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ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 a follow-up survey on 09/04/18 - 09/07/18.	{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: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 7 residents (#6, #7, #8) observed during the medication passes including errors with insulin (#7), a nebulizer treatment (#8), and an iron supplement (#6); and for 3 of 5 residents (#1, #2, #4) sampled including errors with sliding scale insulin and failure to hold routine insulin for low blood sugar (#4), and failure to administer pain medications due to the medications being unavailable (#1, #2).	{D 358}		

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{D 358}	Continued From page 1 The findings are: 1. The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 8:00am, 12:30pm, 4:00pm, and 5:00pm medication passes on 09/05/18. a. Review of Resident #6's current FL-2 dated 12/18/17 revealed: -Diagnoses included dementia, back pain, fall, hyponatremia, seizure, and vitamin D deficiency. -There was an order for Ferrous Sulfate 325mg take one tablet twice a day with meals. (Ferrous Sulfate is an iron supplement used to treat anemia.) Review of Resident #6's physician visit form dated 02/20/18 revealed an order to change Ferrous Sulfate 325mg to one tablet once a day. Review of Resident #6's physician visit form dated 06/11/18 revealed: -There was an order to discontinue Ferrous Sulfate. -There was an order to start Multivitamin with Iron daily. (Multivitamin with Iron is a supplement.) Review of Resident #6's physician visit form dated 08/10/18 revealed there was an order to discontinue Ferrous Sulfate. Review of Resident #6's physician's orders revealed there were no orders to restart Ferrous Sulfate after the order was discontinued on 06/11/18. Observation of the 8:00am medication pass on 09/05/18 revealed: -The medication aide (MA) prepared and	{D 358}		

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{D 358}	Continued From page 2	{D 358}		

administered medications scheduled for 8:00am to Resident #6.
-Ferrous Sulfate 325mg tablet and a Daily Vitamin with Iron tablet (same as Multivitamin with Iron) were prepared and both were administered to Resident #6.

Review of Resident #6's electronic June 2018 medication administration record (e-MAR) revealed:
-There was an entry for Ferrous Sulfate 325mg one tablet once a day and it was scheduled to be administered at 8:00am.
-Ferrous Sulfate was documented as administered from 06/01/18-06/12/18 and was discontinued on 06/12/18.
-Ferrous Sulfate 325mg was restarted on 06/14/18 and was documented as administered from 06/14/18-06/30/18.
-There was an entry for Daily Vitamin with Iron one tablet once a day and it was scheduled to be administered at 8:00am.
-Daily Vitamin with Iron one tablet was documented as administered daily from 06/13/18-06/30/18.

Review of Resident #6's July 2018 e-MAR revealed:
-There were two entries for Ferrous Sulfate 325mg one tablet once a day and it was scheduled to be administered at 8:00am under each entry.
-Ferrous Sulfate 325mg was documented as administered from 07/01/18-07/31/18 at 8:00am under the first entry (except for 07/16/18 which was not given due to "awaiting delivery" from pharmacy).
-Ferrous Sulfate 325mg was documented as administered from 07/17/18-07/31/18 at 8:00am under the second entry.

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{D 358}	Continued From page 3 -There was an entry for Daily Vitamin with Iron one tablet once a day and it was scheduled to be administered at 8:00am. -Daily Vitamin with Iron one tablet was documented as administered daily from 07/01/18-07/31/18. Review of Resident #6's August 2018 e-MAR revealed: -There were two entries for Ferrous Sulfate 325mg one tablet once a day and it was scheduled to be administered at 8:00am under each entry. -Ferrous Sulfate 325mg was documented as administered from 08/01/18-08/31/18 at 8:00am under the first entry. -Ferrous Sulfate 325mg was documented as administered from 08/01/18-08/10/18 at 8:00am and then discontinued on 08/10/18 under the second entry. -There was an entry for Daily Vitamin with Iron one tablet once a day and it was scheduled to be administered at 8:00am. -Daily Vitamin with Iron one tablet was documented as administered daily from 08/01/18-08/31/18. Review of Resident #6's September 2018 e-MAR revealed: -There was an entry for Ferrous Sulfate 325mg one tablet once a day and it was scheduled to be administered at 8:00am. -Ferrous Sulfate was documented as administered from 09/01/18-09/05/18. -There was an entry for Daily Vitamin with Iron one tablet once a day and it was scheduled to be administered at 8:00am. -Daily Vitamin with Iron one tablet was documented as administered daily from 09/01/18-09/05/18.	{D 358}		

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{D 358}	Continued From page 4 Observation of Resident #6's medications on hand on 09/05/18 at 12:10pm revealed there were four Ferrous Sulfate 325mg tablets on hand that originally had 28 tablets in the pill packet with a dispense date of 08/14/18. Review of pharmacy dispensing records for Resident #6 revealed: -There was a supply of 28 Ferrous Sulfate tablets dispensed on 03/22/18. -There was a supply of 28 Ferrous Sulfate tablets dispensed on 04/17/18. -There was a supply of 28 Ferrous Sulfate tablets dispensed on 05/15/18. -There was a supply of 28 Ferrous Sulfate tablets dispensed on 06/12/18. -There was a supply of 28 Ferrous Sulfate tablets dispensed on 07/14/18. -There was a supply of 28 Ferrous Sulfate tablets dispensed on 08/14/18. Interview with the MA on 09/05/18 at 12:05pm revealed: -She was not aware the Ferrous Sulfate 325mg per day order had been discontinued for Resident #6. -Only the Resident Care Coordinator (RCC) or the pharmacy could make changes to the e-MAR. -If there was a medication order change on the weekend, the MA would use a paper MAR to write the order and it would be updated in the e-MAR later by the RCC or pharmacy. -The medication order would be faxed to the pharmacy by the MA or RCC. -If the MAs got an order to discontinue a medication, they would remove the medication from the cart and fax the order to the pharmacy. -The pharmacy would enter the order in the system and it would be highlighted with gray color	{D 358}		

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{D 358}	Continued From page 5 in the e-MAR and have "DC'd" beside it, meaning discontinued. Interview with the RCC on 09/05/18 at 2:20pm revealed: -She was not aware the Ferrous Sulfate 325mg once per day order had been discontinued for Resident #6. -The process for getting a discontinued medication order into the e-MAR depended on what time of the day the order was written. -If the pharmacy was open, it would be faxed to them. -If the pharmacy was closed, the RCC could enter it in the e-MAR. -The RCC could add or delete medication orders in the e-MAR. -The facility did not use the option to review and approve or reject any orders entered by the pharmacy in the e-MAR system. -There were a few issues in August 2018 after the pharmacy changed the monthly cycle fill date for the facility's medications. -She thought there were some instances where discontinued medications reappeared on the e-MAR. -She had checked some of the e-MARs for errors but she had not checked all of the e-MARs. -She had not checked Resident #6's e-MARs so she had not noticed any issues. Telephone interview with the primary pharmacy's quality assurance specialist (QAS) on 09/07/18 at 4:30pm revealed: -The pharmacy staff usually entered discontinued orders into the pharmacy software system if they received the orders from the facility. -The facility staff could also enter orders, including discontinued orders, into the e-MAR system.	{D 358}		

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{D 358}	Continued From page 6 -There was also an option for the facility to review and approve or reject any orders entered by the pharmacy in the e-MAR system. -The pharmacy encouraged facilities to use that option to help ensure orders were correct in the e-MAR system. -They received an order dated 06/11/18 to discontinue Resident #6's Ferrous Sulfate and start Multivitamin with Iron daily on 06/12/18 at 7:30am from the facility. -They discontinued the Ferrous Sulfate from the pharmacy software system and entered the order for Multivitamin with Iron on 06/12/18. -On 07/16/18, the pharmacy got a refill request for the Ferrous Sulfate from the facility through the e-MAR system. -The pharmacy responded to the request and notified the facility of the discontinue order received on 06/12/18. -The facility requested a copy of the discontinue order dated 06/11/18 for their records because they could not locate it. -The pharmacy technician could not locate the copy of the 06/11/18 discontinue order previously received so the pharmacy technician reactivated the order for Ferrous Sulfate. -They did not hear from the facility again until they received another order to discontinue Ferrous Sulfate on 08/10/18 at 3:50pm. -The pharmacy discontinued the Ferrous Sulfate from the pharmacy software system again on 08/10/18. -The pharmacy did not reactivate the order for Ferrous Sulfate after the discontinue order was entered on 08/10/18. -She did not know if the facility reactivated the order after 08/10/18. -They did not have any current orders for the Ferrous Sulfate to be administered. -The entry to administer Ferrous Sulfate had	{D 358}		

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been overridden in the e-MAR system and was no longer active in the system as of today.
-The facility's cycle fill date had changed recently but changing the cycle fill start date would not cause orders to reappear on the e-MAR.
-No issues of orders reappearing on the MAR had been reported by the facility to her knowledge.

Interview with Resident #6 on 09/06/18 at 9:58am revealed:
-He did not know the names of the medications he was administered.
-He usually took whichever medications were given to him by the MAs.
-He denied any side effects of taking Ferrous Sulfate such as constipation or stomach pain and irritation.

Attempted interviews with Resident #6's primary care provider (PCP) on 09/07/18 at 3:20pm and 4:58pm were unsuccessful.

b. Review of Resident #7's current FL-2 dated 08/03/18 revealed diagnoses included type II diabetes mellitus, congestive heart failure, dehydration, acute kidney injury, myocardial infarction, falls frequently, failure to thrive, atrial fibrillation, chronic obstructive pulmonary disease, dementia, shortness of breath, hyperlipidemia, coronary artery disease, and hypertension.

Review of a physician's order dated 08/07/18 for Resident #7 revealed orders for fingerstick blood sugars with meals and Humalog insulin 8 units was to be injected with meals at 7:30am, 12:30pm, and 5:30pm. Hold insulin if blood sugar was less than than 120 or if resident does not eat the meal. (Humalog is rapid-acting insulin used to lower blood sugar.)

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{D 358}	Continued From page 8	{D 358}		

Review of a second physician's order dated 08/07/18 for Resident #7 revealed switch Humalog insulin to Novolog insulin using the same administration directions. (Novolog is rapid-acting insulin used to lower blood sugar. Novolog Flexpen should be primed with a 2 unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)

Review of Resident #7's electronic September 2018 medication administration record (e-MAR) revealed:
-There was an entry to check the resident's blood sugar 3 times a day with meals.
-There was an entry to administer Novolog Flexpen - inject 8 units subcutaneously with meals and hold if blood sugar is less than 120 or if resident does not eat this meal.

Observation of the 12:30pm medication pass on 09/05/18 revealed:
-The resident's blood sugar was 133 at 12:29pm.
-The medication aide (MA) administered 8 units of Novolog insulin into Resident #7's left upper arm at 12:31pm.
-The MA did not perform a 2 unit air shot prior to dialing up and administering the 8 units of insulin with the Novolog Flexpen.

Interview with the MA on 09/07/18 at 10:30am revealed:
-She had been trained on the use of the Novolog Flexpen and was told to prime it with 2 units to get the air out before giving the injection.
-She forgot to perform the air shot when she administered insulin to Resident #7 on 09/05/18 at lunchtime.
-She was aware if the Flexpen was not primed, it may result in the resident not getting the proper

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{D 358}	Continued From page 9 amount of insulin. Interview with a second MA on 09/06/18 at 9:55am revealed he had been trained on the use of the Novolog Flexpen and was told to prime it with 2-3 units to get the air out before giving the injection. Interview with the Resident Care Coordinator (RCC) on 09/05/18 at 2:20pm revealed: -The MAs were trained to perform a 2 unit air shot with the Novolog Flexpen. -It was an expectation that all MAs performed this step prior to administering the insulin. Interview with Resident #7 on 09/04/18 at 11:33am revealed: -Staff usually checked his blood sugar and gave him insulin before meals. -His blood sugar usually "runs good". Attempted interviews with Resident #7's primary care provider (PCP) on 09/07/18 at 3:20pm and 4:58pm were unsuccessful. c. Review of Resident #8's current FL-2 dated 08/16/18 revealed: -Diagnoses included Alzheimer's dementia, depression, sick sinus syndrome, pacemaker generator, anxiety, history of gastrointestinal bleed and bradycardia. -There was an order for Duoneb, inhale 1 vial via nebulizer 4 times a day. (Duoneb is used for breathing problems / lung disease.) Review of Resident #8's electronic September 2018 medication administration record (e-MAR) revealed: -There was an entry for Duoneb, inhale 1 vial via nebulizer 4 times a day.	{D 358}		

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{D 358}	Continued From page 10 -Duoneb was scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. Observation during the 4:00pm medication pass on 09/05/18 revealed: -The medication aide (MA) put the contents of one 3ml Duoneb vial into the nebulizer machine at 3:55pm. -The MA turned on the nebulizer at 3:56pm and put the mouthpiece to Resident #8's mouth. -The MA did not instruct the resident to take deep breaths. -Resident #8 was sitting on the bed holding the mouthpiece in his mouth, but removed it several times from his mouth for a few seconds each time to talk during the nebulizer treatment. -The MA instructed the resident to "breath normally, like you know how to do". -The resident did not take deep breaths to allow the medication to reach his lungs. -The resident bit on the mouthpiece several times which made it difficult to inhale. -The MA asked the resident if he was done. -Resident #8 stated, "2 or 3 more draws". -At 4:05pm, the MA turned off the nebulizer machine and said to Resident #8 "good enough". -There were vapors still coming out of the nebulizer when the machine was turned off. -There was approximately 1ml of medication left in the nebulizer machine. Interview with the MA on 09/05/18 at 7:10pm revealed: -When he gave nebulizer treatments, he had always told the residents to breath normally, and he made sure the vial was empty of medication and there were no continuing vapors before turning it off. -The usual timeframe for a nebulizer treatment was 5 minutes.	{D 358}		

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{D 358}	Continued From page 11 -He did not realize that Resident #8 had medication left in the vial after his treatment. -He was not aware the resident needed to take deep breaths. Interview with the Resident Care Coordinator (RCC) on 09/05/18 at 7:30pm revealed: -The MAs had been trained on nebulizer treatments and should instruct residents to hold the nebulizer in their mouth and inhale it. -When the treatment was done, they should give the resident some water. -She was not sure how long the treatments usually lasted. -She did not know the resident should be told to take deep breaths. -She would make sure she and the MAs received updated training on nebulizer treatments. Interview with Resident #8 on 09/05/18 at 4:43pm revealed that the nebulizer treatments helped him breathe better. Attempted interviews with Resident #8's primary care provider (PCP) on 09/07/18 at 3:20pm and 4:58pm were unsuccessful. 2. Review of Resident #1's current FL-2 dated 05/04/18 revealed: -Diagnoses included Alzheimer's dementia, hypertension, arterial stenosis, asthma, hyperlipidemia, schizophrenia effective disorder, and arthritis. -There was an order for Tramadol 50mg 1/2 tablet (25mg) twice daily. (Tramadol is a controlled substance used to treat moderate to severe pain.) Review of Resident #1's electronic July 2018 - September 2018 medication administration	{D 358}		

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records (e-MARs) revealed:
-There was an entry on each e-MAR for Tramadol 50mg take ½ tablet (25mg) twice a day and it was scheduled to be administered at 8:00am and 8:00pm.
-Tramadol was not administered as ordered on 7 occasions from 07/05/18 - 09/04/18.
-Tramadol was not administered on 07/01/18 at 8:00pm due to "awaiting delivery" from pharmacy.
-Tramadol was not administered on 08/06/18 - 08/10/18 at 8:00am due to "awaiting delivery" from pharmacy.
-Tramadol was not administered on 08/08/18 at 8:00pm due to "awaiting delivery" from pharmacy.

Review of pharmacy dispensing records for Resident #1 revealed:
-There was a supply of 30 Tramadol 50mg tablets dispensed on 05/18/18.
-There was a supply of 15 Tramadol 50mg tablets dispensed on 06/12/18.
-There was a supply of 30 Tramadol 50mg tablets dispensed on 07/05/18.
-There was a supply of 30 Tramadol 50mg tablets dispensed on 08/10/18.

Review of Resident #1's controlled substance (CS) logs for Tramadol revealed:
-The July 2018 CS logs were not available for review.
-There were 30 Tramadol 50mg half tablets (=25mg) dispensed on 08/10/18 and the last documented dose of that supply was administered on 09/04/18 at 8:00am, with 5 tablets remaining.
-There were 30 Tramadol 50mg half tablets (=25mg) dispensed on 08/10/18 and the last documented dose of that supply was administered on 09/02/18 at 8:00pm, with 8 tablets remaining (the resident refused the

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{D 358}	Continued From page 13 09/03/18 8:00pm dose). Observation of Resident #1's medications on hand on 09/04/18 at 5:12pm revealed: -There were 5 Tramadol 25mg (1/2 50mg) tablets on hand for the 8:00am dose. -There were 8 Tramadol 25mg (1/2 50mg) tablets on hand for the 8:00pm dose. Interview with Resident #1 on 09/06/18 at 10:30am revealed: -She took Tramadol for arthritis pain in her legs. -The facility sometimes ran out of her Tramadol and they would have to call the doctor for more. Interview with the Resident Care Coordinator (RCC) on 09/04/18 at 5:05pm revealed: -She was not aware that Resident #1 missed 7 doses of Tramadol between July/August 2018 due to "awaiting delivery" from pharmacy. -They were usually notified by the pharmacy when a medication was out of refills. -They had to get a paper prescription for Tramadol since it was a controlled substance. -There was sometimes a delay when the primary care provider (PCP) sent a paper prescription if it was a weekend or holiday. -They also had a local back-up pharmacy they could get medications from but they would still need a paper prescription for Tramadol. Telephone interview with the primary pharmacy's quality assurance specialist (QAS) on 09/07/18 at 4:30pm revealed: -Medications that came in the facility's monthly cycle fill were sent each month unless refills were needed. -The pharmacy notified a facility when refills were needed. -There were 6 times in August 2018 that the	{D 358}		

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{D 358}	Continued From page 14 Tramadol was documented as unavailable for Resident #1. -Tramadol was dispensed and delivered to the facility on 08/10/18 when the pharmacy received the hardcopy order on 08/10/18 at 3:22pm. -Tramadol was dispensed on 07/05/18 and delivered to the facility on 07/06/18. -The pharmacy received a prescription for Tramadol dated 07/23/18 on 08/10/18 that stated "hold until next fill is due". -There was a back-up pharmacy that could be used by the facility every day, including weekends and holidays. -An emergency supply of medication could be filled if the medication was out and the pharmacy was notified. Attempted interviews with Resident #1's PCP on 09/07/18 at 3:20pm and 4:58pm were unsuccessful. 3. Review of Resident #2's current FL-2 dated 05/22/18 revealed: -Diagnoses included vascular dementia, gout, depression, blindness with glaucoma, hypertension, congestive heart failure, and chronic urinary tract infection. -There was an order for Tramadol 50mg 1 tablet twice daily. (Tramadol is a controlled substance used to treat moderate to severe pain. Review of Resident #2's electronic July 2018 - September 2018 medication administration records (e-MARs) revealed: -There was an entry on each e-MAR for Tramadol 50mg 1 tablet twice a day and it was scheduled to be administered at 8:00am and 8:00pm. -Tramadol was not administered as ordered on 4 occasions from 07/01/18 - 09/04/18. -Tramadol was not administered on 07/04/18 at	{D 358}		

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8:00pm and on 07/05/18 at 8:00am and 8:00pm due to "awaiting delivery" from pharmacy.
-Tramadol was not administered on 08/06/18 at 8:00am due to "awaiting delivery" from pharmacy.

Review of Resident #2's controlled substance (CS) logs for Tramadol revealed:
-There were 30 Tramadol 50mg tablets dispensed on 06/19/18 and the last documented dose of that supply was administered on 07/03/18 at 8:00pm.
-There was a second supply of 60 Tramadol 50mg tablets dispensed on 07/04/18 and the first documented dose used was on 07/06/18 at 8:00am.
-No Tramadol was documented as administered on the CS logs from 07/04/18 at 8:00am through 07/05/18 at 8:00pm (4 doses).
-The last dose documented from the supply dispensed on 07/04/18 was on 08/04/18 at 8:00pm, leaving a balance of zero tablets.
-A third supply of 60 Tramadol 50mg tablets was dispensed on 08/06/18 and the first documented dose was administered on 08/07/18 at 8:00am.
-No Tramadol was documented as administered on the CS logs from 08/05/18 at 8:00am through 08/06/18 at 8:00pm (4 doses).
-A total of 8 doses of Tramadol were not administered in July and August 2018.
-The remaining balance was 4 of 60 tablets on 09/04/18.

Observation of Resident #2's medications on hand on 09/04/18 at 4:42pm revealed there were 4 Tramadol 50mg tablets.

Interview with Resident #2 on 09/06/18 at 10:05am revealed:
-He took Tramadol for pain in his knees and it usually helped when he took it.

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{D 358}	Continued From page 16 -They ran out of his Tramadol one time (could not recall when) and he "hurt a little more than normal" when they ran out. Interview with the Resident Care Coordinator (RCC) on 09/04/18 at 5:05pm revealed: -Resident #2's Tramadol was usually delivered in the monthly cycle fill around the middle of the month. -They were usually notified by the pharmacy when a medication was out of refills. -They had to get a paper prescription for Tramadol since it was a controlled substance. -There was sometimes a delay when the primary care provider (PCP) sent a paper prescription if it was a weekend or holiday. -They also had a local back up pharmacy they could get medications from but they would still need a paper prescription for Tramadol. -She could not recall what happened with Resident #2's missed doses of Tramadol but she thought there may have been a delay due to the holiday in July 2018. Interview with a medication aide (MA) on 09/07/18 at 10:32am revealed: -The MAs were supposed to reorder the Tramadol when they got to the last 5 tablets in the blue strip on the bubble card. -The pharmacy would let them know if a refill was needed and they would contact the PCP to get a new paper prescription since Tramadol was a controlled substance. -The PCP would fax a new prescription to the facility and the pharmacy. -She was unsure why Resident #2's Tramadol was unavailable in July and August 2018. -There may have been a delay in getting the new prescriptions.	{D 358}		

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{D 358}	Continued From page 17 Telephone interview with the primary pharmacy's quality assurance specialist (QAS) on 09/07/18 at 4:30pm revealed: -Medications that came in the facility's monthly cycle fill were sent each month unless refills were needed. -The pharmacy notified a facility when refills were needed. -Tramadol was dispensed on 07/04/18 for Resident #2 but it was not delivered to the facility until 07/05/18 due to the holiday. -There was a back-up pharmacy that could be used by the facility every day, including weekends and holidays. -An emergency supply of medication could be filled if the medication was out and the pharmacy was notified. Attempted interviews with Resident #2's PCP on 09/07/18 at 3:20pm and 4:58pm were unsuccessful. 4. Review of Resident #4's current FL-2 dated 06/06/18 revealed: -Diagnoses included vascular dementia, diabetes mellitus, cerebrovascular accident, hypertension, depression, chronic renal insufficiency, sinus tachycardia, neuropathy, and hyperlipidemia. -There was an order for Novolog insulin inject 8 units with meals, hold if fingerstick blood sugar (FSBS) is less than (<) 110 or if the resident does not eat that meal. (Novolog is a rapid-acting insulin used to lower blood sugar.) -There was an order for Novolog sliding scale insulin (SSI) according to the following scale: <200 = 0 units; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 450 = 5 units; and greater than (>) 450 = 5 units and recheck blood sugar in 1 hour, if >450 call primary care provider (PCP).	{D 358}		

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{D 358}	Continued From page 18 Review of Resident #4's electronic July 2018 medication administration record (e-MAR) revealed: -There was an entry for Novolog inject 8 units with meals, hold if blood sugar is <110 or the resident does not eat that meal. -The resident's FSBS was 107 at 7:30am on 07/19/18 and 8 units of scheduled Novolog insulin were documented as administered in the right arm instead of being held as ordered. -There was an entry for Novolog SSI <200 = 0 units; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 450 = 5 units; and > 450 = 5 units and recheck blood sugar in 1 hour, if >450 call PCP. -The wrong amount of Novolog SSI was documented as administered on 2 occasions. -The FSBS was 312 on 07/27/18 at 5:30pm and 2 units were documented but 3 units were ordered. -The FSBS was 205 on 07/28/18 at 5:30pm and 2 units were documented but 1 unit was ordered. -The resident's FSBS ranged from 107 - 446 from 07/01/18 - 07/31/18. Review of Resident #4's August 2018 e-MAR revealed: -There was an entry for Novolog inject 8 units with meals, hold if blood sugar is <110 or the resident does not eat that meal. -The resident's FSBS was 100 at 7:30am on 08/27/18 and 8 units of scheduled Novolog insulin were documented as administered in the right arm instead of being held as ordered. -There was an entry for Novolog SSI <200 = 0 units; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 450 = 5 units; and > 450 = 5 units and recheck blood sugar in 1 hour, if >450 call PCP. -The wrong amount of Novolog SSI was	{D 358}		

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documented as administered on 5 occasions.
-The FSBS was 337 on 08/02/18 at 5:30pm and no SSI was documented as administered but 3 units were ordered.
-The FSBS was 350 on 08/03/18 at 5:30pm and 2 units were documented but 3 units were ordered.
-The FSBS was 255 on 08/06/18 at 5:30pm and 1 unit was documented but 2 units were ordered.
-The FSBS was 323 on 08/11/18 at 5:30pm and 2 units were documented but 3 units were ordered.
-The FSBS was 234 on 08/24/18 at 5:30pm and 2 units were documented but 1 unit was ordered.
-The resident's FSBS ranged from 95 - 493 from 08/01/18 - 08/31/18.

Review of Resident #4's September 2018 e-MAR revealed:
-There was an entry for Novolog SSI <200 = 0 units; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 450 = 5 units; and > 450 = 5 units and recheck blood sugar in 1 hour, if >450 call PCP.
-The FSBS was 381 on 09/02/18 at 5:30pm and no SSI was documented as administered but 4 units were ordered.
-The resident's FSBS ranged from 91 - 381 from 09/01/18 - 09/05/18.

Interview with a medication aide (MA) on 09/06/18 at 4:20pm revealed:
-Resident #4's routine Novolog was supposed to be held if the blood sugar was <110.
-If he held the insulin, it would be documented as held on the MAR.
-The MAs were supposed to administer the Novolog SSI according to the scale on the MAR.
-He was not sure why the wrong amount of insulin was documented on some days for the SSI unless it was an error.

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{D 358}	Continued From page 20 Interview with a second MA on 09/07/18 at 10:40am revealed: -The MAs had been trained to read the MARs and administer the SSI according to the scale on the MAR. -She usually held Resident #4's routine Novolog insulin if the blood sugar was <110. -She made a mistake on 07/19/18 and the routine Novolog should have been held for the blood sugar of 107. Interview with the Resident Care Coordinator (RCC) on 09/07/18 at 1:30pm revealed: -The MAs had been trained to read the e-MARs and administer the SSI according to the scale. -The MAs were supposed to hold the routine Novolog insulin if the resident's blood sugar was <110 and document it as held on the e-MAR. -She usually did random checks on the e-MARs for routine insulin and SSI about every 2 weeks. -She had noticed some errors and documentation issues with the insulin during the random checks and she had reminded the MAs to follow the orders and use proper documentation. -She thought it was getting better because it looked like the errors had decreased. Interview with the Administrator on 09/07/18 at 5:04pm revealed: -He occasionally filled in as a medication aide. -He did not monitor medications at the facility. -It was the RCC's responsibility to monitor medications. Observation and interview with Resident #4 on 09/07/18 at 3:20pm revealed: -The resident was lying in bed and nodded her head up and down (indicating yes) when asked if she was okay. -The resident did not want to answer any more	{D 358}		

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{D 358}	Continued From page 21 questions. Attempted interviews with Resident #4's PCP on 09/07/18 at 3:20pm and 4:58pm were unsuccessful.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 3 of 5 residents sampled (#1, #3, #4) including inaccurate documentation of scheduled and	{D 367}		

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sliding scale insulin (#4), inaccurate documentation of a controlled substance for moderate to severe pain (#3), and failure to document the administration of a prn (as needed) medication used to treat constipation (#1).

The findings are:

1. Review of Resident #4's current FL-2 dated 06/06/18 revealed:
-Diagnoses included vascular dementia, diabetes mellitus, cerebrovascular accident, hypertension, depression, chronic renal insufficiency, sinus tachycardia, neuropathy, and hyperlipidemia.
-There was an order for Novolog insulin inject 8 units with meals, hold if fingerstick blood sugar (FSBS) is less than (<) 110 or if the resident does not eat that meal. (Novolog is a rapid-acting insulin used to lower blood sugar.)
-There was an order for Novolog sliding scale insulin (SSI) according to the following scale: <200 = 0 units; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 450 = 5 units; and greater than (>) 450 = 5 units and recheck blood sugar in 1 hour, if >450 call primary care provider (PCP).

Review of Resident #4's August 2018 electronic medication administration record (e-MAR) revealed:
-There was an entry for Novolog inject 8 units with meals, hold if blood sugar is <110 or the resident does not eat that meal.
-There was an entry for Novolog SSI <200 = 0 units; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 450 = 5 units; and > 450 = 5 units and recheck blood sugar in 1 hour, if >450 call PCP.
-Both the routine Novolog insulin and the Novolog SSI were scheduled to be administered at

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7:30am, 12:30pm, and 5:30pm.
-The entry for Novolog SSI had 8 units documented as administered on 18 occasions when the resident's FSBS was <200 and no SSI should have been administered.
-The routine Novolog insulin was documented as administered on those 18 occasions, which appeared the resident received 16 units of Novolog on those occasions.
-The entry for Novolog SSI had 9 to 13 units documented as administered on 19 occasions when the resident's FSBS ranged from 206 - 406 and would have required between 1 unit to 5 units of SSI, which appeared the resident received from 17 to 21 units on those occasions.
-Staff double documented and combined the routine Novolog insulin administration under the routine Novolog entry and the Novolog SSI entry on the e-MAR.
-The resident's FSBS ranged from 95 - 493 from 08/01/18 - 08/31/18.

Review of Resident #4's September 2018 e-MAR revealed:
-There was an entry for Novolog inject 8 units with meals, hold if blood sugar is <110 or the resident does not eat that meal.
-There was an entry for Novolog SSI <200 = 0 units; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 450 = 5 units; and > 450 = 5 units and recheck blood sugar in 1 hour, if >450 call PCP.
-Both the routine Novolog insulin and the Novolog SSI were scheduled to be administered at 7:30am, 12:30pm, and 5:30pm.
-The entry for Novolog SSI had 8 units documented as administered on 3 occasions when the resident's FSBS was <200 and no SSI should have been administered.
-The routine Novolog insulin was documented as

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administered on those 3 occasions, which appeared the resident received 16 units of Novolog on those occasions.
-The entry for Novolog SSI had 10 units documented as administered on 09/03/18 at 5:30pm when the resident's FSBS was 283 and would have required 2 units of SSI, which appeared the resident received 18 units on that occasion.
-Staff double documented and combined the routine Novolog insulin administration under the routine Novolog entry and the Novolog SSI entry on the e-MAR.
-The resident's FSBS ranged from 91 - 381 from 09/01/18 - 09/05/18.

Interview with a medication aide (MA) on 09/06/18 at 4:20pm revealed:
-When he administered Resident #4's routine Novolog and Novolog SSI, he added the amounts needed for each together and administered it in the same syringe since it was the same insulin.
-When he documented on the e-MAR, he would enter the combined total administered in the Novolog SSI entry.
-He also clicked on the entry for the routine Novolog 8 units as being administered.
-He had not double dosed the resident but he had documented the routine Novolog under both entries in error on the e-MAR.

Interview with a second MA on 09/07/18 at 10:40am revealed:
-The MAs had been trained to document Resident #4's routine Novolog and Novolog SSI separately on the e-MAR.
-She documented the routine and SSI separately on the e-MARs.

Interview with the Resident Care Coordinator

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	HAL043026	A. BUILDING: _____ B. WING _____	R 09/07/2018

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ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 367}	Continued From page 25 (RCC) on 09/07/18 at 1:30pm revealed: -The MAs had been trained to document the routine insulin and SSI separately on the e-MARs. -She usually did random checks on the e-MARs for scheduled insulin and SSI about every 2 weeks. -She had noticed some documentation issues with the routine and SSI during the random checks. -"It was a habit". -She had reminded the MAs to use proper documentation. Observation and interview with Resident #4 on 09/07/18 at 3:20pm revealed: -The resident was lying in bed and nodded her head up and down (indicating yes) when asked if she was okay. -The resident did not want to answer any more questions. Attempted interviews with Resident #4's PCP on 09/07/18 at 3:20pm and 4:58pm were unsuccessful. Refer to interview with the Administrator on 09/07/18 at 5:04pm. 2. Review of Resident #1's current FL-2 dated 05/04/18 revealed diagnoses included Alzheimer's dementia, hypertension, arterial stenosis, asthma, hyperlipidemia, schizophrenia effective disorder, and arthritis. Review of Resident #1's standing orders for medications and treatments revealed an order for Milk of Magnesia 30cc as needed for constipation. May repeat times one, if no results notify the primary care provider (PCP). (Milk of Magnesia is used to treat constipation.)	{D 367}		

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{D 367}	Continued From page 26 Review of Resident #1's electronic July 2018 - September 2018 medication administration records (e-MARs) revealed: -There was an entry on each e-MAR for Milk of Magnesia take 30ml by mouth as needed for constipation; do not exceed 2 doses in 24 hours. -Milk of Magnesia was documented as administered once on 07/03/18, 07/06/18, 07/09/18, and 07/22/18 on the July 2018 MAR. -Milk of Magnesia was not documented as administered on the August 2018 and September 2018 e-MARs. Review of pharmacy dispensing records for Resident #1 revealed: -There was a supply of Milk of Magnesia 473 fluid ounces dispensed on 05/29/18. -There was a supply of Milk of Magnesia 473 fluid ounces dispensed on 06/20/18. -There was a supply of Milk of Magnesia 473 fluid ounces dispensed on 07/06/18. -There was a supply of Milk of Magnesia 473 fluid ounces dispensed on 07/23/18. -There was a supply of Milk of Magnesia 473 fluid ounces dispensed on 08/19/18. -There was a supply of Milk of Magnesia 473 fluid ounces dispensed on 09/04/18. Observation of Residents #1's medications on hand on 09/04/18 at 5:35pm revealed there was an empty 473 fluid ounce bottle of Milk of Magnesia that had a dispense date of 08/19/18. Interview with the medication aide (MA) on 09/04/18 at 5:35pm revealed: -Resident #1 took Milk of Magnesia "every day at night and in the morning". -They didn't document it on the e-MAR because it "slipped through the cracks".	{D 367}		

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{D 367}	Continued From page 27 -He was aware the Milk of Magnesia should be documented on the e-MAR each time it was administered, to be able to monitor so that it was not given more than two times in 24 hours. -He had not notified the PCP that Resident #1 took Milk of Magnesia every day. Interview with a second MA on 09/05/18 at 12:45pm revealed: -Resident #1 usually asked for Milk of Magnesia early in the morning each day. -She administered it to the resident on 09/04/18 in the morning but forgot to document it on the e-MAR. -She was aware that it needed to be documented on the e-MAR and she had not called the PCP to report the resident's continued use of Milk of Magnesia. Interview with the Resident Care Coordinator (RCC) on 09/05/18 at 2:20pm revealed: -She was not aware that Resident #1 was being administered Milk of Magnesia every day and it was not documented on the e-MAR. -She expected that the MAs document any medications administered on the e-MAR. -She was told by the MAs that they had been administering Resident #1 Milk of Magnesia and not documenting it on the e-MAR. -One MA told the RCC that she was not aware that standing order medications had to be documented on the e-MAR. Interview with Resident #1 on 09/06/18 at 10:30am revealed: -She got Milk of Magnesia every morning for about the last six months. -It helped her to have a bowel movement. -The MA asked her each morning "do you want the white stuff again" and she always told them	{D 367}		

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{D 367}	Continued From page 28 yes. Refer to interview with the Administrator on 09/07/18 at 5:04pm. 3. Review of Resident #3's current FL-2 dated 07/27/18 revealed: -Diagnoses included dementia without behaviors, chronic obstructive pulmonary disease, diabetes mellitus type II, anxiety, dysphagia, hyperlipidemia, and history of transient ischemic attack (also known as a mini-stroke). -There was an order for Tramadol 50mg, one tablet every 6 hours as needed. (Tramadol is a controlled substance used to treat moderate to severe pain.) Review of Resident #3's electronic August 2018 medication administration record (e-MAR) revealed: -There was an entry for Tramadol 50mg take one tablet by mouth every 6 hours as needed for pain control. -Tramadol was documented as administered on 08/05/18 at 7:34am for hip pain. Review of Resident #3's controlled substance (CS) log for Tramadol revealed: -There was no entry for Tramadol being administered on 08/05/18. -The last documented dose for Tramadol 50mg tablet was on 08/28/18. -The amount remaining was documented as 26 tablets. Observation of Resident #3's medications on hand on 09/07/18 at 12:35pm revealed there were 26 Tramadol 50 mg tablets on hand. Attempted interview with Resident #3 on 09/06/18	{D 367}		

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{D 367}	Continued From page 29 at 3:47pm was unsuccessful. Interview with a medication aide (MA) on 09/07/18 at 1:07pm revealed: -He did not recall why he documented on Resident #3's MAR that she was administered Tramadol 50mg on 08/05/18 at 7:34am and did not document it on the resident's CS log. -He may have initialed it on the e-MAR and then did not administer it. -The process he followed was to get the controlled medication out, document it on the CS log, administer it to the resident and then document on the e-MAR. Interview with the Resident Care Coordinator (RCC) on 09/07/18 at 1:35pm revealed: -Their process for controlled medications was to confirm the medication on the e-MAR, take the medication out, sign the CS log, administer the medication to the resident and then document on the e-MAR. -She performed quality checks on the e-MARs and CS logs but only confirmed that the counts were correct. -She would begin immediately checking all e-MARs and CS logs to assure each date and time of the medication matched. Refer to interview with the Administrator on 09/07/18 at 5:04pm. _____ Interview with the Administrator on 09/07/18 at 5:04pm revealed: -He occasionally filled in as a medication aide. -He did not monitor medications or the e-MARs. -It was the RCC's responsibility to monitor medications, including the e-MARs.	{D 367}		