PRINTED: 12/19/2017
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	FCL092189	JAN 29 2018	R 11/30/2017

NAME OF PROVIDER OR SUPPLIER: JACKSON FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 221 EAST BARBEE STREET, ZEBULON, NC 27597

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on November 8, 9, and 30, 2017.	C 000	Addendum per telephone conversation with Mary McCullers, Administrator on February 12, 2018 at 10:00 am.	
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 3 residents (Resident #1) sampled received a 2 step tuberculosis (TB) test upon admission to the facility in compliance with control measures adopted by the Commission of Health Services. The findings are: Review of Resident #1's FL-2 dated 9/25/17 revealed: - Diagnoses included Osteoarthritis, Peripheral Neuropathy, Vitamin B 12 deficiency, Dementia with behavioral disturbance and Gastroesophageal Reflux disease. Review of the resident register revealed Resident	C 202	- Date of correction will be 01/26/2018. - Any resident admitted to the facility will have the 1st step TBST completed prior to admission. - The 2nd step TBST will be done within one week of the resident's admission to the facility. - The Administrator will be responsible to schedule 2nd-step TBST and ensure staff availability to transport the resident to have the TBST performed. - Staff will transport the resident back to the provider for reading of the TBST within 72 hrs of TBST being placed. - The Administrator will ensure completed 2-step TBST is done and documentation is in the residents record for review. H Zorto, Sr Licensure Consultant 02/12/2018	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary McCullers-Gaddis | TITLE: Administrator | (X6) DATE: 1-26-18

Reviewed and accepted with Addendum. 02/12/2018 HZ

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C 202	Continued From page 1 #1 was admitted on 8/10/17. Review of tuberculosis (TB) documentation for Resident #1 revealed: - A tuberculosis skin test was given by another facility. - A tuberculosis skin test was administered one month prior to her admission to the facility. - A tuberculosis skin test was given on 7/6/17 and read on 7/8/17. - The result of the TB skin test was negative, zero millimeters (mm) in diameter. - A 2 step TB skin test was not documented. Interview with Supervisor In Charge (SIC) on 11/30/17 at 9:50 A.M. revealed: - She reviewed the FL-2 when residents were admitted. - The tuberculosis test results were provided in different formats (forms, labs, cards). - She was not present when Resident #1 was admitted. - She was aware that residents needed two-step TB skin tests. - When residents did not have a TB skin test, an appointment was made at the health department. - She was not aware Resident #1 was missing a second TB skin test. Interview with the Guardian of Resident #1 on 11/30/17 at 10:08 A.M. revealed: - Resident #1 was admitted from another family care home. - She did not have documentation of a TB skin test for Resident #1. - She was not aware of any previous documentation of a two-step TB skin test for Resident #1. - She was aware that Resident #1 needed documentation of a TB skin test prior to	C 202		

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C 202	Continued From page 2 admission to the family care home. - She only provided the medication administration record, letter of guardianship appointment, and letter of guardian responsibilities to the facility. Interview with the relief SIC on 11/30/17 at 10:30 A.M. revealed: - She assisted the SIC with the admissions. - She reviewed the charts when time allowed if called in to work by the Administrator. - The Administrator and the SIC reviewed the paperwork for new admissions. - An appointment was made at the health department if a resident needed a TB test. - She was not aware Resident #1 was missing a second TB skin test. Interview with Administrator on 11/30/17 at 1:35 P.M. revealed: - When residents were admitted, the TB skin test results come with them. - The TB skin test results were requested and called to her prior to the admission. - Residents without a two-step TB skin test, were scheduled an appointment at the health department and the results were mailed. - The staff notified her when the resident attended the health department appointment. - She reviewed the resident records at the family care home. - There was not a process in place to assure the two step TB skin test was completed and documented for residents. - She was not aware Resident #1 was missing a second TB skin test. Based on observations, and interviews with staff and guardian on 11/8/17 and 11/9/17, Resident #1 was determined not to be interviewable.	C 202		

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C 248	Continued From page 3	C 248	Per telephone conversation with Administrator of 02/12/18 at 10:00 am.	
C 248	10A NCAC 13G .0902 (c-2) Health Care 10a NCAC 13G .0902 Health Care The facility shall assure documentation of the following in the resident's record: (2) all visits of the resident to or from the resident's physician, physician service or other licensed health professional, including mental health professional, of which the facility is aware. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure documentation for a chest x-ray completed for follow up to a positive tuberculosis skin test was in the record for 1 of 3 residents sampled (Resident #3). The findings are: Review of Resident #3's current FL-2 dated 07/10/2017 revealed diagnoses included Schizoaffective Disorder, Bipolar, Nicotine Dependence, History of Poly-substance abuse, Hypertension, Hyperlipidemia, Urinary Incontinence, and Diabetes. Review of the Resident Register for Resident #3 dated 07/15/2017 revealed the resident was admitted to the facility on 07/15/2017. Review of tuberculosis (TB) screening documentation for Resident #3 revealed: -The resident had a TB skin test placed on 07/14/2017 and read on 07/17/2017 as "positive, 10mm [millimeter] induration". -There was documentation from the provider recommending the TB clinic be contacted to schedule a chest x-ray.	C 248	- Staff will notify the Administrator of any and all resident appointments. - The Administrator will ensure all documentation is in the residents records for medical appointments by visiting the facility on the day of the resident's appointment and reviewing all documentation sent from the provider. If the information is not complete, the Administrator will be responsible to call the Provider and request completed documentation be sent to the facility. - The Administrator will review all residents records monthly to ensure all documentation is available in the record. - Date of correction will be January 26, 2018. H Foote, Lic Licensure Consultant 02/12/2018.	

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C 248	Continued From page 4 -There was no documentation found in Resident #3's record for a chest x-ray being completed to screen for TB. Interview with the Supervisor-in-Charge (SIC) on 11/08/2017 at 12:50pm revealed: -The Administrator/Owner interviewed residents for admission to the facility and would notify the facility when a resident was to be admitted. -She was responsible for reviewing paperwork received at the facility for a new resident admission. -She usually reviewed the paperwork for a current FL-2 and two step TB skin test. -The FL-2 and TB skin testing information was received at the facility on the day the resident was scheduled for admission. -When Resident #3 was admitted to the facility, the resident had a TB skin test. -The facility took her to the local health department to get the step two TB skin test. -The health department informed the facility staff that Resident #3 needed to get a chest x-ray. -She thought there was documentation in Resident #3's record to confirm the chest x-ray had been completed. -She could not find the documentation in Resident #3's record confirming the chest x-ray was completed but she knew it had been scheduled as recommended and was completed the week after the positive TB skin test reading. -She "assumed" the relief SIC had gotten the results of the chest x-ray. -The relief SIC would have been responsible to make sure results of the chest x-ray was in Resident #3's record. -She had not heard anything about the chest x-ray. Interview with the Administrator/Owner on	C 248		

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C 248	Continued From page 5 11/08/2017 at 3:45pm revealed: -The relief SIC had taken Resident #3 to the local health department where the chest x-ray was done. -She did not know the exact date the chest x-ray was completed. -The relief SIC said the chest x-ray was negative and the health department would mail the results to the facility. -She did not have any documentation for the results of the chest x-ray. -She thought there was documentation for previous TB skin testing for Resident #3 because the resident had come from another facility. -She did not have any documentation for any previous TB skin testing for Resident #3. Review of a chest x-ray for Resident #3 faxed to the facility from the local health clinic on 11/08/2017 at 4:13pm revealed: -The chest x-ray was completed on 08/10/2017. -The chest x-ray was requested to screen for tuberculosis. -There was no evidence for active chest disease. Interview with the relief SIC on 11/30/2017 at 11:10am revealed: -She did not know anything about the TB testing for Resident #3. -She remembered transporting the resident to a local health department to obtain the requested chest x-ray. -She did not receive anything in writing from the health department on the day the chest x-ray was completed but was informed the results would be mailed to the facility. -She had called the Administrator/Owner from the health department and informed her the results of the chest x-ray would come in the mail. -The full time SIC was supposed to have followed	C 248	In the future, I Mary McCullers-Gaddis will ensure that all residents coming into the home will have the first step TB test within a year and do the second step within a week of admission	1/26/18

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C 248	Continued From page 6 up to get the results of the chest x-ray. Interview with the Administrator/Owner on 11/30/2017 at 1:15pm revealed: -If a resident had a positive TB skin test, the facility would get a chest x-ray. -Staff knew residents were supposed to have documentation of two-step TB screening. -She went to the facility within the first couple of days or the same day and reviewed information in a new resident's record. -If documentation for a second step TB skin test was not in the record, she would have staff to schedule with the health department to get the second step TB screening completed. -She did not have a process in place for auditing resident records to ensure appropriate documentation was in the record.	C 248		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 3 sampled residents (Resident #1) with physician orders for a texture modified diet. The findings are: Review of Resident #1's current FL-2 dated	C 284	SIC stated client didn't like the soft pureed diet and would grab food from the counter but was observed when eating.	

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C 284	Continued From page 7 09/25/2017 revealed: -Diagnoses included Dementia with behavioral disturbances, Vitamin B12 Deficiency, Osteoarthritis, Peripheral Neuropathy, and Gastro-Esophageal Reflux Disorder. -There was documentation for a pureed diet order. Review of a subsequent physician's order dated 09/29/2017 revealed a physician's order for a chopped meats, mechanical soft diet. Review of the Resident Register dated 08/10/2017 for Resident #1 revealed the resident was admitted to the facility on 08/10/2017. Review of progress notes for Resident #1 dated 08/27/2017 revealed: -The "resident had a choking incident around 12:45pm". -The resident was transported to the local hospital by the emergency medical service. -The resident returned to the facility on 08/27/2017 around 7:00pm. Interview with the Supervisor-In-Charge (SIC) on 11/08/2017 at 9:40am revealed: -There was not a diet roster posted in the kitchen. -All of the residents at the facility, except one, was prescribed a 1800/regular diet. -Resident #1 was prescribed a pureed diet. Review of Resident #1's Care Plan dated 08/25/2017 revealed the resident required limited assistance with eating. Interview with the SIC on 11/08/2017 at 11:00am revealed the residents were supposed to have lunch from a local fast food restaurant on 11/08/2017.	C 284	client is no longer in the facility. In the future we will not accept clients on a pureed or mechanical soft diet. All menus will be posted for the appropriate diet.	1/24/18

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C 284	Continued From page 8 Observation on 11/08/2017 at 11:45am revealed the Administrator delivered bag lunch from a local fast food restaurant. Observation on 11/08/2017 from 11:45am to 12:10pm of the lunch meal service revealed: -The meal served to Resident #1 by the SIC included a whole hamburger patty with cheese (cheeseburger) and pickles, and french fried potatoes. -Resident #1 removed the pickle from the cheeseburger. -Resident #1 broke the french fries into small pieces that were approximately one inch sized. -Resident #1 fed herself. -Resident #1 took sips of water between bites of food. -Resident #1 ate without difficulty and consumed 100% of the cheeseburger and french fried potatoes. -The SIC walked in and out of the dining room periodically during the lunch meal. Interview with the SIC on 11/08/2017 at 3:15pm revealed: -She was unaware Resident #1 was on a chopped meats mechanical soft diet. -She thought the resident was on a pureed diet. -She had never witnessed the resident choking since the resident had been prescribed the pureed diet. -A blender was usually used for pureeing the resident's food. Following record review, observations, and attempted Interview on 11/08/2017 at 10:10am with Resident #1, she was determined not to be interviewable.	C 284	Addendum per telephone conversation with Mary McCullers, Administrator on 02/12/2018 at 10:00am: - When a resident is admitted to the facility, the Administrator will review the FL-2 for the diet ordered. - The Administrator will conduct unannounced observations of staff preparing resident meals twice weekly to ensure meals are being prepared and served as ordered by the physician. - Date of correction will be January 26, 2018. H. Lotto, Qs Assurance Consultant 02/12/2018	

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C 284	Continued From page 9 Observation of Resident #1 on 11/09/2017 from 8:30am to 11:45am during the survey revealed there was no meal delivery. Interview with the Supervisor-in-Charge (SIC) on 11/30/2017 at 9:30am revealed: -Resident #1 was being discharged to another facility on today (11/30/2017). -The resident's Social Worker was in route to the facility to transport Resident #1 to the other facility. -The resident's family wanted the resident closer to family members. Observation of Resident #1 on 11/30/2017 at 10:20am revealed the resident left the facility with the Social Worker. Interview with the Administrator on 11/30/2017 at 1:35pm revealed: -She did not know Resident #1 was supposed to be served a mechanical soft, chopped meats diet. -She knew Resident #1 was at one time on a pureed diet. -She thought the SIC "blended up her food". Interview with the SIC on 11/30/2017 at 1:50pm revealed: -Resident #1 had been ordered a puree diet after the resident had to go to the hospital when she choked on a piece of meat shortly after admission to the facility. -Resident 1 did not like the pureed food. -Resident #1 would not eat hamburger that was chopped up. -The SIC did not chop up Resident #1's hamburger on 11/08/2017 because the resident would not eat it if she (SIC) chopped it up. -Resident #1 would pull her meat apart with her fork.	C 284	client left with her guardian on 11/30/17 going to [redacted] NC [redacted]	

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C 284	Continued From page 10 -The fast food restaurant would grind the meat up and run it back through the grinder for the facility.	C 284		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 assure Zithromax (an antibiotic used to treat various types of infections) and Cetirizine (an antihistamine used to treat hay fever, and allergies) were administered as ordered for 1 of 3 residents (Resident #1) sampled to treat congestion and cold symptoms. The findings are: Review of Resident #1's FL-2 dated 9/25/17 revealed diagnoses included Osteoarthritis, Peripheral Neuropathy, Vitamin B12 deficiency, Dementia with behavioral disturbance, and Gastroesophageal reflux disease. Review of Resident #1's physician order form dated 10/3/17 revealed: - The document contained a handwritten order for Cetirizine and Zithromax, written by the primary care physician. - The order did not specify a dose, route or	C 330		

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C 330	Continued From page 11 frequency for the medications. - The order noted "sent to local pharmacy." Review of Resident #1's Medication Administration Records (MAR) for October 2017 revealed Cetirizine and Zithromax had not been transcribed to the October 2017 and November 2017 MARs. Review of Resident #1's pharmacy review completed by the consulting pharmacist dated 10/11/17 revealed: - A physician's note was seen by the reviewer for Cetirizine and Zithromax orders. - A physician's note was seen by the reviewer that indicated the orders were sent to the pharmacy from the physician's office. - The medications were not in the "med box" or on the MAR. - A recommendation was made by the consulting pharmacist for a review and clarification of orders for the Cetirizine and Zithromax. - A duplicate pharmacy review was signed on 11/9/17 by the primary care physician who wrote the original order. - The physician did not change the Cetirizine or Zithromax orders on the pharmacy review document. Interview with the pharmacy representative on 11/30/17 at 12:28 P.M. revealed: - The orders for Zithromax and Cetirizine were not received. - The medications did not appear on Resident #1's current list of medications. - There were no notes in the system concerning the pharmacy review on 10/11/17. Interview with medical assistant at the primary care physician's office on 11/30/17 at 12:59 P.M.	C 330	1/26/18 en the future SIC will make sure when a order is written, and electronically sent she will check with the phramacy to make sure they got the precription and transcribe the orders accordinally. Phramacy was notified and they never recieved the order. Client is no longer in the facility and order was D/c by the doctor.	

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C 330	Continued From page 12 revealed: - Resident #1 attended a scheduled appointment on 10/3/17. - She was seen for cold and congestion. - The physician documented if she wasn't better in 10 days to return. - Resident #1 did not return for a follow up visit. - The prescription was printed and given to caregiver. - She did not know how the prescription was handled. - No other appointments were noted in the system for Resident #1 after 10/3/17. - No notes were in the system regarding discontinuing Cetirizine and Zithromax. - Both the nurse and physician were unavailable. Interview with Supervisor in Charge (SIC) on 11/30/17 at 1:00 P.M. revealed: - She did not receive a prescription for Resident #1's Cetirizine and Zithromax. - The physician's office only does electronic prescriptions. - The physician's office began using electronic prescriptions before Resident #1 became sick on 10/3/17. - The physician's office sent all prescriptions to the pharmacy. - She did not notify the physician when the order was not received. - She called the primary care physician's office during the interview and asked to speak with the nurse. - She asked if the nurse could call her back. Interview with SIC on 11/30/17 at 2:05 P.M. revealed: - She took Resident #1 to see her physician on 10/3/17. - Resident #1 had the "sniffles" on 10/3/17.	C 330	Administrator will be notified when a client goes to the doctor and will come and check orders to insure everything is correct and no mistake like that occur in the future	

Division of Health Service Regulation

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	FCL092189		R 11/30/2017

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C 330	Continued From page 13 - The physician's office did not give her a presciption for Resident #1. - She did not give the medications because they were not received. - Resident #1 does not like to take medication. - Resident #1 told the physician she did not want any medication when offered cough medication on 10/3/17. - Resident #1 did not have a fever on 10/3/17 when checked at the physician's office. - She called the primary care physician's office during the interview. - She requested to speak with someone because she needed a discontinuation order for medication for Resident #1. - Resident #1 did not go back to the physician's office after 10/3/17. Interview with SIC on 11/30/17 at 3:00 P.M. revealed: - She did not give Resident #1 the Ceftirizine and Zithromax. - The pharmacy did not receive the order. - She did not give the medications because they were not received. - She saw the order on the physician order sheet. - She did not notify the pharmacy when the medications were not received. - She did not have or receive orders for discontinuation of Cetirizine and Zithromax. Interview with Administrator on 11/30/17 at 1:35 P.M. revealed: - Pharmacy reviews were done quarterly. - She checked the MARs in the past. - She did not indicate how often she checked the MARs in the past. - She had not reviewed the MARs since July 2017. - There was not a process in place to assure the	C 330	mars will be checked weekly by the administrator for a month and then will be checked monthly thereafter.	1/26/18

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C 330	Continued From page 14 MARs were accurate. Based on observations, record reviews and interviews of Resident #1 on 11/8/17 and 11/9/17, the resident was determined not to be interviewable.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the medication administration records (MARs) were accurate for 2 of 3 sampled residents (#2, #3) including documenting administration on the	C 342		

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C 342	Continued From page 15 MARs for Metformin, Simvastatin, Omeprazole, and Risperidone, (Resident #3) and Olanzapine, Ferrous Sulfate, Multivitamin, and Ascorbic Acid (Resident #2). The findings are: 1. Review of Resident #3's current FL-2 dated 07/10/2017 revealed: -Diagnoses included Schizoaffective Disorder, Bipolar, Nicotine Dependence, History of Poly-substance abuse, Hypertension, Hyperlipidemia, Urinary Incontinence, and Diabetes. -There were no physician's orders written on the FL-2. a. Review of a medication list for Resident #3 dated 07/13/2017 revealed there was a physicians order for Metformin (used to treat diabetes) 500 milligram (mg) tablet take one tablet twice a day. Review of a subsequent physician's order for Resident #3 dated 09/25/2017 revealed there was a physician's order for Metformin 500mg take one tablet twice daily with meals. Review of the September 2017 MARs for Resident #3 revealed: -Metformin 500mg tablet take one tablet twice a day with meals, scheduled for 8am and 8pm daily, start 09/26/17 was handwritten to the MARs. -There was documentation for administration at 8am and 8pm daily from 09/26/2017 through 09/30/2017. Review of the October 2017 MARs for Resident #3 revealed:	C 342	According to the SIC This was a documentation error, medication was given but not charted. Administrator will watch SIC give medications and make sure she is giving it correctly and charted after it is given. Training will be put in place for medication administration and documentation. SIC will be observed for everyday for a 1/26/18	

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C 342	Continued From page 16 -Metformin 500mg tablet take one tablet twice a day with meals, scheduled for 8am and 8pm daily, start 10/09/17 was handwritten to the MARs. -There was documentation for administration at 8am and 8pm daily from 10/09/2017 through 10/31/2017. -There was no documentation for administration of the Metformin 500mg tablet twice daily for 10/01/2017 through 10/08/2017. Interview with the Supervisor-in-Charge (SIC) on 11/08/2017 at 2:45pm revealed the provider pharmacy printed the residents MARs for the facility. Telephone interview with the physician's office Registered Medical Assistant (RMA) on 11/09/2017 at 8:50am revealed medication orders for Resident #3 were sent to the pharmacy electronically. Interview with the SIC on 11/09/2017 at 9:30am revealed she usually got copies of physician's orders from the pharmacy. Interview with the Pharmacy Technician at the provider pharmacy on 11/09/2017 at 9:35am revealed: -The pharmacy received physician orders either handwritten or electronically. -The pharmacy sent a copy of orders received electronically to the facility either by fax or in the medication tote delivered. -Any new medications were sent to the facility nightly and added to the next month cycle fill. -If new medication orders were sent to the pharmacy after the pharmacy printed the MARs, the facility was responsible to transcribe the new order to the MARs.	C 342	week and then weekly ~~for~~ mmG for a month and then will check all charts and MARS weekly.	

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C 342	Continued From page 17 Interview with the SIC on 11/09/2017 at 10:30am revealed: -She had administered the Metformin to Resident #3 as ordered. -She failed to document correctly on the MAR. Observation of Resident #3's Metformin 500mg tablets on hand on 11/09/2017 revealed: -There were two pharmacy labeled blister packs for Metformin 500mg take one tablet twice daily with meals dispensed 11/02/2017. -There were 26 tablets of Metformin 500mg remaining on each blister pack. Interview with the Pharmacy Technician on 11/30/2017 at 12:50pm revealed there was no record of any returned medications to the pharmacy for Resident #3. b. Review of a medication list for Resident #3 dated 07/13/2017 revealed there was a physicians order for Simvastastin (used to treat high cholesterol) 40mg tablet take one tablet at bedtime. Review of the September 2017 MAR for Resident #3 revealed: -Simvastatin 40mg tablet take one tablet at bedtime, scheduled for 8pm daily, was printed to the MAR. -There was no documentation for administration of the Simvastatin 40mg at 8pm daily from 09/01/2017 through 09/30/2017. Review of the October 2017 MAR for Resident #3 revealed: -Simvastatin 40mg tablet take one tablet at bedtime, scheduled for 8pm daily, was printed to the MAR.	C 342		

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C 342	Continued From page 18 -There was documentation for administration of the Simvastatin 40mg at 8pm daily from 10/01/2017 through 10/31/2017. Review of the November 2017 MAR for Resident #3 revealed: -Simvastatin 40mg tablet take one tablet at bedtime, scheduled for 8pm daily, was printed to the MAR. -There was documentation for administration of the Simvastatin 40mg at 8pm from 11/01/2017 through 11/06/2017. -There was no documentation for administration of the Simvastatin 40mg at 8pm for 11/07/2017. Interview with the SIC on 11/09/2017 at 10:30am revealed: -She had administered the Simvastatin 40mg to Resident #3 as ordered. -She failed to document correctly on the MAR. Observation of Resident #3's Simvastatin 40mg tablets on hand on 11/09/2017 revealed: -There was a pharmacy labeled blister pack for Simvastatin 40mg tablet take one tablet at bedtime dispensed on 11/02/2017. -There were 26 tablets remaining. Interview with the Pharmacy Technician on 11/30/2017 at 12:50pm revealed there was no record of any returned medications to the pharmacy for Resident #3. c. Review of a medication list for Resident #3 dated 07/13/2017 revealed there was a physicians order for Omeprazole (used to treat food digestion disorders) 20mg tablet take one tablet twice a day. Review of the September 2017 MARs for	C 342		

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C 342	Continued From page 19 Resident #3 revealed: -Omeprazole 20mg tablet take one tablet twice a day, scheduled for 8am and 8pm daily, was printed to the MARs. -There was no documentation for administration of the Omeprazole 20mg at 8pm daily from 09/01/2017 through 09/30/2017. Review of the October 2017 MARs for Resident #3 revealed: -Omeprazole 20mg tablet take one tablet twice a day, scheduled for 8am and 8pm daily, was printed to the MARs. -There was documentation for administration of the Omeprazole 20mg at 8am and 8pm daily from 10/01/2017 through 10/31/2017. Review of the November 2017 MARs for Resident #3 revealed: -Omeprazole 20mg tablet take one tablet two times a day, scheduled for 8am and 8pm daily, was printed to the MARs. -There was documentation for administration of the Omeprazole 20mg daily at 8am from 11/01/2017 through 11/08/2017. -There was documentation for administration of the Omeprazole 20mg daily at 8pm from 11/01/2017 through 11/06/2017. -There was no documentation for administration of the Omeprazole 20mg daily at 8pm for 11/07/2017. Interview with the Pharmacy Technician at the provider pharmacy on 11/09/2017 at 9:35am revealed: -The pharmacy received physician orders either handwritten or electronically. -The pharmacy sent a copy of electronic orders received to the facility either by fax or in the medication tote delivered.	C 342		

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C 342	Continued From page 20 -Medications were refilled at the facility on a monthly cycle. Interview with the SIC on 11/09/2017 at 10:30am revealed: -She had administered the Omeprazole 20mg to Resident #3 as ordered. -She failed to document correctly on the MAR. Observation of Resident #3's Omeprazole 20mg tablets on hand on 11/09/2017 revealed: -There were two pharmacy labeled blister packs for Omeprazole 20mg tablet take one tablet twice daily dispensed on 11/02/2017. -There were 26 tablets remaining on each blister pack. Interview with the Pharmacy Technician on 11/30/2017 at 12:50pm revealed there was no record of any returned medications to the pharmacy for Resident #3. d. Review of a medication list for Resident #3 dated 07/13/2017 revealed there was a physicians order for Risperidone (used to treat behaviors) 3mg tablet take one tablet twice a day. Review of the September 2017 MARs for Resident #3 revealed: - Risperidone 3mg tablet take one tablet twice a day, scheduled for 8am and 8pm daily, was printed to the MARs. -There was no documentation for administration of the Risperidone 3mg at 8pm daily from 09/01/2017 through 09/30/2017. Review of the October 2017 MARs for Resident #3 revealed: - Risperidone 3mg tablet take one tablet twice a day, scheduled for 8am and 8pm daily, was	C 342		

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C 342	Continued From page 21 printed to the MARs. -There was documentation for administration of the Risperidone 3mg at 8am and 8pm daily from 10/01/2017 through 10/31/2017. Review of the November 2017 MARs for Resident #3 revealed: - Risperidone 3mg tablet take one tablet two times a day, scheduled for 8am and 8pm daily, was printed to the MARs. -There was documentation for administration of the Risperidone 3mg daily at 8am from 11/01/2017 through 11/08/2017. -There was documentation for administration of the Risperidone 3mg daily at 8pm from 11/01/2017 through 11/06/2017. -There was no documentation for administration of the daily Risperidone 3mg at 8pm for 11/07/2017. Interview with the Pharmacy Technician at the provider pharmacy on 11/09/2017 at 9:35am revealed: -The pharmacy received physician orders either handwritten or electronically. -The pharmacy sent a copy of electronic orders received to the facility either by fax or in the medication tote delivered. -Medications were refilled at the facility on a monthly cycle. Interview with the SIC on 11/09/207 at 10:30am revealed: -She had administered the Risperidone 3mg to Resident #3 as ordered. -She failed to document correctly on the MAR. Interview with the Pharmacy Technician on 11/30/2017 at 12:50pm revealed there was no record of any returned medications to the	C 342		

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C 342	Continued From page 22 pharmacy for Resident #3. Interview with Resident #3 on 11/08/2017 at 4:30pm revealed: -She had been living at the facility for about two months. -She was administered medication by the SIC. -Her medications were "excellent". -She did not recall missing any medications. -She took medications for hypertension, heart pills, and water pills. -She was administered medication in the morning and evening. 2. Review of Resident #2's FL-2 dated 8/17/17 revealed - Diagnoses include Schizophrenia, Cognitive disorder non-specific, rule out Dementia, Latent TB (INH completed 8/9/17), poor dentition, Anemia, and Onychomyocosis. - Medications on the FL-2 were Olanzapine (an antipsychotic used to treat mental disorders) 25 mg every night for psychosis; Iron Sulfate (used to treat iron deficiency anemia) 325 mg twice a day for anemia; Multivitamin (used as a dietary supplement) one tablet every morning for anemia; Ascorbic acid (used to treat low levels of vitamin C) 1000 mg by mouth twice a day for anemia; Acetaminophen 650 mg by mouth every six hours as needed for pain, fever. Review of Resident #2's resident register revealed an admission date of 8/17/17. Review of Resident #2's medication administration record (MAR) for September 2017 revealed: - The MAR was handwritten. - All physician ordered medications were documented on the MAR.	C 342		

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C 342	Continued From page 23 - A line was drawn through 9/1/17 through 9/16/17 at the 8 A.M. dose for Olanzapine. - A line was drawn through 9/1/17 through 9/17/17 at the 8 A.M. and 8 P.M. doses for Ferrous Sulfate . - A line was drawn through 9/1/17 through 9/18/17 at the 8 A.M. dose for Multivitamin. - A line was drawn through 9/1/17 through 9/17/17 at the 8 AM and 8 P.M. doses for Ascorbic Acid. - Documentation for Multivitamin was blank from 9/19/17-9/29/17 and was documented as administered on 9/30/17 at the 8 A.M. dose. - Documentation for Ferrous Sulfate was blank from 9/20/17-9/29/17 an documented as administered on 9/18/17, 9/19/17 and 9/30/17 at the 8 A.M. and 8 P. M. doses. - There was no reason for omissions of the medications documented on the MAR. Observation of medications on hand on 11/9/17 and 11/30/17 revealed; - All the medications ordered by the physician were available. - The medications were filled by the VA pharmacy. - Olanzapine was last filled on 8/26/17. - Ferrous Sulfate was last filled on 8/30/17. - Multivitamin was last filled on 9/1/17. - Ascorbic Acid was last filled on 10/26/17. - Acetaminophen was last filled on 10/25/17. Interview with Supervisor in Charge (SIC) on 11/30/17 at 1:58 P.M. revealed: - There was another September 2017 MAR for Resident #2. - She made a MAR for Resident #2 for September 2017. - She remembered documenting on Resident #2's MAR for September 2017. - She took Resident #2 to the Veterans	C 342	staff is no longer employed c̄ JFCH Don't really know what the lines drawn through was about, stated medication was given. Will ensure training in place and close supervision of medication administration	1/26/18

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C 342	Continued From page 24 Administration (VA) hospital emergency room to have medications renewed on 8/30/17. - She waited at the VA for prescriptions to be filled on 8/30/17. - The VA provided all Resident #2's medications. Interview with relief Supervisor in Charge (SIC) on 11/30/17 at 12:05 P.M. revealed: - She responded "I am not sure" when asked about documentation on September 2017 MAR. - She forgot to sign the blank areas on Resident #2's September 2017 MAR. Interview with relief Supervisor in Charge (SIC) on 11/30/17 at 3:10 P.M. revealed she did not know what happened concerning the lined through areas and blank areas on the September 2017 MAR for Resident #2. Interview with Administrator on 11/30/17 at 1:35 P.M. revealed: - She checked the medication administration records in the past. - She has not reviewed the MARs since July 2017. - There was not a process in place to assure the medication administration records were accurate. Interview with Resident #2 on 11/30/17 at 3:55 P.M. revealed: - His medications were obtained from the VA. - He had not been told by staff that he had no medications available during his stay at the facility. - He had not missed any doses of medications during his stay at the facility.	C 342		