STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092182	A. BUILDING: _____ B. WING _____	10/30/2019

RECEIVED
NOV 27 2019
ADULT CARE LICENSURE SECTION
RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on October 28, 2019 through October 30, 2019.	D 000	Response to stated deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged, or conclusions set forth, in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state laws.	
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 TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#4, #6) sampled including errors with two diuretics for swelling and fluid retention (#4) and a narcotic pain reliever not administered due to the medication being unavailable (#6). The findings are: 1. Review of Resident #4's current FL-2 dated 09/30/19 revealed: -Diagnoses included congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, gastroesophageal reflux disease without esophagitis, and essential hypertension.	D 358	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 facilities policy and procedures. On 10.28.2019, during a review of resident's orders (#4), it was noted the time of administration via imported record for the metolozaone 5mg to be given daily 30 minutes prior to furosemide at 6:00am had defaulted to 8am. Medication error report completed, with hour of administration time changed to	

Reviewed and accepted
12/17/19 MAJ

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D 358	Continued From page 1 -There was an order for Furosemide 40mg 1 tablet once daily. (Furosemide is a diuretic used to treat excess fluid/swelling.) Review of Resident #4's physician's orders dated 10/14/19 revealed there was an order to start Metolazone 2.5mg 1 tablet 30 minutes before Furosemide dose once daily. (Metolazone is a diuretic used to treat excess fluid/swelling. Metolazone may be given 30 minutes prior to Furosemide to increase the diuretic effects of the medications.) Review of Resident #4's physician's orders dated 10/28/19 revealed: -A chest x-ray showed worsening heart failure. -There was an order to discontinue Metolazone 2.5mg once a day. -There was an order to start Metolazone 5mg once in the morning to be given 30 minutes before Furosemide dose at 6:00am. -There was an order to add Furosemide 20mg 1 tablet daily at 1:00pm. Review of Resident #4's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 40mg every day with a scheduled administration time of 8:00am. -Furosemide 40mg was documented as administered daily at 8:00am from 10/01/19 - 10/29/19. -There was a second entry for Furosemide 40mg every day with a scheduled administration time of 6:00am and it was documented as administered on 10/30/19. -There was an entry for Furosemide 20mg every day at 1:00pm printed in the instructions section but the scheduled time was 8:00am.	D 358	reflect the administration time of the directions in the order. On 10.28.19, orders were received for resident #4 via imported record for furosemide 20mg to be administered daily at 1pm. Administration time defaulted to 8:00am. Medication error report completed, with hour of administration time changed to reflect the proper administration time of the directions in the order. On 10.29.19, Resident #6 was not administered her 25mg Tramadol with her other 8am meds. Medication was documented as unavailable for administration, but procured from her PRN tramadol outside of time compliance. Medication script was obtained, and medication received by the pharmacy. Error report completed for the doses not received as ordered. In September 2019, community changed from Unit Dose Bubble Pack to Multidose Packaging. Inservices were held with staff responsible for medication administration on 9/10/19. Omnicare Representative, Kimberly Bissonette, provided the education regarding bar code	

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D 358	Continued From page 2 -Furosemide 20mg was documented as administered at 8:00am on 10/30/19 instead of 1:00pm as ordered. -There was an entry for Metolazone 2.5mg once a day with a scheduled administration time of 8:00am. -Metolazone 2.5mg was documented as administered daily at 8:00am from 10/15/19 - 10/28/19, at the same time (8:00am) as Furosemide 40mg, instead of 30 minutes before Furosemide 40mg. -There was a second entry for Metolazone 2.5mg once a day 30 minutes before Furosemide dose and it was scheduled and documented as administered at 7:00am on 10/29/19. -There was an entry for Metolazone 5mg 1 tablet every morning to be given 30 minutes before Furosemide at 6:00am but it was scheduled to be administered at 8:00am. -Metolazone 5mg was documented as administered at 8:00am on 10/30/19 at the same time (8:00am) as Furosemide 40mg, instead of 30 minutes before Furosemide 40mg as ordered. Interview with a medication aide (MA) on 10/30/19 at 12:13pm revealed: -She usually administered Resident #4's Furosemide 40mg and Metolazone 2.5mg at the same time during the 8:00am medication pass because that was when they were scheduled on the eMAR. -She had not noticed the instructions on the eMAR to administer the Metolazone 30 minutes before the Furosemide. -She had administered Furosemide 20mg that morning on 10/30/19 during the 8:00am medication pass because it was scheduled for 8:00am. -She had not noticed the instructions on the eMAR to administer the Furosemide 20mg at	D 358	scanning, multidose administration, 7 day cycle-fill and reordering bulk meds and PRN medications. In October 2019, a mandatory in-service was held for all staff responsible for medication administration. Items reviewed were from NC "Guidelines for Completing the Medication Administration Clinical Skills Checklist", Medication Ordering, Medication Error reports, Matrixcare and Bloodborne Pathogens. Emphasis was placed on the 6 rights of medication administration. An in-service will be held by a registered nurse on 11/22/19. Topics included are the Guidelines for Medication Administration, Six rights of medication administration and application of these areas in day-to-day practice.	

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D 358	Continued From page 3 1:00pm. -She also administered the Furosemide 40mg that was scheduled for 6:00am on 10/30/19 during the 8:00am medication pass because it was late and had not been administered yet. -The MAs did not enter times or medication orders into the eMAR system. Interview with Resident #4 on 10/30/19 at 12:55pm revealed: -She was taking diuretics because her legs and stomach were swollen and she needed to get rid of the extra fluid. -She was taking one diuretic to "boost" the effects of the Furosemide. -She thought she received the diuretics in the morning and afternoon, but she was not sure of the times. -The extra fluid in her body was causing her to have shortness of breath. Interview with the Resident Care Coordinator (RCC) on 10/30/19 at 12:17pm revealed: -Either she, the Director of Resident Care (DRC), or the pharmacy staff could enter orders and times into the eMAR system. -She and the DRC approved entries entered by the pharmacy before the orders became active on the eMARs. -The MAs should stop and notify her or the DRC if instructions and times on the eMARs did not match. Interview with the DRC on 10/30/19 at 1:20pm revealed: -She and the RCC had access and could enter orders into the eMAR system. -The facility's contracted pharmacy also entered orders into the eMAR system. -If orders were entered by the pharmacy, the	D 358	The Executive Director, Resident Care Director, Memory Care manager or the Executive Director's Designee, will monitor imported orders and availability of medications in the community. The Folder system will be used for orders received. The six rights of medication administration will be utilized when approving orders and passing medications. Clarification will be obtained as indicated. The medication aide responsible for administration will notify the pharmacy in the event a medication is not available. Physician is to be notified of the unavailability and a medication error report completed. Date of Correction November 22, 2019	

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D 358	Continued From page 4 facility was supposed to get a notification in the eMAR system to approve the orders before they became active on the eMAR. -They did not always get a notification to approve the orders when the pharmacy entered the orders and she did not know why they did not always get notifications. -She corrected the scheduled times on the eMAR for Resident #4's Furosemide and Metolazone when the orders were first entered by the pharmacy prior to approving the orders. -She did not know why the corrections did not take effect in the eMAR system. -The MAs were supposed to read the eMARs and the medication labels and if something did not match, the MAs should stop and let her or the RCC know about it. -She and the RCC started reconciling eMARs and medication orders on 09/26/19 but they had not completed that process. -They had not noticed the discrepancies with Resident #4's eMARs because they had not reconciled the resident's eMARs yet. -She would notify Resident #4's primary care provider (PCP) of the errors. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/30/19 at 4:19pm revealed: -Either the facility staff or the pharmacy staff could enter orders into the eMAR system. -The facility had to approve any orders entered by the pharmacy staff before the orders became active on the eMARs. -If a medication was entered as once a day, the default time in the eMAR system was 8:00am unless it was entered to be taken at a different time. -It appeared the Furosemide and Metolazone may have been entered as once a day and	D 358		

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D 358	Continued From page 5 defaulted to the 8:00am time. -The time could be changed by the facility during the approval process. Telephone interview with Resident #4's PCP on 10/30/19 at 3:58pm revealed: -Resident #4 was taking Furosemide and Metolazone because the resident was volume overloaded (too much excess fluid retention). -She was not aware the Furosemide and Metolazone were being administered together. -She ordered the Metolazone to be administered before the Furosemide to make the diuretic effects of the medications more potent so more fluid could be removed from the resident's body. -She expected the medications to be administered as ordered. 2. Review of Resident #6's current FL-2 dated 07/30/19 revealed: -Diagnoses included congestive heart failure, peripheral vascular disease, dementia, chronic obstructive pulmonary disease, hypertension, and hyperlipidemia. -There was an order for Tramadol 50mg take ½ tablet (25mg) twice daily. (Tramadol is a narcotic pain reliever.) -There was an order for Tramadol 50mg take 1 tablet every 6 hours prn (as needed) for pain. Observation of the 8:00am medication pass on 10/29/19 revealed: -The medication aide (MA) prepared and administered 8:00am medications to Resident #6 at 8:46am. -Tramadol 50mg ½ tablet (25mg) was not administered to the resident when she received her other morning medications. Interview with the MA on 10/29/19 at 8:46am	D 358		

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D 358	Continued From page 6 revealed: -She did not administer Resident #6's scheduled Tramadol 50mg ½ tablet (25mg) that morning (10/29/19) because there was none available to administer. -The resident's primary care provider (PCP) came to the facility yesterday (10/28/19) and wrote a new hard script (prescription) for the Tramadol. -The MAs usually reordered medications or got a new hard script for controlled substances when there was a 1 week supply remaining. -She did not know why a hard script was not obtained for Resident #6's scheduled Tramadol until after the medication had run out. -The medication had not come in from the pharmacy so she would check with the Resident Care Coordinator (RCC) to see what needed to be done. Review of Resident #6's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg take ½ tablet (25mg) twice daily with scheduled administration times of 8:00am and 8:00pm. -Tramadol 50mg ½ tablet (25mg) was not documented as administered from 8:00am on 10/27/19 through 8:00am on 10/29/19 (5 doses) due to the medication being unavailable and on order. -There was an entry for Tramadol 50mg take 1 tablet every 6 hours as needed for pain but no prn doses were documented as administered. Interview with the Director of Resident Care (DRC) on 10/29/19 at 9:55am revealed: -The MA just notified her this morning (10/29/19) that Resident #6 did not have any scheduled Tramadol 50mg ½ tablets (25mg) on hand. -She instructed the MA to administer the	D 358		

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D 358	Continued From page 7 Tramadol dosage using Resident #6's prn supply of Tramadol 50mg tablets until the scheduled Tramadol tablets were received from the pharmacy. -She instructed the MA to use the pill splitter to cut the Tramadol 50mg tablet in half and administer ½ tablet (25mg) to the resident. A second interview with the MA on 10/29/19 at 9:58am revealed: -She had just spoken with the DRC about Resident #6's scheduled Tramadol dosage being unavailable. -The DRC instructed the MA to administer the Tramadol dosage by splitting in half one of the resident's prn Tramadol 50mg tablets. -She called the pharmacy and they were working on sending the Tramadol 50mg ½ tablets (25mg) for the resident's scheduled dose and they should be received by the facility today (10/29/19.) Observation on 10/29/19 at 10:02am revealed the MA administered ½ Tramadol 50mg tablet (25mg) to Resident #6 from the prn supply of Tramadol on hand. Interview with the RCC on 10/30/19 at 12:17pm revealed: -The MAs were responsible for ordering all medications. -The MAs should reorder medications when there was a 5-day supply remaining. -The MAs did not always reorder medications in a timely manner, but they were improving. -The MAs should let her know if they needed a hard script for refills for a controlled substance. -She would text the primary care provider (PCP) and let them know if a hard script was needed. -The PCP would either go to facility and write a hard script or the PCP would send an electronic	D 358		

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D 358	Continued From page 8 prescription to the pharmacy. A second interview with the DRC on 10/30/19 at 1:20pm revealed: -The MAs were responsible for ordering all medications, including controlled substances. -If a hard script was needed for a controlled substance, the MAs were supposed to notify her or the RCC and they would contact the PCP. -The MAs were supposed to audit the medication carts daily and let her or the RCC know if any medications were unavailable. -Resident #6 should not have run out of the scheduled Tramadol 50mg ½ tablet (25mg) dosage. Interview with Resident #6 on 10/30/19 at 3:35pm revealed: -She took pain medication for arthritis. -The pain medication usually helped with her pain. -She was not aware of the facility running out of any of her medications. Telephone interview with Resident #6's PCP on 10/30/19 at 3:58pm revealed: -The facility staff told her on Monday, 10/28/19, that Resident #6 was out of Tramadol. -She had told the facility staff in the past (no date provided) to let her know before a resident ran out of medication and she could get a new hard script to the facility or the pharmacy usually the same day it was requested. -Resident #6 took Tramadol for osteoarthritis in her hands and knees. -The resident had not complained of pain to the PCP.	D 358		