Sunrise Senior Living, Inc.
Plan of Correction

Name of Community: Brighton Gardens of Winston Salem
Address: 2601 Reynolds Road Winston Salem, NC 27106
License number: HAL034026
Inspection date(s): March 2, 2017
Name and Title of Sunrise Representative Signing the Plan of Correction:
Randy LeMaster, Regional Director of Operations
Signature of Sunrise Representative: Randy LeMaster, RDO
Date of Submission: April 4, 2017

Regulation	Target Date by Which Correction will be completed	Plan of Correction
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	3/2/17	**A. With respect to the specific resident/situation cited:** Resident # 4: Notified doctor (nurse practitioner) and family on day of survey 3/2/17. Resident was evaluated. Resident experienced no negative outcomes as a result of the event. Obtained an updated FL2 with orders for blood pressure.
	3/10/17	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Resident Care Director (RCD) or designee conducted an audit of MARs and physician orders to confirm that medications are being given per current physician orders.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Reviewed and Accepted 04/19/17 Bonnie Moore

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	3/31/17	During monthly wellness visits, the RCD, wellness nurse or designee will review orders and MARs for accuracy.
	3/16/17 3/31/17	**C. With respect to what systemic measures have been put into place to address the stated concern:** The RCD conducted a re-training session for the wellness team and medication care managers with the support of Home Health and a licensed physician. The RCD will conduct trainings with the wellness nurses and the med techs if discrepancies or issues are identified with the medication administration program, and confirm that documentation is maintained. The RCD will monitor MAR accuracy; confirming components of receiving, transcribing, and adhering to physician orders are in place; confirming related pharmacy communication occurs; and confirming that the month to month MAR transition is accurately performed. The RCD and/or the wellness nurses will conduct MAR reviews; reviewing and clarifying new orders or changes to existing orders; conducting quality reviews of med carts to MARs; and conducting medication pass observations for med techs.
	6/30/17	**D. With respect to how the plan of correction will be monitored:** The ED or designee will report the results of the weekly audit (or monthly reviews) at the Quality Assurance and Performance Improvement Meetings for 3 months. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	3/2/17	**A. With respect to the specific resident/situation cited:** Resident # 2: The pharmacy corrected the orders for the Coumadin. The RCD notified the doctor and the family on the day of the survey, 3/2/17. The RCD obtained an updated FL2.

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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.		Resident #2 was evaluated and experienced no negative outcomes as a result of the event. Resident #1: Resident #1 orders were corrected by the pharmacy during the survey. The RCD notified the doctor and family on 3/2/17. The RCD obtained an updated FL2. Resident #1 was evaluated and experienced no negative outcomes as a result of the event. Resident # 6: The pharmacy corrected the orders for the Coumadin. The RCD notified the doctor and family on 3/2/17. The RCD obtained an updated FL2. Resident #6 was evaluated and experienced no negative outcomes as a result of the event.
	3/23/17	Residents #1,2,6 continue to reside in the community and remain stable.
	3/23/17	A med review was completed by the Physician's Assistant to confirm orders were valid for each resident.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	3/16/17	The RCD, who oversees the Wellness department, re-trained Med Techs and Wellness Nurses regarding medication administration and documentation, guidelines, policies/procedures, anticoagulants, communication of medication refusal, verifying orders and communicating discrepancies to wellness nurse, RCD or designee.
	3/10/17	The RCD, wellness nurse or designee completed a MAR audit on residents which consisted of comparing the MARs to the Physician Order Sheets (POSs) and to new orders or changes in orders that may have occurred after the MARs were printed.
	3/10/17	The RCD or designee conducted an audit of MARs and physician orders beginning with an audit of Coumadin and other anticoagulants and nebulizers to confirm that medications are given in compliance with physician orders.

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	5/2/17 3/31/17	During the audit, the RCD and the wellness nurses made necessary revisions or additions to the MARs to confirm that the medication orders appeared accurately and clearly on the MARs and will perform this audit on a weekly basis for two months. This will be re-evaluated after the two months. On-site quarterly pharmacy audits occur including a medication order review of resident charts. This review incorporates a comparison with the MARs.
	   3/31/17 3/10/17	**C. With respect to what systemic measures have been put into place to address the stated concern:** The RCD is responsible for monitoring MAR accuracy; confirming components of receiving, transcribing, and adhering to physician orders are in place; confirming related pharmacy communication occurs; and confirming that the month to month MAR transition is accurately and thoroughly performed. The RCD and/or the wellness nurses are responsible for conducting MAR reviews; reviewing and clarifying new orders or changes to existing orders; conducting quality reviews of med carts to MARs; and conducting medication pass observations for med techs. MARs/POSs are reviewed throughout the month and at the end of each month by the RCD and/or the wellness nurses for the upcoming month to confirm active orders are accurately reflected in the upcoming MARs and are written with clarity. The RCD conducted a re-training session and conducts trainings with the wellness nurses and the med techs if discrepancies or issues are identified with the medication administration program, and documentation is maintained.
	   6/30/17	**D. With respect to how the plan of correction will be monitored:** The ED or designee will report the results of the weekly audit (or monthly reviews) at the Quality Assurance and Performance Improvement Meetings for 3 months.

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		At the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
Regulation	**Target Date by Which Correction will be completed**	**Plan of Correction**
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.	3/12/17	**A. With respect to the specific resident/situation cited:** Resident # 4: Notified doctor (nurse practitioner) and family on day of survey 3/2/17. Resident was evaluated. Resident experienced no negative outcomes as a result of the event. Obtained an updated FL2 with orders for blood pressure.
	3/10/17 3/31/17	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The RCD or designee conducted an audit of MARs and physician orders to ensure that medications are being given per current physician orders. During monthly wellness visits, the Resident Care Director (RCD), wellness nurse or designee will review orders and MARs for accuracy.
		C. With respect to what systemic measures have been put into place to address the stated concern:

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	3/16/17 3/31/17	The RCD conducted a re-training session for the wellness team and medication care managers with the support of Home Health and a licensed physician. The RCD will conduct trainings with the wellness nurses and the med techs if discrepancies or issues are identified with the medication administration program, and documentation is maintained. The RCD will monitor MAR accuracy; ensuring components of receiving, transcribing, and adhering to physician orders are in place; ensuring related pharmacy communication occurs; and ensuring that the month to month MAR transition is accurately performed. The RCD and/or the wellness nurses will for conduct MAR reviews; reviewing and clarifying new orders or changes to existing orders; conducting quality reviews of med carts to MARs; and conducting medication pass observations for med techs.
	6/30/17	**D. With respect to how the plan of correction will be monitored:** The ED or designee will report the results of the weekly audit (or monthly reviews) at the Quality Assurance and Performance Improvement Meetings for 3 months. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
Regulation	**Target Date by Which Correction will be completed**	**Plan of Correction**
G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	3/2/17	**A. With respect to the specific resident/situation cited:** Resident # 2: The pharmacy corrected the orders for the Coumadin. The RCD notified the doctor and the family the day of the survey on 3/2/17. The RCD obtained an updated FL2. Resident #2 was evaluated and experienced no negative outcomes as a result of the event.

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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.	3/23/17 3/23/17	Resident #1: Resident #1 orders were corrected by the pharmacy during the survey. The RCD notified the doctor and the family the day of the survey on 3/2/17. The RCD obtained an updated FL2. Resident #1 was evaluated and experienced no negative outcomes as a result of the event. Resident # 6: The pharmacy corrected the orders for the Coumadin. The RCD notified the doctor and the family the day of the survey on 3/2/17. The RCD obtained an updated FL2. Resident #6 was evaluated and experienced no negative outcomes as a result of the event. Residents #1,2,6 continue to reside in the community and remain stable. A med review was completed by the Physician's Assistant to ensure orders were valid for each resident
	3/21/17	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The RCD is responsible for monitoring MAR accuracy; ensuring components of receiving, transcribing, and adhering to physician orders are in place; ensuring related pharmacy communication occurs; and ensuring that the month to month MAR transition is accurately and thoroughly performed. The RCD and/or the wellness nurses are responsible for conducting regular MAR reviews; reviewing and clarifying new orders or changes to existing orders; conducting random quality reviews of med carts to MARs; and conducting regular medication pass observations for med techs. MARs/POSs are reviewed randomly throughout the month and at the end of each month by the RCD and/or the wellness nurses for the upcoming month to confirm active orders are accurately reflected in the upcoming MARs and are written with clarity.

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	3/10/17	The RCD conducted a re-training session and regularly conducts trainings with the wellness nurses and the med techs if discrepancies or issues are identified with the medication administration program, and documentation is maintained.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	3/31/17	The RCD is responsible for monitoring MAR accuracy; ensuring components of receiving, transcribing, and adhering to physician orders are in place; confirming related pharmacy communication occurs; and confirming that the month to month MAR transition is accurately and thoroughly performed. The RCD and/or the wellness nurses are responsible for conducting MAR reviews; reviewing and clarifying new orders or changes to existing orders; conducting quality reviews of med carts to MARs; and conducting medication pass observations for med techs. MARs/POSs are reviewed throughout the month by the RCD and/or the wellness nurses for the upcoming month to confirm active orders are accurately reflected in the upcoming MARs and are written with clarity.
	3/10/17	The RCD conducted a re-training session and regularly conducts trainings with the wellness nurses and the med techs if discrepancies or issues are identified with the medication administration program, and documentation is maintained.
		D. With respect to how the plan of correction will be monitored:
	6/30/17	The ED or designee will report the results of the weekly audit (or monthly reviews) at the Quality Assurance and Performance Improvement Meetings for 3 months. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.

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
	HAL034026	A. BUILDING: _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(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 on 02/28/17 through 03/02/17.	D 000		
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 observations, interviews, and record reviews, the facility failed to implement an order for weekly blood pressure (BP) checks for 1 of 7 sampled residents (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 07/14/16 revealed diagnoses included hypertension and dementia. Review of Resident #4's record revealed a physician's order dated 01/20/17 to "check BP weekly WITH MANUAL CUFF ONLY, if BP greater than 150/89, recheck in 10 minutes using the same arm and record on MAR" (Medication Administration Record). Review of Resident #4's January 2017 MAR revealed the order for weekly BP checks was not transcribed to the MAR.	D 276		

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D 276	Continued From page 1 Review of Resident #4's February 2017 MAR revealed there was no entry for weekly BP checks on the MAR. Review of monthly BP checks for Resident #4 from 11/03/16 through 02/01/17 revealed: -On 11/03/16, BP was documented as 162/97. -On 12/01/16, BP was documented as 157/89. -On 01/01/17, BP was documented as 157/96. -On 02/01/17, BP was documented as 124/62. A blood pressure check by facility staff during survey on 03/01/17 was reported as 120/60. Telephone interview on 03/02/17 at 2:00 pm with the Nurse Practitioner (NP) revealed: -During an onsite visit in January, 2017, she noticed documentation of a high BP reading for Resident #4. -She wrote an order for staff to check Resident #4's BP weekly using a manual cuff because there were variations in readings when using digital equipment. -She wanted to monitor Resident #4's BP "better and more accurately" because the resident was taking antipsychotic medications. -Antipsychotic medications increase the risk for hypertensive episodes and stroke. -She entered the BP order into the electronic system and faxed it to the facility while she was still present in the facility. -She waited for the faxed order to come through on the facility fax machine, retrieved the order, and "personally" took it to a staff member to ensure it was implemented. Interview on 03/01/17 at 2:49 pm with a Wellness Nurse revealed: -She transcribed the 01/20/17 physician's orders.	D 276		

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D 276	Continued From page 2 -She missed transcribing the order for weekly blood pressures to the MAR. -The facility had routine auditing procedures at the end of every month to ensure MARs were accurate, but the omission of the order for weekly BPs was missed. Based on review of Resident #4's record, interviews with staff and attempted interview with Resident #4, it was determined the resident was not interviewable.	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 B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 7 sampled residents, regarding aspirin 81 mg (#1), warfarin (#2), and Mucinex and DuoNebs (#6). The findings are: A. Review of Resident #2's current FL2 dated	D 358		

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D 358	Continued From page 3 07/18/16 revealed: -Diagnoses including tachycardia, acute urinary retention and acute cystitis. -Level of care recommended was assisted living facility-memory care. -An order for warfarin 3 mg daily (warfarin is used to thin the blood). Review of Resident #2's Resident Register revealed an admission date to the memory care unit of 02/15/15. Review of Resident #2's record revealed a subsequent physician's order dated 11/18/16 for warfarin 4.5 mg on Monday, Wednesday, Friday, and 3.0 mg on Tuesday, Thursday, Saturday and Sunday [based on an international normalized ratio (INR) result of 1.82 dated 11/18/16). (The therapeutic dose of warfarin should produce an INR in the range of 2.0 to 3.0). Continued review of Resident #2's record revealed INR checks and physician's orders for warfarin as follows: -On 12/02/16, the INR was 1.9 with the dose of warfarin 4.5 mg on Monday, Wednesday, Friday, and 3.0 mg on Tuesday, Thursday, Saturday and Sunday continued. -On 01/13/17, the INR was 2.8 and the same dose of warfarin was continued. -On 02/10/17, the INR was 1.55 and the dose of warfarin was changed on a physician's order dated 2/14/17 to warfarin 3.0 mg on Monday, Wednesday, Friday, and 4.5 mg on Tuesday, Thursday, Saturday and Sunday. Review of Resident #2's December 2016 and January 2017 Medication Administration Record (MAR) revealed warfarin was administered as ordered.	D 358		

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D 358	Continued From page 4 Interview on 02/28/17 at 3:00 pm with the Resident Care Director (RCD) revealed the facility had converted to electronic Medication Administration Record (eMAR) on 02/21/17 and administration of medications was documented on the eMAR beginning on 02/21/17. Review of Resident #2's February 2017 MAR and eMAR, warfarin was not documented as administered as ordered 8 of 28 opportunities. Review of Resident #2's February 2017 MAR from 02/01/17 to 02/21/17 revealed: -An entry for warfarin 4.5 mg on Monday, Wednesday, Friday, and 3.0 mg on Tuesday, Thursday, Saturday and Sunday and scheduled for administration at 7:00 pm. (Warfarin was given as ordered from 02/01/17 to 02/15/17). -A handwritten entry for warfarin 3.0 mg on Monday, Wednesday, Friday, and 4.5 mg on Tuesday, Thursday, Saturday and Sunday on the MAR starting 02/15/17. -On 02/16/17 (Thursday), 02/18/17 (Saturday), and 02/19/17 (Sunday), warfarin 4.5 mg was documented as not administered with "not on cart awaiting" documented as the reason for not administered. Review of Resident #2's February 2017 eMAR from 02/21/17 to 02/28/17 for administration of warfarin revealed: -On 02/21/17 (Tuesday), warfarin 3.0 mg was documented as administered and 4.5 mg should have been administered. -On 02/22/17 (Wednesday), warfarin 4.5 mg was documented as administered and 3.0 mg should have been administered. -On 02/23/17 (Thursday), warfarin 3.0 mg was documented as administered and 4.5 mg should	D 358		

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D 358	Continued From page 5 have been administered. -On 02/26/17 (Sunday), warfarin 2.0 mg was documented as administered and 4.5 mg should have been administered. -On 02/28/17 (Tuesday), there was no documentation of administration on the eMAR and 4.5 mg should have been administered. Observation on 03/02/17 of warfarin 2.0 mg on hand for administration to Resident #2 revealed: -A bingo card with a quantity of 14 dispensed on 02/07/17 with 8 tablets remaining, labeled take one tablet with a 2.5 mg tablet on Monday, Wednesday, and Friday. -A bingo card with a quantity of 9 dispensed on 02/15/17 with 6 tablets remaining, labeled take one tablet with a 2.5 mg tablet on Tuesday, Thursday, Saturday and Sunday. -A bingo card with a quantity of 6 dispensed on 02/24/17 with 6 tablets remaining, labeled take one tablet with a 2.5 mg tablet on Tuesday, Thursday, Saturday and Sunday. Observation on 03/02/17 of warfarin 2.5 mg on hand for administration to Resident #2 revealed: -A bingo card with a quantity of 13 dispensed on 12/20/16 with 3 tablets remaining, labeled take one tablet with 2.0 mg on Monday, Wednesday, and Friday. -A bingo card with a quantity of 13 dispensed on 01/13/17 with 8 tablets remaining, labeled take one tablet with 2.0 mg on Monday, Wednesday, and Friday. -A bingo card with a quantity of 13 dispensed on 02/08/17 with 12 tablets remaining, labeled take one tablet with 2.0 mg on Monday, Wednesday, and Friday. -A bingo card with a quantity of 8 dispensed on 02/15/17 with 8 tablets remaining, labeled take one tablet with a 2.0 mg tablet on Tuesday,	D 358		

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D 358	Continued From page 6 Thursday, Saturday and Sunday. -A bingo card with a quantity of 6 dispensed on 02/24/17 with 6 tablets remaining, labeled take one tablet with a 2.0 mg tablet on Tuesday, Thursday, Saturday and Sunday. -A bingo card with a quantity of 2 dispensed on 02/24/17 with 2 tablets remaining, labeled take one tablet with a 2.0 mg tablet on Tuesday, Thursday, Saturday and Sunday. Observation on 03/02/17 of warfarin 3.0 mg on hand for administration to Resident #2 revealed: -A bingo card with a quantity of 20 dispensed on 12/21/16 with 4 tablets remaining, labeled one tablet on Tuesday, Thursday, Saturday and Sunday. -A bingo card with a quantity of 6 dispensed on 02/15/17 with 6 tablets remaining, labeled one tablet on Monday, Wednesday, and Friday. -A bingo card with a quantity of 6 dispensed on 02/24/17 with 6 tablets remaining, labeled one tablet on Monday, Wednesday, and Friday. Interview on 03/02/17 at 3:15 pm with the evening shift Medication Aide (MA) revealed: -She had been working as a MA in the facility for one year. -She worked different shifts in both the assisted living and special care unit. -The facility had recently changed from paper MARs to eMARs and staff had been trained on documentation in the eMAR system before the changeover. -The Wellness Nurses or the Resident Care Director(RCD) would be responsible assuring the eMAR was correct for administering medications to the residents. -The MAs were responsible to administer medications as ordered. -MA staff were trained to notify the pharmacy if	D 358		

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D 358	Continued From page 7 any medication was out of stock and the pharmacy could arrange for the medication to be received the same day. -The facility had stickers that could be used to note when direction changes occurred which would allow for the medication to be used. -Resident #2 had a "large overstock" of warfarin that could be used in combination strengths to administer the 3.0 mg or 4.5 mg dose. Interview on 03/02/17 at 3:55 pm with the RCD revealed: -The RCD, the Wellness Nurses, and the Assisted Living Coordinator reviewed the residents' MARs compared to the eMARs when the facility converted from paper to electronic MARs on 02/21/17 and worked through 02/24/17 auditing the eMAR conversion. -The eMAR conversion had taken most of her time and she had not performed routine audits on residents' eMARs for accuracy of medication administration. -MA staff were responsible to administer medications according to the eMAR but did not routinely enter orders to the eMAR system. -The Wellness Nurses or the RCD were responsible for reviewing and releasing any new orders or changes to the eMAR. -MA staff or Wellness Nurses had not informed her Resident #2 had not been administered warfarin as ordered. Telephone interview on 03/02/17 at 4:55 pm with the pharmacy provider revealed: -The pharmacy did not have documentation for notification that Resident #2 was out of warfarin at any time within the last 5 months. -The pharmacy sent warfarin bubble packs for Resident #2 anytime there was a change in the directions for administration.	D 358		

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	HAL034026	A. BUILDING: _____ B. WING _____	03/02/2017

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D 358	Continued From page 8 Interview on 03/02/17 at 5:20 pm with the physician revealed: -He preferred to have residents taking warfarin on one dose due to the complexity of alternating doses. -He ordered a recheck of INR for Resident #2 earlier today, (03/02/17), when he was on a routine visit to the facility, since the resident had a recent change in the warfarin therapy. -He was not aware Resident #2 had any variations to the warfarin dose ordered. Based on record review and observation on 03/01/17, it was determined Resident #2 was not interviewable. B. Review of Resident #1's current FL2 dated 07/18/16 revealed: -Diagnoses included advanced dementia, delirium, and syncopate episodes. -An order for aspirin 81 mg chewable daily. (aspirin is used to improve circulation.) Review of Resident #1's Resident Register revealed an admission date to the memory care unit on 03/18/13. Review of Resident #1 record revealed signed physician's orders dated 11/26/16 and 12/26/16 with orders for aspirin 81 mg chewable. Review of Resident #1's record revealed no order to discontinue aspirin 81 mg chewable daily. Review of Resident #1's record revealed signed physician's orders dated 01/24/17 did not include aspirin 81 mg chewable. Telephone interview on 03/02/17 at 3:10 pm with	D 358		

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D 358	Continued From page 9 the physician revealed: -The pharmacy generated the list of current medications monthly and the facility forwarded them to him for his signature. -He had to "try to trust" they were updating the medication list appropriately. -He relied on the facility and pharmacy to ensure the list was correct before being presented to him for signature. -If there was a change in the medication list, he expected the facility to ensure the list was corrected or contact him for clarification. Review of Resident #1's January 2017 Medication Administration Record (MAR) revealed: -An entry for Aspirin 81 mg chewable tablets, scheduled for administration at 8:00 am daily, and documented as administered from 01/01/17 to 01/31/17. Interview on 02/28/17 at 3:00 pm with the Resident Care Director (RCD) revealed the facility had converted to electronic Medication Administration Record (eMAR) on 02/21/17 and administration of medications was documented on the eMAR beginning on 02/21/17. Review of Resident #1's paper MAR for February 2017 revealed: -Aspirin 81 mg chewable tablets was not preprinted on the MAR. -An entry for aspirin 81 mg chewable tablets were transcribed (handwritten) on the MAR, scheduled for 8:00 am and documented as administered from 02/01/17 to 02/21/17. Review of Resident #1's eMAR for February 2016 revealed: -Aspirin 81 mg chewable tablets was not printed	D 358		

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D 358	Continued From page 10 on the eMAR for February. -There was no documentation of administration of aspirin 81 mg chewable tablets from 02/22/17 to 02/28/17. Review of Resident #1's eMAR for March 2016 revealed: -Aspirin 81 mg chewable tablets was not printed on the eMAR March. -There was no documentation of administration of aspirin 81 mg chewable tablets on 03/01/17 or 03/02/17. Observation on 03/02/17 at 3:30 pm of Resident #1's medication on hand for administration revealed there was no aspirin 81 mg chewable tablets available for administration. Telephone interview on 03/01/17 at 10:05 am with a representative for the pharmacy provider revealed: -Aspirin 81 mg chewable was discontinued incorrectly by the pharmacy on 01/11/17. -Aspirin 81 mg chewable was not included in the medications that were transferred to the electronic Medication Administration Record (eMAR) on 02/22/17. -The pharmacy would add the aspirin 81 mg chewable back to the eMAR and send a supply to the facility for Resident #1. -The facility was responsible to notify the pharmacy for any current medication that was found to not be listed on the MAR when doing month to month MAR audits. --The facility was responsible to notify the pharmacy for any current medication that was found to not be listed on the eMAR after the conversion on 02/21/17. -There was no documentation that the facility had contacted the pharmacy for notification that	D 358		

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D 358	Continued From page 11 Resident #1's aspirin 81 mg chewable tablets were discontinued without an order to discontinue. Interview on 03/02/17 at 3:15 pm with the evening shift Medication Aide (MA) revealed: -She had been working as a MA in the facility for one year. -She worked different shifts in both the assisted living and special care unit. -The facility had recently changed from paper MAR to eMAR and staff had been trained on documentation in the eMAR system before the changeover. -The Wellness Nurses or the Resident Care Director (RCD) would be responsible assuring the eMAR was correct for administering medications to the residents. -The MAs were responsible to administer medications as ordered. -MA staff were trained to notify the pharmacy if any medication was out of stock and the pharmacy could arrange for the medication to be received the same day. Interview on 03/02/17 at 3:55 pm with the RCD revealed: -The RCD, the Wellness Nurses, and the Assisted Living Coordinator reviewed the residents' MARs compared to the eMARs when the facility converted from paper to electronic MARs on 02/21/17 and worked through 02/24/17 auditing the eMAR conversion in an attempt to assure the eMAR matched the paper MAR for February 2017. -Apparently, one of the auditors missed that aspirin 81 mg chewable had been handwritten on the February 2017 paper MAR and since it was not in the pharmacy's current medication profile for Resident #1, it was not added to the eMAR	D 358		

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D 358	Continued From page 12 and scheduled for administration. -The eMAR conversion had taken most of her time and she had not performed routine audits on residents' eMARs for accuracy of medication administration. -MA staff were responsible to administer medications according to the eMAR but did not routinely enter orders to the eMAR system. -The Wellness Nurses or the RCD were responsible for reviewing and releasing any new orders or changes to the eMAR. -MA staff or Wellness Nurses had not informed her Resident #1 had not been administered aspirin 81 mg chewable tablets as ordered from 02/22/17 to 03/02/17. -She had already notified the resident's physician, on 03/01/17, for the missed aspirin. -She would complete a medication error report and fax to the physician as follow-up. Based on record review and observation on 03/01/17, it was determined Resident #2 was not interviewable. Telephone interview on 03/02/17 at 5:20 pm with the physician revealed: -The facility routinely did a good job notifying him of any medication problems with the residents. -He had been informed about Resident #1 had missed aspirin for a few days. -His understanding was the medication would be started again for the resident. C. Review of Resident #6's current FL2 dated 09/19/16 revealed a diagnoses of unspecified dementia, history of falls, chronic atrial fibrillation. Review of Resident #6's Resident Register revealed an admission date of 09/19/16.	D 358		

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D 358	Continued From page 13 Review of Resident #6's record revealed a subsequent order in Resident #6's record dated 01/18/17 for Duoneb 1ml via handheld 3 times a day for 10 days, then 3 times a day as needed for wheezing (a bronchodilator that relax muscles in the airways and increase air flow to the lungs), and Mucinex 600 mg 2 times a day for 10 days (an expectorant), a verbal order from Resident #6's physician. Review of Resident #6's January 2017 Medication Administration Record (MAR) revealed: -An entry for Duoneb 1ml via handheld 3 times daily, was transcribed onto the MAR and documented as administered daily at 10:00 am, 3:00 pm and 9:00 pm 01/01/17 to 01/31/17. -No documentation of administration of "as needed", or for the 10 days as ordered. -Duoneb was documented as administered correctly from 01/01/17 at 10:00 am to 01/19/17 at 10:00 am. -Duoneb was not documented as administered correctly from 01/19/17 at 10:00 am till 01/31/17 at 9:00 pm. -No entry for Mucinex 600 mg to be administered for 10 days. Review of Resident #6's February 2017 MAR revealed: -An entry for Duoneb 1ml via handheld 3 times daily, was transcribed onto the MAR and documented as administered daily at 10:00 am, 3:00 pm and 9:00 pm 02/01/17 at 10:00 am till 02/28/17 at 9:00 pm. -No documentation of administration of "as needed", or for the 10 days as ordered. -Duoneb was not documented as administered correctly from 02/01/17 at 10:00 am till 02/28/17 at 9:00 pm.	D 358		

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D 358	Continued From page 14 -No entry for Mucinex 600 mg to be administered for 10 days. Interview on 02/28/17 at 9:36 am with Resident #6's family member revealed: -"Gets a breathing treatment 3 times a day but is very congested". -She thinks that "the congestion has gotten worse in the past month". Interview on 02/28/17 at 9:36 am with Resident #6 revealed: -The staff are aware of increased congestion. -"I just saw the doctor on February 1st. and was ok then. -"All I do is cough up phlegm". -I have breathing treatments 3 times a day but "the congestion has been going on since January" and "I can't eat because of it". Interview on 03/01/17 at 9:25 am with the Resident Care Director (RCD) revealed: -She was not aware Duoneb had been given 3 times a day and the Mucinex had not been given until it had been brought to her attention, by the surveyors. -All new orders were to be put in the computer by the Wellness Nurse, the orders were to be faxed to the pharmacy to be put in the residents profile and then filled. -On the 23rd of each month a new paper MAR was sent to the facility and reviewed 1st by the Medication Aides then a 2nd and 3rd review was done by the Wellness Nurse and the RCD for accuracy and completeness. -As of February 21, 2017 the facility used the Electronic Medication Administration Record (eMAR) instead of paper MARs and the review was the same except now it was in the computer.	D 358		

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D 358	Continued From page 15 Interview on 03/01/17 at 10:05 am with the pharmacy revealed: -Resident #6's MAR's had been printed on 01/23/17 and was sent to the facility for review. -There was no documentation of an order dated 01/18/17 for Duoneb 1ml 3 times a day via handheld for 10 days and then 3 times a day as needed for wheezing or Mucinex 600 mg a day for 10 days. -The only order noted in Resident #6's profile was dated 11/07/16 for Duoneb 1ml nebulizer 3 times a day. -The facility was responsible for faxing the order to the pharmacy so it could be entered into the residents profile and then dispensed. Interview on 03/01/17 at 3:00 pm with the Wellness Nurse revealed: -"All orders that I receive are stamped, faxed and initialed that they are completed by me". -"Prior to 02/21/17, I wrote the new order on the paper MAR, faxed the order to the pharmacy and then initialed that faxed copy that the order was completed". -After 02/21/17, I enter the order into the eMAR, fax the copy to the pharmacy and initial the faxed copy and put the order in a book in the record room so that the doctor can see and then it is to be put in the resident's record after being viewed by the doctor. Telephone interview on 03/01/17 at 3:45 pm with Resident #6's primary care physician revealed: -The resident had not been seen by the physician since November 2016. -"My Physician's Assistant sees this resident". Interview on 03/02/17 at 9:00 am with Resident #6 revealed: -"I get the breathing treatment every day and	D 358		

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D 358	Continued From page 16 sometimes I feel that I don't need them". -He was not aware he was to get Mucinex 600 mg for 10 days. -"It would have helped with my congestion". Telephone interview on 03/02/17 at 2:00 pm with Resident #6's Physician Assistant (PA) revealed: -She was not aware of an order dated 01/18/17 for Duoneb 1ml nebulizer 3 times a day for 10 days and then 3 times a day as needed for wheezing or the Mucinex 600 mg a day for 10 days. -"The order does not show up in the Resident's computer record at the office". -A concern for Resident #6 getting the Duoneb 3 times a day instead of as needed could cause his atrial fibrillation to become more irregular and cause harm to his heart. -Resident #6 not getting his Mucinex 600 mg a day for the 10 days "increased/prolonged his illness". -It was her expectation that the order should have been followed as written. -"Any new order should be kept in a book in the record room for all doctors to look at" and no order was written there. - The new verbal or telephone order was to be counter signed by a physician and the copy in the record was not. The facility failed to administer medications as ordered by the physician regarding Resident #2 not receiving warfarin anticoagulant therapy as ordered could result in either the blood becoming too thin which can cause gastro-intestinal bleeding and/or hemorrhaging in various areas or blood that is too thick which could lead to clotting in the brain or lungs; Resident #1 not receiving aspirin 81 mg as ordered could increase blood thickness resulting in decreased circulation to the	D 358		

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D 358	Continued From page 17 brain and extremities; and Resident #6 regarding not receiving DuoNebs as ordered could result in complications from diminished air supply to the lungs leading to shortness of breath and increased stimulation to the heart resulting in increased heart rate and exacerbation of atrial fibrillation. Mucinex (an expectorate) is used to thin mucous secretion which could cause fluid to gather in the lungs and result in pneumonia. The failure of the facility to administer medications as ordered was detrimental to residents and constitutes a Type B Violation. A Plan of Protection was provided by the facility on 03/02/17 revealed: -The Resident Care Director (RCD) or designee will conduct an audit of eMARs and Physician's orders, beginning with orders for warfarin (Coumadin is a brand) and other anticoagulants and nebulizers, to confirm that medications are being administered in compliance with physicians' orders. -The audit will be completed by 03/10/17 and any issues will be resolved by the RCD and the Wellness Team. -Medication Aide staff will be trained on the policy and procedures for medication administration. -A weekly audit of warfarin (Coumadin is a brand) and other anticoagulants and nebulizers will be conducted by the RCD or designee for 2 months. -The RCD or designee will report the results of the weekly audit at the facility Leadership Team Meetings. -At the conclusion of the two months, the Leadership Team will re-evaluate and initiate any necessary action or extend the audit/review period. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 16,	D 358		

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D 358	Continued From page 18 2017.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding medication administration. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 7 sampled residents, regarding aspirin 81 mg (#1), warfarin (#2), and Mucinex and DuoNebs (#6). [Refer to Tag 358, 10A NCAC 13F .1004(a) (Type B Violation).]	D912		