26/16.
-No recommendations were made for consideration by the resident's provider.
-Documentation was absent for quarterly pharmacy reviews in August and November 2016.

Refer to interview on 12/29/16 at 11:05am with the facility's HWD, RN.

Refer to interview on 12/30/16 at 1:15pm with the contract pharmacy Pharmacist Reviewer.

Refer to review of the Pharmacy Products and

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D 400	Continued From page 19 Services Agreement from the consulting pharmacy. E. Review of Resident #4's current FL2 dated 01/13/16 revealed: -Diagnoses included diabetes mellitus and Alzheimer's dementia. Medications included sertraline (an antidepressant), 25 mg, one tablet every day; Atropine 1% (an anticholinergic medication to reduce secretions), place two drops under the tongue every 4 hours as needed; Morphine Sulfate solution (a narcotic pain medication), 20 mg/ml, give .25 ml (5 mg) orally or sublingually every 4 hours as needed for moderate to severe pain or for shortness of breath. -The resident had orders for many additional medications. Review of Resident #4's Resident Register revealed an admission date of 01/14/14. Review of physician orders for Resident #4 revealed: -An order dated 09/28/16 for hydrocodone/acetaminophen (a narcotic pain medication), 5 mg/325 mg, one tablet twice a day for pain. -An order dated 09/28/16 for phenytoin sprinkles (an anti-seizure medication), 100 mg, open one capsule and sprinkle into applesauce twice a day. Review of Resident #4's last completed quarterly pharmacy review revealed: -A date of 5/26/16. -No recommendations were made for consideration by the resident's provider. -Documentation was absent for quarterly pharmacy reviews in August and November 2016.	D 400		

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Refer to interview on 12/29/16 at 11:05am with facility's HWD, RN.

Refer to interview on 12/30/16 at 1:15pm with the contract pharmacy Pharmacist Reviewer.

Refer to review of the Pharmacy Products and Services Agreement from the consulting pharmacy.

F. Review of Resident #5's current FL2 dated 10/05/16 revealed:
-Diagnoses included Alzheimer's dementia, vascular dementia with behavioral disturbances, depression/anxiety, hypertension, asthma and dyspnea (difficulty breathing).
-Medications which included oxycodone (a narcotic pain medication), 5 mg, ½ tablet twice a day; tramadol (a controlled pain medication), 50 mg, ½ tablet every six hours as needed; and sertraline (an antidepressant), 25 mg, one table every morning.
-The resident had orders for many additional medications.

Review of Resident #5's Resident Register revealed an admission date of 11/09/11.

Review of Resident #5's last completed quarterly pharmacy review revealed:
-A date of 5/26/16.
-No recommendations were made for consideration by the resident's provider.
-Documentation was absent for quarterly pharmacy reviews in August and November 2016.

Refer to interview on 12/29/16 at 11:05am with the facility's HWD, RN.

Refer to interview on 12/30/16 at 1:15pm with the

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D 400	Continued From page 21 contract pharmacy Pharmacist Reviewer. Refer to review of the Pharmacy Products and Services Agreement from the consulting pharmacy. _____ Interview on 12/29/16 at 11:05am with the HWD, RN revealed: -Whoever did pharmacy reviews would provide us their recommendations to give to the doctors. -The Health and Wellness Director had been at the facility since July, 2016 and since that time pharmacy reviews had not been done. -The Resident Care Coordinator (RCC) would normally be responsible for ensuring pharmacy reviews were completed but she left in November, 2016 and her position is still vacant. -Resident record audits might catch discrepancies between physician orders and medication administration but they had not been regularly scheduled. -The contract pharmacy was contacted and stated someone would be coming to the facility on 12/30/16 to complete pharmacy reviews. -"It would be good to have something on our calendar" to remind the facility when pharmacy reviews were due. Interview on 12/30/16 at 1:15pm with the contract pharmacy Pharmacist Reviewer revealed: -This past year the facility changed from one contract pharmacy to the current one. -The new contract pharmacy consulted with many facilities and his supervisor did not add the facility to the list for required pharmacy reviews. -The facility called the contract pharmacy the day before and he was directed to come and do pharmacy reviews. -Pharmacy reviews were important to confirm	D 400		

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D 400	Continued From page 22 orders were correct and to notify providers of any discrepancies. -Medication Administration Records were electronic and as lab results were scanned into the electronic record, he would have access to all required records for the facility. -He compared pharmacy electronic records to the facility electronic records to note any differences. -Pharmacy reviews for the whole facility would be done by the end of the New Year's weekend. Review of the Pharmacy Products and Services Agreement from the consulting pharmacy revealed: -A consultant pharmacist employed by the Pharmacy will perform 4 annual on-site clinical medication assessments of all residents in the Community. -The consultant pharmacist will not provide any remote clinical assessments for residents in a memory care or Alzheimer's Community. The facility's failure to assure quarterly on-site medication reviews for 6 of 6 residents (#1, #2, #3, #4, #5, and #6) resulted in Resident #6, with diagnoses of Alzheimer's disease, diabetes mellitus, and peripheral vascular disease, missing 71 doses of gabapentin (used to treat neuropathic pain) 200mg at bedtime, from 10/19/16 to 12/29/16. The failure of the facility to assure quarterly on-site medication reviews was detrimental to the health and safety of the residents, and constitutes a Type B Violation. The facility provided the following Plan of Protection on 1/06/17: -Consulting pharmacy notified and confirmed that reviews were not completed in August or	D 400		

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D 400	Continued From page 23 November. -Pharmacy Consultant will complete reviews on 12/30/16. -Consulting pharmacy will complete all pharmacy reviews quarterly. -HWD/RCC will place their next review due date on calendar to ensure reviews are completed timely. DATE OF CORRECTION FOR THIS TYPE B VIOLATION WILL BE FEBRUARY 20, 2017.	D 400		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations, related to medication administration and pharmaceutical care. The findings are: A. Based on observations, interviews and record reviews, the facility failed to assure the administration of gabapentin 200mg at bedtime, was in accordance with orders by a licensed prescribing practitioner for 1 of 6 sampled	D912		

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D912	Continued From page 24 residents (Resident #6) in the memory care unit. [Refer to Tag 358, Medication Administration 10A NCAC 13F .1004(a)(1), (Type B Violation).] B. Based on observations, record reviews, and interviews, the facility failed to assure quarterly on-site medication reviews, that identified and prevented medication related problems for 6 of 6 (#1, #2, #3, #4, #5, and #6) sampled residents, in the memory care unit. [Refer to Tag 400, Pharmaceutical Care 10A NCAC 13F .1009(a), (Type B Violation).]	D912		