STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092150	A. BUILDING: _____ B. WING _____	C 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACIE STURDIVANT CARE HOME	1004 EDENBURGH KEEPS DRIVE KNIGHTDALE, NC 27545

(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 survey on 12/11/14.	C 000		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure clarification of medication orders for 3 of 3 residents (#1, #2, #3) sampled including medications for acid reflux, breathing problems, nausea and vomiting, diarrhea, decreased appetite, attention deficit disorder, anxiety, swelling, allergies, constipation, cough, psychosis/mood disorders, and vitamin supplement. The findings are: 1. Review of Resident #1's current FL-2 dated 07/29/14 revealed diagnoses included cognitive impairment, severe protein deficiency, hypertension, chronic obstructive pulmonary disease, failure to thrive, Vitamin B12 and folate deficiency, history of anal cancer 2008, and	C 315		

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C 315	Continued From page 1 history of tobacco abuse. A. Review of Resident #1's 10/2014, 11/2014 and 12/2014 medication administration records (MARs) revealed the following medications were included on the MARs: - Omeprazole 20mg was documented as administered once daily at 8:00 a.m. (Omeprazole is for acid reflux.) - Albuterol nebulizer solution continuously as needed for wheezing was listed but not documented as administered. (Albuterol is for breathing problems.) - Zofran ODT 4mg every 6 hours as needed was listed but not documented as administered. (Zofran is for nausea and vomiting.) - Imodium ½ to 1 tablet 5 times a day as needed for diarrhea was listed and documented as administered on one occasion on 10/03/14. (Imodium is for diarrhea.) Review of Resident #1's current FL-2 dated 07/29/14 revealed Omeprazole, Albuterol, Zofran ODT, and Imodium were not included on the FL-2 as current physician's orders. Review of Resident #1's record revealed: - Order prior to the FL-2 dated 10/18/13 for Omeprazole 20mg once daily. - No order for Albuterol. - Order prior to the FL-2 dated 05/21/13 for Zofran ODT 4mg every 6 hours as needed (no indicated for the prn was noted.) - Order prior to the FL-2 dated 07/08/14 for Imodium ½ to 1 tablet 4 times day as needed for diarrhea. - No documentation the physician was contacted to clarify whether the medications orders were to continue since they were not included on the current physician's orders on the FL-2 dated	C 315		

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C 315	Continued From page 2 07/29/14. Review of medications on hand revealed: - Supply of Omeprazole 20mg, Albuterol nebulizer solution, and Imodium. - No supply of Zofran ODT. Telephone interview with the nurse at the primary physician's office on 12/11/14 at 3:30 p.m. revealed: - Resident #1 was last seen by the physician in August 2014. - Omeprazole, Albuterol, and Zofran were listed on the resident's medication profile. - She did not see Imodium on the list but it may have been from the oncologist. - She was unsure why these medications were omitted from the current FL-2 dated 07/29/14. - She would fax clarification orders for these medications to the facility the next day. Refer to interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m. B. Review of Resident #1's record revealed: - Order on the current FL-2 dated 07/29/14 for Megace 20mg with dose cup as needed. (Megace may be used to stimulate appetite.) - Prior order dated 07/14/14 for Megace Liquid 40mg/ml take 800mg by mouth as needed. (No frequency or indication for use was included.) - Order dated 10/28/14 for Ritalin 5mg once daily as needed. (No indication for use was included). (Ritalin is a stimulant used to treat attention deficit disorder.) - Order dated 10/28/14 for Xanax 0.25mg 3 times daily as needed for sleep. (Xanax is for anxiety.) Review of Resident #1's record revealed no	C 315		

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C 315	Continued From page 3	C 315		

documentation the physician had been contacted to clarify the incomplete orders.

Review of Resident #1's 10/2014, 11/2014 and 12/2014 medication administration records (MARs) revealed:
- Megace was listed as Megace 40mg/ml take 20ml (800mg) once daily as needed.
- Megace was documented as administered on 30 occasions from 10/01/14 - 12/11/14 for "poor appetite" and "improve eating".
- Ritalin was listed as 5mg daily in the morning as needed and was documented as administered once on 11/04/14 to "improve alertness".
- Xanax was listed as 0.25mg 3 times daily as needed for anxiety and/or sleep but none was documented as administered.

Review of medications on hand revealed a supply of Megace, Ritalin, and Xanax.

Interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m. revealed:
- She had not clarified the medication orders.
- If a resident needed a prn (as needed) medication they would contact her first and she would tell them which prn medication to give the resident depending on the resident's symptoms.
- She was unaware prn psychotropic medications required a maximum dosage in 24 hours.
- She would contact the physician to clarify the orders.

Refer to interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m.

2. Review of Resident #2's current FL-2 dated 07/29/14 revealed diagnoses included vascular dementia, atrial fibrillation, chronic obstructive

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C 315	Continued From page 4 pulmonary disease, depression, osteoarthritis, and osteoporosis. A. Review of Resident #2's current FL-2 dated 07/29/14 revealed an order for Lasix 40mg once daily. (Lasix is a diuretic.) Review of Resident #2's 10/2014, 11/2014 and 12/2014 medication administration records (MARs) revealed Lasix 20mg once daily at 8:00 a.m. was administered from 10/01/14 - 12/11/14 instead of Lasix 40mg. Review of medications on hand revealed Lasix 20mg once daily was dispensed on 11/19/14 with original order date of 02/20/14. Review of Resident #2's record revealed: - Prior order dated 02/20/14 for Lasix 20mg once daily. - No documentation the physician was contacted for clarification. Interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m. revealed: - She had not noticed the order for Lasix on the FL-2 did not match what the resident was currently receiving. - She did not usually send FL-2 forms to the pharmacy. Telephone interview with the nurse at the primary physician's office on 12/11/14 at 3:30 p.m. revealed: - Most current listing she could find for the Lasix was 40mg once daily. - It was listed as Lasix 20mg daily in the old computer system. - She would clarify with the physician.	C 315		

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C 315	Continued From page 5 Observation of Resident #2 on 12/11/14 at 9:40 a.m. revealed the resident's legs and ankles did not appear to be swollen. Refer to interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m. B. Review of Resident #2's 10/2014, 11/2014 and 12/2014 medication administration records (MARs) revealed the following medications were included on the MARs: - Zyrtec 10mg once daily as needed for allergies was documented as administered once on 10/31/14. (Zyrtec is for seasonal allergies.) - Miralax 17gram in 8 ounces of liquid once daily as needed was listed but not documented as administered. (Miralax is for constipation.) - Phenergan with Codeine syrup take 5ml every 4 to 6 hours as needed was listed but not documented as administered. (Phenergan with Codeine is for cough.) Review of Resident #2's current FL-2 dated 07/29/14 revealed Zyrtec, Miralax, and Phenergan with Codeine were not included on the FL-2 as current physician's orders. Review of Resident #2's record revealed: - Order prior to the FL-2 dated 04/08/14 for Zyrtec 10mg daily as needed for allergies. - Order prior to the FL2 dated 05/07/13 for Miralax 17 gram in 8 ounces liquid daily as needed (no indication for use). - Order prior to the FL-2 dated 10/25/12 for Phenergan with Codeine 5ml every 4 to 6 hours as needed (no indication for use). - No documentation the physician was contacted to clarify whether the medications orders were to continue since they were not included on the current physician's orders on the FL-2 dated	C 315		

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C 315	Continued From page 6 07/29/14. Review of medications on hand revealed: - Supply of Zyrtec 10mg. - No supply of Miralax or Phenergan with Codeine. Telephone interview with the nurse at the primary physician's office on 12/11/14 at 3:30 p.m. revealed: - Resident #1 was last seen by the physician in August 2014. - Zyrtec and Miralax were listed on the resident's medication profile. - The resident should not be receiving Phenergan with Codeine. - She would fax clarification orders for these medications to the facility the next day. Refer to interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m. 3. Review of Resident #3's current FL-2 dated 07/29/14 revealed diagnosis of dementia. A. Review of Resident #3's current FL-2 dated 07/29/14 revealed orders for: - Seroquel 25mg at bedtime as needed (no indication for use or maximum dosage in 24 hours). (Seroquel is an antipsychotic.) - Xanax 0.25mg every 4 to 6 hours as needed (no indication for use or maximum dose in 24 hours). (Xanax is for anxiety.) Review of Resident #3's 11/2014 and 12/2014 medication administration records (MARs) revealed: - Seroquel 50mg was being administered twice daily at 8:00 a.m. and 8:00 p.m. instead of 25mg as needed.	C 315		

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C 315	Continued From page 7	C 315		

- Xanax was being administered 0.25mg at bedtime as needed for sleep and had been administered on 11/16/14 and 11/24/14.

Review of medications on hand revealed:
- Seroquel 50mg twice daily was dispensed on 11/19/14 with original date of 05/14/14.
- Xanax 0.25mg at bedtime as needed for sleep was dispensed on 09/25/14.

Review of Resident #3's record revealed no documentation the physician was contacted for clarification.

Interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m. revealed:
- She had not noticed the orders for Seroquel and Xanax on the FL-2 did not match the MARs.
- She usually used the orders in the resident's records to write the FL-2s and the physician would sign the FL-2s.
- She did not usually send FL-2 forms to the pharmacy.

Telephone interview with the nurse at the primary physician's office on 12/11/14 at 3:30 p.m. revealed:
- Resident #3's medication list included Seroquel 50mg twice daily but she also saw Seroquel 25mg at bedtime as needed on a previous list.
- Xanax 0.25mg at bedtime as needed for sleep was included on the resident's medication list.
- She would clarify with the physician.

Refer to interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m.

B. Review of Resident #3's 10/2014, 11/2014 and 12/2014 medication administration records (MARs) revealed Vitamin D 2000 units was being

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administered daily at 8:00 a.m. from 10/01/14 - 12/11/14. (Vitamin D is a supplement.)

Review of Resident #3's current FL-2 dated 07/29/14 revealed Vitamin D was not included on the FL-2 as a current physician's order.

Review of Resident #3's record revealed:
- Order prior to the FL-2 dated 03/14/14 for Vitamin D 2000 units once daily. (Vitamin D is a supplement.)
- No documentation the physician was contacted to clarify whether the Vitamin D was to continue since it was not included on the current FL-2 dated 07/29/14.

Review of medications on hand revealed supply of Vitamin D dispensed on 11/19/14 with original date of 03/14/14.

Telephone interview with the nurse at the primary physician's office on 12/11/14 at 3:30 p.m. revealed:
- Vitamin D was listed on the resident's medication profile.
- She was did not know why it was not included on the current FL-2
- She would fax a clarification order to the facility the next day.

Refer to interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m.

_____

Interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:15 p.m. revealed:
- She did not usually go by the FL-2 for medication orders.
- She used the written prescriptions and

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C 315	Continued From page 9 medication orders in the resident's record. - She thought as long as she had an order in the record no matter how old it was, she was to continue to give the medication unless she received a discontinue order. - She had not contacted the physician for clarification.	C 315		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication	C 375		

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C 375	Continued From page 10 outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the medication regimen review was complete and included the identification, prevention, and resolution of medication related problems for 3 of 3 residents (#1, #2, #3) sampled. The findings are: 1. Review of Resident #1's current FL-2 dated 07/29/14 revealed diagnoses included cognitive impairment, severe protein deficiency, hypertension, chronic obstructive pulmonary disease, failure to thrive, Vitamin B12 and folate deficiency, history of anal cancer 2008, and history of tobacco abuse. Review of Resident #1's record and medication administration records (MARs) revealed: - Omeprazole, Albuterol nebulizer solution, Zofran ODT, and Imodium were included on the resident's 10/2014 - 12/2014 MARs. - These medications were not included as current orders on the resident's FL-2 dated 07/29/14. - No documentation the physician was contacted to clarify whether the medications orders were to continue since they were not included on the current physician's orders on the FL-2 dated 07/29/14. - Orders for Megace, Ritalin, and Xanax were incomplete and included on the 10/2014 - 12/2014 MARs. - No documentation the physician had been contacted to clarify the incomplete orders.	C 375		

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C 375	Continued From page 11 Review resident's most recent medication regimen review completed on 11/02/14 revealed: - Facility's Administrator/Registered Nurse (RN) completed the review. - No problems were documented as identified. - No recommendations for this resident. - RN failed to identify Resident #1's medication orders needed clarification. Refer to interview with the Administrator/RN on 12/11/14 at 3:50 p.m. 2. Review of Resident #2's current FL-2 dated 07/29/14 revealed diagnoses included vascular dementia, atrial fibrillation, chronic obstructive pulmonary disease, depression, osteoarthritis, and osteoporosis. Review of Resident #2's record and medication administration records (MARs) revealed: - Lasix 40mg once daily was ordered on the current FL-2 dated 07/29/14 but resident was being administered Lasix 20mg once daily in 10/2014 - 12/2014. - Zyrtec, Miralax, and Phenergan with Codeine syrup were included on the resident's 10/2014 - 12/2014 MARs. - These medications were not included as current orders on the resident's FL-2 dated 07/29/14. - No documentation the physician was contacted to clarify whether the medications orders were to continue since they were not included on the current physician's orders on the FL-2 dated 07/29/14. Review resident's most recent medication regimen review completed on 11/02/14 revealed: - Facility's Administrator/Registered Nurse (RN)	C 375		

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completed the review.
- No problems were documented as identified.
- No recommendations for this resident.
- RN failed to identify the problems with Resident #2's Lasix, Zyrtec, Miralax, or Phenergan with Codeine.

Refer to interview with the Administrator/RN on 12/11/14 at 3:50 p.m.

3. Review of Resident #3's current FL-2 dated 07/29/14 revealed diagnosis of dementia.

Review of Resident #3's record and medication administration records (MARs) revealed:
- Entries for Seroquel and Xanax on the 11/2014 and 12/2014 MARs did not match the current orders on the FL-2 dated 07/29/14.
- Orders for prn Seroquel and Xanax on the current FL-2 dated 07/29/14 did not include an indication for use or a maximum dosage to be administered in 24 hours.
- Vitamin D 2000 units daily was being administered but there was no order for Vitamin D on the current FL-2 dated 07/29/14.
- No documentation the physician was contacted for clarification of the orders.

Review resident's most recent medication regimen review completed on 11/02/14 revealed:
- Facility's Administrator/Registered Nurse (RN) completed the review.
- No problems were documented as identified.
- No recommendations for this resident.
- RN failed to identify Resident # 3's medication orders for Seroquel, Xanax, and Vitamin D needed clarification.

Refer to interview with the Administrator/RN on 12/11/14 at 3:50 p.m.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACIE STURDIVANT CARE HOME	1004 EDENBURGH KEEPS DRIVE KNIGHTDALE, NC 27545

(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 375	Continued From page 13 Interview with the Administrator / Registered Nurse (RN) on 12/11/14 at 3:50 p.m. revealed: - She handles all medication orders for the facility and transcribes them to the MARs. - She does the FL-2s for the residents annually and has the physician to sign them. - She usually filled out the FL-2s by looking at the residents' current medications. - She did not usually go by the FL-2s for medication orders. - She used the written prescriptions and medication orders in the residents' records. - She thought as long as she had an order in the record no matter how old it was, she could continue to give the medication unless she received a discontinue order. - She does all medication reviews for the facility since she is a nurse. - She looks for medication changes, weight loss, new diagnoses, behaviors, new orders, drug interactions, and she compares the orders with the MARs. - She had not identified clarification issues with the residents' medications because she was not aware they needed clarifying. - In the future, she will have the contract pharmacy send someone to do the medication reviews.	C 375		