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OCT 27 2017
ADULT CARE
LICENSURE SECTION
RALEIGH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL097010	A. BUILDING _____ B. WING _____	C 09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGES OF WILKES TRADITIONAL LIVING	206 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Wilkes County Department of Social Services conducted an annual survey and complaint investigation on September 25-27, 2017. The complaint investigation was initiated by the Wilkes County Department of Social Services on August 21, 2017.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to administer aspirin and potassium chloride as ordered for 2 of 5 residents observed (Residents #8 and #9) during a morning medication pass. The findings are: A. Review of Resident #8's current FL2 dated 3/22/17 revealed: -Diagnoses included paroxysmal atrial fibrillation, paroxysmal ventricular tachycardia, and cardiac pacemaker. -A physician's order for aspirin (used to prevent blood clots) 81 mg 2 tablets once daily.	D 358	All medication cards were reviewed and labeled on 9-26-17 with noting the dosage or assuring that the green sticker noting: "note dosage" was on the medication cards. The medication tote checks were initiated immediately to assure that medication packaging was correct. All cards received to date have been correct with either the full dosing amount in one bubble or the "note dosage" sticker has been on the medication. The totes continue to be checked in by the Guest Care Coordinators. This will continue to be completed daily along with administrative staff for one month. If 100% compliant, on November 1, 2017, the med techs will be allowed to check in medications again, as all staff have been provided with the new procedure. (Please see attached signature page)	9-27-17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kendra Byrd — TITLE: Administrator — (X6) DATE: 10-16-17

Reviewed and Accepted
Date: 10/24/17 cs

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D 358	Continued From page 1 Review of Resident #8's initial evaluation physician note dated 3/15/17 revealed: -"History of paroxysmal atrial fibrillation." -"She is not on anticoagulation other than aspirin." Review of Resident #8's signed physician order sheet dated 6/7/17 revealed aspirin 81mg 2 tablets once daily. Review of Resident #8's signed physician order sheet dated 9/9/17 revealed aspirin 81mg 2 tablets once daily. Observation of Staff A, Medication Aide (MA), on the 8am medication pass on 9/26/17 revealed Resident #8 was administered 1 crushed 81 mg aspirin tablet at 8:00am along with ten additional other scheduled medications in applesauce. Observation of Resident #8's aspirin 81mg tablets available on the medication cart on 9/26/17 at 10:10am revealed: -The medication label directions were aspirin 81mg 2 tablets once daily. -There were two bubble packs for the resident and both had been dispensed 9/4/17. -One bubble pack had 7 tablets. -The second bubble pack had 31 tablets. -There were 38 tablets of 81mg aspirin available for resident use. Review of Resident #8's Medication Administration Records (MAR) March 2017 through August 2017 revealed: -Entries for aspirin 81mg take 2 tablets once daily scheduled for 8am. -The aspirin 81mg 2 tablets had been documented administered daily beginning 3/14/17	D 358	On a monthly basis, the Guest Care Coordinator and the director of nursing will do a complete cart audit and back up medication check to assure continued compliance. Findings will be reported in the monthly QA meeting. This will remain on the monthly QA calendar. Any deviations will be addressed immediately by the administrative team. Medications will be returned to the Pharmacy with new dosage orders. The pharmacy sent a statement as well to reflect plan for flagging cards. It is included. [redacted] repeated the Medication Administration Update with Southern Pharmacy. Copy of certificates are included. All med techs including new hires since 9-27-17 have signed the procedure. A copy is included. Please see the five step plan of correction	9-27-17 10-13-17 10-13-17

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D 358	Continued From page 2 to 9/27/17 except for the following dates 8/18/17, 8/27/17, 9/14/17, 9/20/17, and 9/24/17 which were all documented as 'patient refused.' -386 tablets of aspirin 81mg were documented as administered Telephone interview with the facility pharmacy on 9/26/17 at 12 10pm revealed: -The latest order they had for Resident #8 was aspirin 81mg 2 tablet once daily from an FL2 dated 3/3/17. -They had dispensed 60 tablets of aspirin 81 mg for Resident #8 on the following dates: 3/13/17, 4/7/17, 5/7/17, 6/5/17, 7/5/17, 8/3/17, and 9/4/17. -420 tablets of aspinn 81mg were dispensed to the facility for Resident #8. Review of Resident #8's aspirin supply in the facility, the total number of tablets dispensed from the pharmacy, and the documented administrations revealed there were 4 tablets too many available in the resident supply for the resident to have received 2 tablets for every documented administration. Interview with the Special Care Coordinator (SCC) on 9/26/17 at 10:10am revealed: -The Medication Aides had been trained to "check the bubble pack against the medication administration record (MAR) when they take the medications out of the drawer." -"Then you check the MAR again once you pop the med out." -"The last check is right before you are putting the [medication] cards away." Interview with Staff A, Medication Aide, on 9/26/17 at 10:23am revealed: -Resident #8's aspirin was packaged with one 81mg tablet per bubble.	D 358		

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D 358	Continued From page 3 -The pharmacy usually packaged the entire dose in one bubble. -"If the med is packaged one tablet per bubble, but the dose is two tablets, when the medication comes in we write on the corner of the bubble pack 'pop 2' or 'use 2 tabs' as a reminder to staff to give the correct dose." -No one had made a note on Resident #8's aspirin package. Interview with the SCC on 9/27/17 at 1:24pm revealed: -Resident #8 "takes aspirin for atrial fibrillation." -"She will refuse meds at times and you can't do that with [some anticoagulants]." -"I did notify [Resident #8's physician's name] yesterday about the error and to see if we could give the medication late." -He documented everything in Resident #8's record. Interview with the Administrator on 9/27/17 at 11:34am revealed: -"The pharmacy will package the meds as dosed if there is room in the bubble." -She did not understand why the pharmacy had not packaged the two 81mg aspirin dose for Resident #8 into each bubble. -Usually when the bubble did not have the entire dose, the pharmacy would put a green label on the top of the bubble pack to indicate "note dosage." -However, the pharmacy had not put a green sticker on Resident #8's aspirin bubble pack. -When the pharmacy doesn't put the green label, "staff try to write 2 tabs" as a reminder. -"I'm not sure why they didn't do that on the Special Care Unit." -"That's why we are going to have the SCC start checking in the medications on delivery."	D 358		

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D 358	Continued From page 4 -The SCC was going to start checking medications in from the pharmacy deliveries for the Special Care Unit (SCU) residents Monday through Friday to ensure there were reminders put on the bubble packs to alert staff to 'note dosage.' -5 of 6 medication deliveries in the SCU would be covered by the SCC checking in the medications. -The weekend medication delivery would be checked in by the facility Registered Nurse, Assistant Administrator, and the Administrator who were required to come in 2 hours every weekend. B. Review of Resident #9's current FL2 dated 9/18/17 revealed: -Diagnoses included hypertension, Type 2 Diabetes Mellitus, and proteinuria. -A physician's order for potassium chloride ER (used to supplement potassium levels) 10 meq 2 capsules daily. -A physician's order for furosemide (a potassium depleting diuretic) 40mg 1 tablet two times daily. Review of Resident #9's progress note dated 5/5/17 revealed: -A diagnosis of hypokalemia (low potassium level). -The resident "is maintained on supplemental potassium. She says the tablets are too big for her to swallow even when broken on half." -"Will change to pull apart capsules given in applesauce." Review of Resident #9's signed physician order sheet dated 6/9/17 revealed potassium chloride capsule 10 meq ER 2 capsules mixed in applesauce daily. Review of Resident #9's signed physician order	D 358		

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D 358	Continued From page 5 sheet dated 9/9/17 revealed potassium chloride capsule 10 meq ER 2 capsules mixed in applesauce daily. Review of Resident #9's laboratory results revealed: -On 2/13/17, a potassium level of 3.3 low (reference interval 3.5-5.2). -On 8/22/17, a potassium level of 4.4 normal (reference interval 3.5 - 5.2). -On 9/27/17, a potassium level of 3.9 normal (reference range 3.6 to 5.1). Observation of Staff D, Medication Aide, on the 8am medication pass on 9/26/17 revealed Resident #9 was administered 1 potassium chloride ER 10meq capsule. Observation of Resident #9 on 9/26/17 at 9:08am revealed she told Staff D: -"I have one potassium today" as she looked through the medications in her plastic cup. -"Sometimes I have one and sometimes I have two." -Staff D responded to the resident that she was supposed to get 2 tablets of potassium chloride and she would to back to the cart and get the other one for her. Observation of Staff D, MA, on 9/26/17 at 9:15am revealed she administered 1 additional capsule of potassium chloride 10meq to Resident #9. Review of Resident #9's June 2017 through September 2017 MARs revealed: -Entries for potassium chloride ER 10 meq take 2 capsules mixed in applesauce daily scheduled for 8am. -The potassium chloride ER 2 capsules had been documented administered daily beginning 5/6/17	D 358		

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D 358	Continued From page 6 to 9/26/17. -288 capsules of potassium chloride ER 10meq were documented as administered. Telephone interview with the facility pharmacy on 9/26/17 at 12:10pm revealed: -The latest order they had for Resident #9 was potassium chloride 2 capsules once daily from an order dated 5/5/17. -They had dispensed potassium chloride 10meq for Resident #9 on the following dates: 5/5/17 60 capsules, 6/27/17 58 capsules, 6/30/17 60 capsules, 8/1/17 60 capsules, 8/25/17 60 capsules, and 9/18/17 60 capsules. -358 potassium chloride 10 meq capsules were dispensed to the facility for Resident #9. Observation on 9/26/17 at 12:31pm of Resident #9's potassium chloride ER 10meq capsules available on the medication cart revealed there were two capsules on hand. Interview with the Resident Care Coordinator (RCC) on 9/26/17 at 2:45pm revealed: -There were 3 bubble packs of potassium chloride ER 10meq capsules on hand for Resident #9. -The facility Registered Nurse had contacted Resident #9's physician and spoke with her the issue with the resident's medication. Observation of Resident #9's potassium chloride ER 10meq capsules available in the facility overstock storage on 9/26/17 at 2:45pm revealed: -One package of 30 capsules dispensed 8/25/17. -Two packages of 30 capsules dispensed 9/18/17. -There were 90 total capsules of potassium chloride ER 10meq available in overstock for Resident #9.	D 358		

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D 358	Continued From page 7 Review of Resident #9's potassium chloride ER 10meq supply in the facility, the total number of tablets dispensed from the pharmacy, and the documented administrations revealed there were 22 tablets too many available in the resident supply for the resident to have received 2 tablets for every documented administration. Interview with Resident #9 with the facility Administrator present on 9/26/17 at 4:45pm revealed: -"Sometimes I get one potassium and other times I get two." -"I think because they make different strengths, and so sometimes I get one and sometimes I get two tablets." -Resident #9 was aware she was supposed to get 20meq of potassium chloride once daily. Telephone Interview with Resident #9's physician on 9/27/17 at 8:10am revealed: -"We need to ask the pharmacy to package the medication as it is to be dosed." -She was "not alarmed" that the resident might have only received one 10meq capsule of potassium chloride on occasion. -"I like to keep people above 4" with their potassium level. -"Since she was 4.4 on 8/22/17" then she was not concerned. -She was going to order a potassium level to be drawn "today." -"I will call the [facility Registered Nurse's name] today to get another level drawn." Interview with the Administrator on 9/27/17 at 11:34am revealed: -"The pharmacy will package the meds as dosed if there is room in the bubble."	D 358		

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D 358	Continued From page 8 -The potassium chloride 10meq capsules for Resident #9 were "too big to fit in the bubble." -The RCC was going to start checking medications in from the pharmacy deliveries for the Assisted Living residents Monday through Friday to ensure there were reminders put on the bubble packs to alert staff to 'note dosage.' -5 of 6 medication deliveries for the Assisted Living area residents would be covered by the RCC checking in the medications. -The weekend medication delivery would be checked in by the facility Registered Nurse, Assistant Administrator, and the Administrator who were required to come in 2 hours every weekend.	D 358		