STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 000	Initial Comments The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey on December 30-31, 2014.	C 000		
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: TYPE B VIOLATION Based on observation, interview, and record review the facility failed to assure Humalog and Levemir insulins and Lisinopril were administered as prescribed for 2 of 3 sampled residents (Resident #1 and Resident #3). The findings are: A. Review of Resident #1's current FL2 dated 11/20/14 revealed: -Diagnoses included left hip fracture, status post open reduction and internal fixation of left hip, type 2 diabetes mellitus, bipolar disorder, depression, seizures, and chronic pain. -A medication order for Novolog insulin (used to reduce blood sugar-fast acting) per sliding scale before meals and at bedtime (FSBS 180-200=1 unit, 201-250=2 units, 251-300 = 4 units,	C 330		

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C 330	Continued From page 1 301-350= 6 units, 351-400 = 8 units, greater than 400 notify physician). -A medication order for Levemir (used to reduce blood sugar-long acting) 4 units daily at bedtime. -A medication order for Novolin N (used to reduce blood sugar-intermediate acting) 5 units twice a day before meals. Review of an order written by Resident #1's Primary Care Physician (PCP) dated 11/26/14 revealed: -Discontinue current dose of Levemir -Change Humulin N (bioequivalent to Novolin N) to Levemir 12 units daily times one week, then 14 units daily times one week, then 16 units daily. Review of an order written by Resident #1's Endocrinologist dated 12/11/14 revealed: -Levemir 9 units twice daily. -Humalog (bioequivalent to Novolog) 4 units before meals three times daily. -See attached for sliding scale. -Keep glucometer at bedside. 1. Review of Resident #1's record revealed there was no documentation of a sliding scale for this order dated 12/11/14. Interview with the Supervisor on 12/30/14 at 9:45am revealed: -She was the primary care giver for the residents in the home 24 hours a day / 7 days a week except she had scheduled time off on Tuesdays 9am to 7pm. -The facility had been administering Novolog insulin per sliding scale order from the FL2 dated 11/20/14 for Resident #1. -She had taken Resident #1 to the Endocrinologist for the appointment on 12/11/14. -She stated normally the Transporter would have	C 330		

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taken the resident to the appointment, but the Transporter had been on vacation, so she had taken Resident #1 to the appointment herself.
-To her knowledge there wasn't another sliding scale order initiated by the Endocrinologist visit on 12/11/14.
-To her knowledge the resident had never taken Humalog insulin, but had always been on Novolog insulin.
-She had assumed since the Endocrinologist had been given Resident #1's folder with her current medication administration record he had been referring to that order when he had written "see attached for sliding scale" on the ordered dated 12/11/14.
-She stated she would call the Endocrinology office and get them to send a copy of the order they had on file for the visit on 12/11/14.

Interview with the Administrator on 12/30/14 at 9:53am revealed:
-Resident #1 "fell one weekend twice due to low blood sugar."
-"[Resident #1] had gone to the Endocrinologist and they changed her medicine all up and she fell and had a hip fracture."
-"[Local home health agency name] has been handling aggressive physical therapy with her."

Review of an Endocrinologist's order for Resident #1 dated 12/11/14 received from Resident #1's Endocrinologist on 12/30/14 at 11:11am revealed:
-Blood glucose(BG) monitoring before every meal and bedtime.
-Humalog Insulin (SSI): BG less than 50-Treat low BG, delay injection until immediately after meal; BG 51-70-Immediately eat. Take injection just before eating. Reduce insulin by 2 units; BG 71-150-Take prescribed dose of insulin.
-Take additional Humalog Insulin (Pre: Breakfast,

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C 330	Continued From page 3 Lunch, Supper) BG 151-200, 1 unit; BG 201-250, 2 units; BG 251-300, 3 units; BG 301-350, 5 units; BG 351-400, 7 units. -Take additional Humalog Insulin (bedtime) BG 151-200, none; BG 201-250, 1 unit; BG 251-300, 2 units; 301-350, 3 units; BG 351-400, 5 units. Interview with the Supervisor on 12/30/14 at 11:11am revealed: -"Here's the [order] from the Endocrinologist's office." -"They did not give me that when I was there." -"I assumed she was meant to continue the old sliding scale insulin order because [the Endocrinologist] had her folder [with the her current orders and eMAR] in front of him." -The medication orders were entered into the eMAR system by the pharmacy. -The eMAR system just popped up prompting time for BG to be obtained and then it calculated what dose of insulin to administer to the resident. -She was responsible for faxing over new orders received from a physician. -A copy of the order was also sent to the main office where the staff would double check all the orders entered by the pharmacy. Interview with the Supervisor on 12/31/14 at 2:08pm revealed "[The Endocrinologist's sliding scale order dated 12/11/14] would have been faxed over to the office and the pharmacy if I had got it." Review of Resident #1's November 2014 Electronic Medication Administration Record (eMAR) revealed the BG range from 11/25/14, 7pm to 9pm until 11/30/14, 7pm to 9pm was 42 to 467. Review of Resident #1's December 2014 eMAR	C 330		

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C 330	Continued From page 4 revealed: -A computer generated entry for Novolog as per sliding scale. -The actual sliding scale used was not printed on the eMAR. -The BG range from 12/1/14, 7am to 9am until 12/10/14, 7pm to 9pm was 45 to 473. -The BG range from 12/11/14, 11am to 1pm until 12/14/14, 7am to 9am when Resident #1 was sent to the hospital was 56 to 294. -Administration times were scheduled for 7am to 9am, 11am to 1pm, 4pm to 6pm, and 7pm to 9pm. -From 12/11/14, 11am to 1pm dose to 12/14/14, 7am to 9am dose, there were 2 occurrences out of 2 opportunites where Novolog sliding scale was documented as administered inaccurately. -On 12/12/14, at 7a to 9a, BG 285, 4 units Novolog documented as administered, 3 units required. -On 12/13/14, at 7p to 9p, BG 294, 4 units Novolog documented as administered, 2 units required. Observation of Resident #1's medications on hand in the facility on 12/30/14 at 3:31pm revealed: -There was one partially used multidose vial of Novolog insulin. -The label had Resident #1's name with the following dosing instructions "use as directed sliding scale." Interview with the Supervisor on 12/30/14 at 1:16pm revealed: -She had taken Resident #1 to the Endocrinologist for the appointment on 12/11/14. -She had taken a folder with the resident's current medication administration record which also contained the resident's fingerstick blood sugar	C 330		

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results.
-When she and the resident returned back to the facility she realized when she went to fax the new medication order to the pharmacy, "I realized [the physician] had the wrong medication."
-"Since it was just writing the wrong insulin down [Primary Care Physician's name] fixed it for me that day."
-"I did not realize the sliding scale for the insulin had changed until I called them today to clarify what scale the order referred too."
-She stated she had thought the physician was referring to the same scale ordered on the 11/20/14 FL2.

Telephone interview with the facility pharmacy on 12/30/14 at 2:00pm revealed:
-Resident #1's sliding scale order was from the FL2 dated 11/20/14.
-The order was as follows: Novolog insulin per sliding scale before meals and at bedtime (FSBS 180-200=1 unit, 201-250=2 units, 251-300 = 4 units, 301-350= 6 units, 351-400 = 8 units, greater than 400 notify physician).
-An order had never been received from Resident #1's Endocrinologist dated 12/11/14.

Telephone interview with Resident #1's Endocrinologist's certified medical assistant on 12/30/14 at 3:17pm revealed:
-Resident #1 had been seen in their office last on 12/11/14.
-The order for the sliding scale "was printed at her visit" and given to the resident and caregiver.
-The copy of the order that was faxed to the facility on 12/30/14 was what had been ordered by Resident #1's Endocrinologist and what he had intended the resident receive.
-Their office had followed Resident #1 for a number of years and her blood sugars were

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C 330	Continued From page 6 "erratic." Review of the facility medication administration policy section on medication changes revealed: -Obtain a written order from the physician with clear and concise information as to the name of the medication, the exact dosage, the strength, the purpose of the medication, the date the medication is to be changed, full administrative directions. -Orders are to be faxed to the pharmacy immediately. -The medication administration record is to be changed. -Place a label from the pharmacy, which reads "Directions changed, refer to chart" on the medication over the initial directions. Review of an Accident/Incident Report for Resident #1 dated 12/13/14 revealed: -On 12/13/14 at 7am, "Found resident in floor." -"[The resident] stated that she fell out of bed. Refused to go to [emergency room] at 7am, but by 9am [the resident] stated her leg was feeling worse." -Resident #1 was sent to local emergency room on 12/13/14 at 9:20am for evaluation. -Recommended steps to prevent recurrence: "Encourage [resident] to use call bell when feeling weak or unstable. Contact physician regarding med changes 12/11 that may have contributed to instability." Review of an Accident/Incident Report for Resident #1 dated 12/14/14 revealed: -On 12/14/14 at 7am, "Observed resident in floor. [The resident] could not speak. Called 911 checked [blood glucose] it was 56." -Resident #1 was sent to local emergency room on 12/14/14 at 7:43am for evaluation.	C 330		

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C 330	Continued From page 7 -Recommended steps to prevent recurrence: "[Home Health] to evaluate and treat. [Family Member] requested primary care to manage diabetes due to falls since med change on 12/11/14..." Review of a discharge summary for Resident #1 dated 12/16/14 revealed the resident was admitted to a local hospital for treatment on 12/14/14 for a closed trochanteric fracture of the femur and Type I diabetes mellitus with hemoglobin A1C between 7 and 8. Interview with Resident #1 on 12/30/14 at 8:25am and 12/31/14 at 7:55am revealed: -She had lived in the facility for about 2 months and she really "liked" living there. -Her blood sugars were not well controlled with her medications. -She stated she had been an inpatient in a local hospital in October 2014 when she fell originally and broke her left femur and the hospital "did surgery and put a metal rod in my leg." -She was discharged from that hospital to a skilled nursing facility for rehabilitation. -She stated then she was discharged from the skilled nursing facility and to the current assisted living facility. -She was currently receiving physical therapy with home health in the facility two times a week. -"I can walk, but with a limp." -"I have started using a cane and that helps." -She had fallen twice during December in the current facility. -The first fall had occurred on 12/13/14 and she stated she "didn't want to go to the [emergency room] at first, but later my head started hurting. I had a big egg on my head." -At that point the resident notified staff she wanted to be evaluated and staff sent her out for	C 330		

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evaluation at a local emergency room.
-The resident was evaluated and returned to the facility later in the day on 12/13/14.
-The resident stated she fell again on the morning of 12/14/14 and was sent to the emergency room for evaluation where a CT scan (cross sectional images of the bones) of the her left hip revealed she had "reinjured the femur" and there was a "hairline fracture in the bone I still had left."
-"The surgeon said it should not be a problem since it was a hairline fracture."
-The surgeon told her the fracture would "heal in no time."
-The resident believed her blood sugar getting too low did contribute to her fall.
-She stated she had been "really upset" about the recent changes the Endocrinologist had made to her insulins and "I'd rather my sugar be high than real low."

Interview with the Administrator on 12/30/14 at 3:57pm revealed:
-She stated the Endocrinologist was a fault for the problems Resident #1 had with her low BG which could have led to her fall.
-She stated "He didn't reconcile his orders" or review the current medication administration record (MAR) her staff had provided for him during the visit.
-The Endocrinologist had ordered to "discontinue medications" the resident "wasn't on."
-"Since he didn't attach a new scale we assumed that he was referencing the sliding scale that was in the folder with her current MAR."
-"When [the Endocrinologist] made those changes within days she fell."
-"The primary care provider started following her after the hospital discharge and she's had no falls since."
-"I think the medication changes contributed to

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these falls."
-On 12/11/14, "It was [the Supervisor's] day off and she was in and out throughout the day."
-"[The relief Supervisor] thought [the Supervisor] had faxed the orders to the pharmacy."
-The order for Resident #1 had not ever gotten faxed to the pharmacy.
-"Our office [staff] check order changes against what the pharmacy enters."
-Since the Endocrinologist's order had been on their own form, a copy must not have ever gotten to the outgoing box for the office staff to review.

Interview with the Administrator on 12/31/14 at 8:50am revealed:
-The rehabilitation facility where Resident #1 had been discharged from before coming to the current facility had not told them about "problems with blood sugars."
-She believed both falls were related to medication changes.

Telephone interivew with Resident #1's family member on 12/31/14 at 8:30am revealed:
-She believed Resident #1's falls were related to changes made by the Endocrinologist to the resident's insulin orders.
-Resident #1 and she had recently decided to leave the Endocrinology practice whom the resident had seen for 10 years because the physician "adjusted her evening levemir and she fell twice."
-The "doses were too high making [Resident #1's] sugars too low at night."
-"A normal blood sugar at night is disasterous for her."
-She stated often times changes made to Resident #1's orders after hours or on weekends by the Endocrinology practice physicians did not "get into her chart" in the their office.

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C 330	Continued From page 10 -"[Facility name] is the best care [Resident #1] has had." -She felt a primary care physician was capable of handling Resident #1's insulin orders. Telephone interview with the certified medical assistant for Resident #1's Endocrinologist on 12/31/14 at 9:52am revealed: -The Endocrinologist was caring for patients and could not come to the phone. -However, she stated the Endocrinologist's exact words were "Insulin can cause hypoglycemia and this can cause falls." 2. Review of an Endocrinologist's order for Resident #1 dated 12/11/14 received from Resident #1's Endocrinologist on 12/30/14 at 11:11am revealed Levemir 9 units at breakfast and bedtime daily. Review of the facility medication administration policy revealed medication administration times were defined for a twice daily medication to be administered at 8am and 8pm. Review of Resident #1's November 2014 Electronic Medication Administration Record (eMAR) revealed the BG range from 11/25/14, 7pm to 9pm until 11/30/14, 7pm to 9pm was 42 to 467. Review of Resident #1's December 2014 eMAR revealed: -A computer generated entry originating on 12/11/14 for Levemir 9 units twice daily. -The BG range from 12/1/14, 7am to 9am until 12/10/14, 7pm to 9pm was 45 to 473. -The BG range from 12/11/14, 11am to 1pm until 12/14/14, 7am to 9am when Resident #1 was sent to the hospital was 56 to 294.	C 330		

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C 330	Continued From page 11 -The Levemir 9 units was scheduled on the eMAR to be administered at 6:30am to 9am and 4:30pm to 5:30pm. -Levemir 9 units was documented as administered at 6:30am to 9am and 4:30pm to 5:30pm on 12/12/14 and 12/13/14 until Resident #1 was admitted to the hospital on the morning of 12/14/14. Interview with the Administrator on 12/30/14 at 9:53am revealed: -Resident #1 "fell one weekend twice due to low blood sugar." -"[Resident #1] had gone to the Endocrinologist and they changed her medicine all up and she fell and had a hip fracture." -"[Local home health agency name] has been handling aggressive physical therapy with her." Interview with the Supervisor on 12/30/14 at 11:11am revealed: -The Levemir insulin order dated 12/11/14 was faxed to the facility pharmacy on 12/11/14. -The medication orders were entered into the eMAR system by the pharmacy. -The eMAR system just popped up prompting a time and calculated dose of insulin to administer to the resident. -She was responsible for faxing over new orders received from a physician. -A copy of the order was also sent to the main office where the staff would double check all the orders entered by the pharmacy. Telephone interview with the facility pharmacy on 12/30/14 at 2:00pm revealed they had received the order from the facility for Levemir 9 units twice daily on 12/11/14. Telephone interview with Resident #1's	C 330		

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C 330	Continued From page 12 Endocrinologist's certified medical assistant on 12/30/14 at 3:17pm revealed: -Resident #1 had been seen in their office last on 12/11/14. -The insulin orders were printed at the visit and given to the resident and caregiver. -The copy of the order that was faxed to the facility on 12/30/14 was what had been ordered by Resident #1's Endocrinologist and what he had intended the resident receive. -Their office had followed Resident #1 for a number of years and her blood sugars were "erratic." Review of an Accident/Incident Report for Resident #1 dated 12/13/14 revealed: -On 12/13/14 at 7am, "Found resident in floor." -"[The resident] stated that she fell out of bed. Refused to go to [emergency room] at 7am, but by 9am [the resident] stated her leg was feeling worse." -Resident #1 was sent to local emergency room on 12/13/14 at 9:20am for evaluation. -Recommended steps to prevent recurrence: "Encourage [resident] to use call bell when feeling weak or unstable. Contact physician regarding med changes 12/11 that may have contributed to instability." Review of an Accident/Incident Report for Resident #1 dated 12/14/14 revealed: -On 12/14/14 at 7am, "Observed resident in floor. [The resident] could not speak. Called 911 checked [blood glucose] it was 56." -Resident #1 was sent to local emergency room on 12/14/14 at 7:43am for evaluation. -Recommended steps to prevent recurrence: "[Home Health] to evaluate and treat. [Family Member] requested primary care to manage diabetes due to falls since med change on	C 330		

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	FCL045102	A. BUILDING: _____ B. WING _____	12/31/2014

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C 330	Continued From page 13 12/11/14..." Review of a discharge summary for Resident #1 dated 12/16/14 revealed the resident was admitted to a local hospital for treatment on 12/14/14 for a closed trochanteric fracture of the femur and Type I diabetes mellitus with hemoglobin A1C between 7 and 8. Interview with Resident #1 on 12/30/14 at 8:25am and 12/31/14 at 7:55am revealed: -She had lived in the facility for about 2 months and she really "liked" living there. -Her blood sugars were not well controlled with her medications. -She stated she had been an inpatient in a local hospital in October 2014 when she fell originally and broke her left femur and the hospital "did surgery and put a metal rod in my leg." -She was discharged from that hospital to a skilled nursing facility for rehabilitation. -She stated then she was discharged from the skilled nursing facility and to the current assisted living facility. -She was currently receiving physical therapy with home health in the facility two times a week. -"I can walk, but with a limp." -"I have started using a cane and that helps." -She had fallen twice during December in the current facility. -The first fall had occurred on 12/13/14 and she stated she "didn't want to go to the [emergency room] at first, but later my head started hurting. I had a big egg on my head." -At that point the resident notified staff she wanted to be evaluated and staff sent her out for evaluation at a local emergency room. -The resident was evaluated and returned to the facility later in the day on 12/13/14. -The resident stated she fell again on the morning	C 330		

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C 330	Continued From page 14 of 12/14/14 and was sent to the emergency room for evaluation where a CT scan (cross sectional images of the bones) of the her left hip revealed she had "reinjured the femur" and there was a "hairline fracture in the bone I still had left." -"The surgeon said it should not be a problem since it was a hairline fracture." -The surgeon told her the fracture would "heal in no time." -The resident believed her blood sugar getting too low did contribute to her fall. -She stated she had been "really upset" about the recent changes the Endocrinologist had made to her insulins and "I'd rather my sugar be high than real low." Interview with the Administrator on 12/30/14 at 3:57pm revealed: -She stated the Endocrinologist was a fault for the problems Resident #1 had with her low BG which could have led to her fall. -She stated "He didn't reconcile his orders" or review the current medication administration record (MAR) her staff had provided for him during the visit. -The Endocrinologist had ordered to "discontinue medications" the resident "wasn't on." -"When [the Endocrinologist] made those changes within days she fell." -"The primary care provider started following her after the hospital discharge and she's had no falls since." -"I think the medication changes contributed to these falls." -On 12/11/14, "It was [the Supervisor's] day off and she was in and out throughout the day." -"[The relief Supervisor] thought [the Supervisor] had faxed the orders to the pharmacy." -The order for Resident #1 had not ever gotten faxed to the pharmacy.	C 330		

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C 330	Continued From page 15 -"Our office [staff] check order changes against what the pharmacy enters." -Since the Endocrinologist's order had been on their own form, a copy must not have ever gotten to the outgoing box for the office staff to review. Telephone interivew with Resident #1's family member on 12/31/14 at 8:30am revealed: -She believed Resident #1's falls were related to changes made by the Endocrinologist to the resident's insulin orders. -Resident #1 and she had recently decided to leave the Endocrinology practice whom the resident had seen for 10 years because the physician "adjusted her evening levemir and she fell twice." -The "doses were too high making [Resident #1's] sugars too low at night." -"A normal blood sugar at night is disasterous for her." -She stated often times changes made to Resident #1's orders after hours or on weekends by the Endocrinology practice physicians did not "get into her chart" in the their office. -"[Facility name] is the best care [Resident #1] has had." -She felt a primary care physician was capable of handling Resident #1's insulin orders. Interview with the Administrator on 12/31/14 at 8:50am revealed: -The rehabilitation facility where Resident #1 had been discharged from before coming to the current facility had not told them about "problems with blood sugars." -She believed both falls were related to medication changes. Telephone interview with the certified medical assistant for Resident #1's Endocrinologist on	C 330		

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C 330	Continued From page 16 12/31/14 at 9:52am revealed: -The Endocrinologist was caring for patients and could not come to the phone. -However, she stated the Endocrinologist's exact words were "Insulin can cause hypoglycemia and this can cause falls." B. Review of Resident #3's current FL2 dated 8/28/14 revealed diagnoses included: -encephalopathy -urinary tract infections -coronary atherosclerosis -diabetes mellitus -schizoaffective disorder Review of a physician's order for Resident #3 dated 10/8/14 revealed an order to check vital signs weekly. Review of a physician's order for Resident #3 dated 9/22/14 revealed Lisinopril (used to regulate blood pressure) 10mg daily. Review of a physician's order for Resident #3 dated 11/13/14 revealed: -Lisinopril 10mg daily discontinued. -Lisinopril 20mg daily. Review of a physician's order for Resident #3 dated 11/20/14 revealed: -"[Followup] was needed after [blood pressure] has been very high." -Lisinopril 30mg daily. Review of Resident #3's November 2014 e-MAR revealed: -A computer generated entry for Lisinopril 10mg daily. -Lisinopril 10mg was documented as administered 11/1/14 to 11/13/14 daily at 8am.	C 330		

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C 330	Continued From page 17 -A computer generated entry for Lisinopril 20mg daily beginning 11/14/14. -Lisinopril 20mg was documented as administered 11/14/14 to 11/20/14 daily at 8am. -A computer generated entry for Lisinopril 30mg daily beginning 11/21/14. -Lisinopril 30mg was documented as administered 11/21/14 to 11/30/14 daily at 8am. Normal blood pressure is considered 120/80 according to the National Institute of Health. Continued review of Resident #3's November 2014 e-MAR revealed: -On 11/4/14, blood pressure documented 150/117. -On 11/11/14, blood pressure documented 150/107. -On 11/18/14, blood pressure documented 168/136. -On 11/25/14, blood pressure documented 165/99. Review of Resident #3's December 2014 eMAR revealed: -A computer generated entry for Lisinopril 30mg daily. -Lisinopril 30mg was documented as administered 12/1/14 to 12/30/14 daily at 8am. Continued review of Resident #3's December 2014 eMAR revealed: -On 12/2/14, blood pressure documented 131/109. -On 12/9/14, blood pressure documented 156/89. -On 12/16/14, blood pressure documented 145/86. -On 12/23/14, blood pressure documented 167/98.	C 330		

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C 330	Continued From page 18 Observation of Resident #3's medications on hand on 12/30/14 at 11:00am revealed: -There was one bubble pack of Lisinopril 20mg tablets on hand for the resident. -In the lower drawer on the medication cart, there was a bubble pack of Lisinopril 10mg tablets for Resident #3. -There were no tablets of Lisinopril 30mg strength on the medication cart for Resident #3. Interview with the Supervisor on 12/30/14 at 10:30am revealed: -"I have been giving [Resident #3] Lisinopril 20mg." -"I didn't see the increase to 30mg" because it was before I started working in this facility. Interview with the facility pharmacy on 12/30/14 at 4:28pm revealed: -The pharmacy received an electronic copy of the order for Lisinopril 30mg daily on 11/20/14. -The Lisinopril 30mg was filled on 11/20/14. -The Lisinopril 30mg tablets were delivered on 11/21/14 and signed off as received by the facility Administrator. Review of a pharmacy delivery manifest dated 11/21/14 at 5:06pm revealed: -The Administrator signed as having received the Lisinopril 30mg tablets. Interview with the Administrator on 12/30/14 at 4:45pm revealed: -The medications were scanned into the eMAR system, but did not know where the Lisinopril 30mg tablets went. -The Lisinopril 30mg tablets were not on the medication cart. Telephone interview with Resident #3's primary	C 330		

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C 330	Continued From page 19 care physician's assistant on 12/30/14 at 4:18pm revealed: -He was not concerned about Resident #3 not getting the Lisinopril 30mg daily as ordered. -Lisinopril 30mg daily would have made the blood pressure too low. -Low blood pressure would have increased the resident's risk of falls. Based on observations, record review, and attempted interview with Resident #3 on 12/30/14, Resident #3 was determined not to be interviewable. _____ A plan of protection was provided by the facility on 12/30/14 and included the following: -Administrative staff will review all report of consultations and hospital discharges to ensure all orders are reconciled. -We transport our residents to all medical/hospital visits so we will be aware of each physician visit and check for any new/changed orders. -Administrative check in will be done two to three times weekly to ensure compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 14, 2015.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	C 912		

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C 912	Continued From page 20 This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which are adequate, appropiate and incompliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observation, interview, and record review the facility failed to assure Humalog and Levemir insulins and Lisinopril were administered as prescribed for 2 of 3 sampled residents (Resident #1 and Resident #3). [Refer to tag D330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]	C 912		