

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER HAYWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 27 NORTH MAIN STREET CANTON, NC 28716		
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D 000	Initial Comments Staff with the Adult Care Licensure Section and Haywood County DSS conducted an annual survey on-site January 21 -23, 2015.	D 000		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: Based on observation, interview and record review, the Administrator failed to assure responsibility for the total operation of the facility to maintain compliance in the rule areas related to resident rights and medication administration. The findings are: Interview with the Administrator on 1/23/15 at 12:55pm revealed: -She was responsible for the operation of the facility. -She referred medication questions to the Special	D 176		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 176	Continued From page 1 Care Unit Coordinator. -The Administrator was not aware how the facility staff were reording medications. -The Administrator was not aware staff could not reorder medications on the computer through the electronic Medication Administration Record system. -The Administrator stated she would look at their system to find out where the delays were in obtaining and administering medications. Areas of non-compliance identified during the survey were as follows: A. Based on observation, interview, and record review, the facility failed to assure medications which included Oxycod/Apap, Fentanyl Patches, gabapentin, capsaicin cream, CMPD cream, Brimonidine Solution, beta-carotene, Dulcolax, Seroquel, Haldol, and Senna were administered as ordered for 4 of 6 sampled residents (#2, #3, #4, and #6). Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).] B. Based on observation, interview, and record review, the facility failed to assure 1 of 6 sampled residents (#6) received a reasonable response to the request for a prescribed medication (Oxybutynin) to be discontinued by the prescribing physician. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type B Violation).]	D 176		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,	D 338		

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D 338	Continued From page 2 Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure 1 of 6 sampled residents (#6) received a reasonable response to the request for a prescribed medication (Oxybutynin) to be discontinued by the prescribing physician. The findings are: Review of Resident #6's current FL2, dated 3/6/14, revealed diagnoses which included: -Diabetes mellitus -Anxiety disorder -Urinary retention Review of the 3/6/14 FL2 also revealed Resident #6 was continent of bladder and independent in toileting. Review of the 3/6/14 FL2 revealed an order for Oxybutynin 5 mg 1 tablet two times per day. (Oxybutynin is a medication to treat frequent urination and inability to control urination). Interview with Resident #6 on 1/21/15 at 10:05am revealed: -The physician discontinued her Oxybutynin several months ago but the pharmacy was still sending it. -She asked the Special Care Unit Coordinator (SCUC) to have the pharmacy to quit sending it because the pharmacy was still billing her for it. -She told other facility staff also to get the	D 338		

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D 338	Continued From page 3 Oxybutynin discontinued but nothing had "been done." -Resident #6 expressed frustration that the pharmacy continued to bill her for a medication she had not taken for 6 months. Review of record revealed no physician order to discontinue the Oxybutynin. Review of the August 2014 through January 2015 electronic medication administration records (eMARs) revealed Oxybutynin had not been entered on the eMARs. Observation of medications on hand on 1/22/15 at 10:55am revealed: - Oxybutynin 5 mg was available for administration. -The Oxybutynin 5 mg tablets were dispensed in a multidose package together with all the 8:00am and 8:00pm medications with identifying drug information for each medication in the pack. Confidential interview with two medication aide revealed: -The Oxybutynin 5 mg was always available to administer. -The Oxybutynin 5 mg was not entered on the eMAR so they did not administer it. -They always threw the Oxybutynin 5 mg in the "sharps container." -They had been instructed by the SCUC to dispose of the Oxybutynin 5 mg and not to administer it to Resident #6. Interview with the SCUC on 1/22/15 at 3:10pm revealed: -She did not know why the pharmacy did not discontinue the Oxybutynin 5 mg. -It looked like facility staff had entered	D 338		

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D 338	Continued From page 4 "discontinue" on the eMAR in July 2014. Telephone interview with pharmacy staff on 1/21/15 at 3:40pm revealed: -The pharmacy had an active order for Oxybutynin 5 mg. -It looked like the facility documented "discontinue" the Oxybutynin 5 mg on the July 2014 MAR. -The pharmacy never received a discontinue order signed by the physician. -They had dispensed the Oxybutynin 5 mg on a regular basis since July 2014 because the order was written to be refilled for a year. -They did not know why the Oxybutynin 5 mg did not show up on the eMAR after July 2014. -The pharmacy was responsible for entering medications on the electronic MARs. Telephone interview with the billing clerk at the pharmacy provider on 1/23/15 at 9:20am revealed: -The facility should have contacted the pharmacy and sent them a physician signed order to discontinue the Oxybutynin 5 mg. -She would credit Resident #6's account the co-pay for 5 months. Review of record revealed no documentation that facility staff had faxed requests to the pharmacy to discontinue the Oxybutynin 5 mg nor any requests to the physician to discontinue the Oxybutynin 5 mg. Interview with the SCUC on 1/22/15 at 3:10pm revealed Resident #2's current physician was not the same one who ordered the Oxybutynin 5 mg in July 2014. Interview with the Administrator on 1/23/15 at	D 338		

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D 338	Continued From page 5 1:00pm revealed she was not aware the Oxybutynin 5 mg had been dispensed since July 2014, but not administered. _____ The facility provided a Plan of Protection which revealed: -The supervisor/medication aides will immediately report to the the Special Care Unit Coordinator (SCUC) any concerns expressed by the residents. -The SCUC will respond to the resident requests within 24 hours. -The SCUC will contact the pharmacy to assure residents are not charged for discontinued medications. -The supervisor medication aides will notify the SCUC of discontinued medications that are still being delivered by the pharmacy. -The business office manager will follow up with the pharmacy to assure residents are not charged for medications which have been discontinued. _____ CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 3/9/15.	D 338		
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.	D 358		

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D 358	Continued From page 6 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure medications which included Oxycod/Apap, Fentanyl Patches, gabapentin, capsaicin cream, CMPD cream, Brimonidine Solution, beta-carotene, Dulcolax, Seroquel, Haldol, and Senna were administered as ordered for 4 of 6 sampled residents (#2, #3, #4, and #6). The findings are: Interview with the second shift medication aide on 1/23/15 at 10:25am revealed: -Some medications were on automatic refill, but staff had to request refills for some medications. -They use electronic medication administration records (eMARs), but are not able to reorder medications electronically. -They fax orders and refill requests to the pharmacy. -Sometimes they receive a confirmation from faxes, then call the pharmacy and the pharmacy staff state they had not received the orders. Interview with the Special Care Unit Coordinator (SCUC) on 1/22/15 at 3:10pm revealed their current system for medication acquisition and administration as follows: -Facility staff send medication orders by fax to the pharmacy or place written orders in the medication tote bag which is returned to the pharmacy. -The pharmacy enters the medication orders on the eMARs. -Facility medication aides are not allowed to administer any medications to residents after the	D 358		

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D 358	Continued From page 7 pharmacy sends the medications (although the entries are on the eMARs) until she (the SCUC) physically approved them on the eMARs. -The SCUC does not work on the weekends. -No other staff are allowed to "approve" the medications. -The system for only the SCUC to approve medications may cause some medications to be delayed in being administered. -The SCUC only has access to the eMARs (to approve medications) when she is in the facility. -If the pharmacy requires a hard script, they fax it to the pharmacy and also send the order to the pharmacy in the medication tote bag. -If a medication comes into the facility and is not entered on the eMAR, the medication aides are supposed to call the pharmacy to have them enter the medication onto the eMAR. -Narcotic refills are not dispensed by the pharmacy unless they are requested by the facility. A. Review of record revealed Resident #2 had diagnoses on the current FL2, dated 10/30/14, which included: -Stroke/vascular dementia -Hypertension -Acute and chronic respiratory failure -Chronic obstructive pulmonary disease -Congestive heart failure Review of Resident Register revealed Resident #2 was admitted to the facility on 10/30/14. Review of documentation of a physician visit, dated 11/19/14, revealed Resident #2 had diagnoses of cervical spinal stenosis, acute cervical strain, spondylolisthesis, and joint pain (shoulder). (Spondylolisthesis is a condition in which one of the bones of the spine (vertebrae)	D 358		

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D 358	Continued From page 8 slips out of place onto the vertebra below it. If it slips too much, the bone might press on a nerve, causing pain.) - "She guards the right shoulder... Pain with passive range of motion of the right shoulder." Review of documentation of another physician visit for Resident #2, dated 12/3/14, revealed: - Resident #2 was seen on this visit "for concerns about her neck." - She is having some pain between doses of oxycodone 5-325 mg and has been using between "1 and 3 doses of oxycodone per day." - "Neck range of motion generally reduced with palpable moderate to severe muscle tension in base of neck." One physician diagnosis on 11/25/14 noted Resident #2 had "cervical disc disease." Random observations of Resident #2 during the survey January 21-23, 2015 revealed she was sitting in a wheelchair wearing a cervical neck collar. 1. Interview with Resident #2 on 1/21/15 at 9:33am revealed: - She ran out of "Percocet" [a brand name for Oxycodone/Acetaminophen (Oxycod/Apap)] about a "month ago" and also ran out of "Fentanyl Patches." - She needed pain medication because she had "a fractured neck and back." - She stayed in the bed most of the time and tried not to move when she did not have pain medications. Review of resident record revealed physician orders for Oxycod/Apap 5-325 mg, 1 tablet every 4 hours as needed for pain not to exceed 4	D 358		

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D 358	Continued From page 9 tablets in 24 hours, original order dated 10/30/14. Review of November 2014 Controlled Drug Receipt and Records revealed: -Oxycod/Apap 5-325 was not available for administration after 2:40pm on 11/20/14 until 11/26/14 (time not known.) -Staff documented the first administration of Oxycod/Apap 5-325 mg at 3:25am on 11/27/14 after 12 tablets were delivered by the pharmacy on 11/26/14. Review of December 2014 Controlled Drug Receipt and Records revealed: -Oxycod/Apap 5-325 mg was not available for administration after 4:00pm on 12/18/14 until 12/31/14. -Staff documented the first administration of Oxycod/Apap 5-325 mg at 11:10pm on 12/31/14 after 30 doses were delivered on 12/31/14. Review of the December 2014 eMAR revealed facility staff documented the administration of 36 tablets of Oxycod/Apap 5-325 mg with 35 tablets documented as effective. Review of December 2014 and January 2015 eMARs revealed staff had documented the administration of Oxycod/Apap 5-325 mg to Resident #2 one, two, or three times per day when it was available. Interview with Resident #2 on 1/22/15 at 2:00pm revealed: -She remembered asking for the Oxycod/Apap in November and December (2014) and the medication aides told her there was none available. -Resident #2 said she asked the medication aides every day (when it was not available) for the	D 358		

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D 358	Continued From page 10 Oxycod/Apap to relieve her pain. -She usually requested two or three Oxycodone/Apap tablets per day. -In December when there was no Oxycodone/Apap available and after the first two days, she did not move unless she had to because it hurt to move. -She said she did not get up to go to the dining room for some meals because of the pain, "I just couldn't do it." -Some days it hurt to move her eyelids. -The first few days the medication aides kept saying, "Maybe it will be in tonight." -Then after the first few days, a medication aide said, "I ordered it today so you should get it." -She saw the physician the end of December 2014 and he told the facility staff to always contact him if she needed a prescription. -She asked for "Tylenol" when she was out of Oxcod/Apap, but the medication aides told her they did not have an order for it. Telephone interview with Resident #2's physician on 1/22/15 at 4:00pm revealed: -He remembered writing an order for Oxycod/Apap 5-325 mg for Resident #2 the end of December, 2014. -He said during the 12/31/14 visit, he found out Resident #2 had been without pain medications. He said he was "emphatic" in communicating with facility staff they need to contact him if Resident #2 needed a prescription. -He said the lines of communication were "always open." Review of the 12/31/14 physician visit revealed: -Resident #2 reported to the physician she had ran out of both the "Oxycodone and the Fentanyl patch." -Staff reported to the physician that Resident #2	D 358		

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D 358	Continued From page 11 ran out of pain medications because there was an "error with the order transcription." Interview with the SCUC on on 1/22/15 at 3:10pm revealed: -She said the facility could not get a hard script from the physician until 12/31/14. -Her staff did call the pharmacy in attempt to get the Oxycod/Apap 5-325 mg before 12/31/14. -The delay in administering the Oxycod/Apap 5-325 mg after it was delivered to the facility may have been because the medication aides cannot administer medication until she approves it on the eMARs. Interview with the Administrator on 1/23/15 at 12:55pm revealed: -She did not know why the Oxycod/Apap was delayed in being dispensed from the pharmacy. -She knew they had problems in the past getting in touch with the physician. -She knew they had problems with the pharmacy. Review of record revealed no documentation the facility had contacted the physician for Oxycod/Apap 5-325 mg prescription nor documentation they faxed the pharmacy any requests for Oxycod/Apap 5-325 mg from 12/18/14 through 12/30/14. Confidential interview with a medication aide during the survey revealed: -When Resident #2 was out of Oxycod/Apap 5-325mg, the medication aide said she faxed the pharmacy to reorder the Oxycod/Apap 5-325 mg and she told the next shift medication aide. -She was not aware there was any other prn (as needed) medications available for Resident #2. Review of the December 2014 MAR revealed:	D 358		

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D 358	Continued From page 12 -Acetaminophen 500 mg was on the MAR as standing orders with directions to "take 1 tablet orally every 4 hours as needed for fever up to 101, headache and or minor discomfort" not to exceed 2000 mg in 24 hours. -Staff had not documented any administrations of acetaminophen 500 mg to Resident #2. 2. Review of record revealed a physician order, dated 11/25/14, for Fentanyl Patch, apply 1 topically every 72 hours, remove old one (a transdermal duragesic patch used in chronic pain management). Interview with Resident #2 on 1/22/15 at 2:00pm revealed: -She ran out of Fentanyl Patches the end of December 2014 when she was also out of Oxycod/Apap. -In December when there was no Oxycod/Apap available, after the first two days, she did not move unless she had to because it hurt to move. -She said she did not get up to go to the dining room for some meals because of the pain, "I just couldn't do it." -Some days it hurt to move her eyelids. -Resident #2 said when she ran out of Fentanyl Patches, she asked the medication aides every day if her Fentanyl Patches were available. Review of December 2014 electronic Medication Administration Record (eMAR) revealed: -Staff documented the Fentanyl Patch was not available to administer on 12/28/14 and on 12/31/14, (the scheduled days for the Fentanyl Patch to be administered. -The last Fentanyl Patch documented as administered this month was on 12/25/14. Telephone interview pharmacy staff on 1/21/14 at	D 358		

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D 358	Continued From page 13 3:40pm revealed: -The pharmacy had a "valid order" on file for Fentanyl Patches in December 2014 and did not require a new prescription to dispense the patch. -Fentanyl Patches are not sent unless the facility requests them because they are a narcotic. On 11/28/14, nine Fentanyl Patches were dispensed to the facility. -On 12/31/14, 1 Fentanyl Patch was dispensed to the facility. -On 1/2/15, 9 Fentanyl Patches were dispensed to the facility. -They had no documentation the facility requested Fentanyl Patches in December 2014 before 12/31/14. Review of January 2015 eMAR revealed the Fentanyl Patch was first documented as administered on 1/3/15, three days after it was delivered to the facility (9 days after the last patch was administered on 12/25/14). Interview with the SCUC on 1/22/14 at 3:10pm revealed the delay in administering the Fentanyl Patch after it was dispensed from the pharmacy could have been because she delayed in approving it to be administered. Review of record revealed no documentation the facility had contacted the physician nor the pharmacy for a refill on the Fentanyl Patches before 12/31/14. 3. Review of physician orders, dated 11/5/14 revealed an order to alternate topical capsaicin gel (for pain relief), three times per day as tolerated with Voltaren gel (for arthritis pain). Review of the November and December 2014 and January 2015 electronic Medication	D 358		

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D 358	Continued From page 14 Administration Records revealed no entry for capsaicin gel. On 1/23/15 at 10:15am observations of Resident #2's medications on hand revealed: -Capsaicin cream was not available for administration. -Voltaren gel was available for administration. Telephone interview on 1/23/14 at 9:45am with pharmacy staff revealed 1 tube of capsaicin was dispensed on 11/6/14 and the facility had not requested any refills. Interview with the second shift medication aide on 1/22/14 at 3:55pm revealed she did not know anything about the capsaicin cream. Review of record revealed no documentation the capsaicin cream was discontinued, administered, refused, nor discarded. Review of record revealed no documentation the facility had contacted the physician nor the pharmacy for any clarification, order, or refill for the capsaicin cream. Interview with Resident #2 on 1/23/15 at 10:15am remembered the physician told her he had ordered a topical cream that "might burn" but the topical was never administered. 4. Review of Resident #2's record revealed a physician order, dated 11/25/14, for CMPD Flurbiprofen 10%, Ketoprofen 5%, Cyclobenzaprine HCL2%, Baclofen 2%, Lidocaine 5% with instructions to apply to painful area up to 5 times per day as needed. (a topical external pain compound which is prescribed for pain management.)	D 358		

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D 358	Continued From page 15 Review of the December 2014 and January 2105 electronic Medication Administration Record e(MAR) revealed no entry for the CMPD topical cream. On 1/23/15 at 10:15am observation of medications on hand for Resident #2 revealed the CMPD cream was available and labeled for Resident #2 and dispensed on 12/15/14. Interview with the first shift medication aide on 1/23/15 at 10:15 am revealed: -The CMPD had been specially ordered for Resident #2 because she was allergic to some of the ingredients in the original order. -She did not know if any medication aides had administered the cream. -She did not know why the CMPD was not entered on the eMARs. When the CMPD cream was shown to Resident #2 on 1/23/15 at 10:15am she stated she had never seen the medication. Review of record revealed no documentation the facility had contacted the pharmacy to enter the CMPD on the MAR. 5. Review of the current FL2, dated 10/16/14, revealed an order for gabapentin 300 mg three times per day (A medication to treat pain and neuropathy). Interview with Resident #2 on 1/22/15 at 2:00pm revealed: -She remembered being out of gabapentin in November 2014. -When she did not take gabapentin, her fingers felt like "sandpaper."	D 358		

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D 358	Continued From page 16 Review of the November 2014 electronic Medication Administration Record (eMAR) revealed gabapentin was documented as "not available notified pharmacy" for the following times: -4:00pm on 11/1/14 -12:00pm on 11/2/14 -8:00am, 12:00pm and 4:00pm on 11/3/14 -8:00am and 12:00pm on 11/4/14 -12:00pm on 11/6/14. On 1/21/14 at 3:30pm observations of medications on hand for Resident #2 revealed gabapentin 300 mg available for administration. Telephone interview with pharmacy staff on 1/22/15 at 3:40pm revealed: -The facility sent an FL2 with medication orders on it on 10/30/14, but instructed the pharmacy to delay dispensing the gabapentin. -The pharmacy dispensed the gabapentin on 11/3/14. (It was documented on the November 2014 eMAR after it was delivered as not available from 11/4/14 through 12:00pm on 11/6/14.) Interview with the SCUC on 1/22/14 at 3:10pm revealed the delay in administering the gabapentin after it was dispensed from the pharmacy could have been because she delayed in approving it to be administered. B. Review of Resident #6's current FL2, dated 3/6/14, revealed diagnoses which included: -Diabetes mellitus -Anxiety disorder 1. Review of Resident #6's Optometrist visit on 9/15/14 revealed a diagnosis of glaucoma and an order to "continue" Brimonidine 0.2%, 1 drop	D 358		

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D 358	Continued From page 17 twice per day in right eye. [Ophthalmic Brimonidine is used to lower pressure in the eyes in patients who have glaucoma (high pressure in the eyes that may damage nerves and cause vision loss) and ocular hypertension (pressure in the eyes that is higher than normal but not high enough to cause vision loss)]. Interview with Resident #6 on 1/21/15 at 10:05am revealed: -She ran out of eye drops the end of December and the first of January this year. -A medication aide told her they could not find the eye drops in the medication cart. Telephone interview with pharmacy staff on 1/23/15 at 1:20am revealed: -Brimonidine Solution (Sol) was refilled only upon request from the facility. -The pharmacy dispensed a 5 ml bottle of Brimonidine Sol on 11/21/14. -The pharmacy dispensed a 5 ml bottle of Brimonidine Sol on 1/3/15. -One bottle should last "about 30 days." -The pharmacy had no documentation the Brimonidine Sol was requested by the facility in December 2014. Review of the December 2014 and January 2015 electronic Medication Administration Records (eMARs) revealed the Brimonidine Sol was not available from 12/24/14 through 1/5/15. (Although the medication was delivered on 1/3/15, it was documented as "not available" at the 8:00am administration on 1/4/15 through 1/6/15. Interview with the SCUC on 1/22/15 at 3:55pm revealed: -After the pharmacy dispenses medications and enters in them on the eMAR, the medication aides are not allowed to administer the	D 358		

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D 358	Continued From page 18 medication until she approves them on the eMAR. -If the Brimonidine Sol came in on 1/3/15 and was not administered until 1/6/15, it could have been because she had delayed in approving the medication. 2. Review of Resident #2's current FL2 revealed an order for Beta-carotene 25,000 unit capsule, 1 capsule daily. (Beta-Carotene is a nutritional supplement which is converted to vitamin A, an essential nutrient.) On 1/22/14 at 4:00pm, observation of the medications on hand revealed a bottle of over the counter Biotin (a coenzyme and a B complex vitamin also known as vitamin H.) Interview with the second shift medication aide on 1/22/15 at 4:00pm revealed: -Biotin was the "same thing as Beta Carotene." -Staff had picked it up at the local pharmacy. -She administered one of the Biotin tablets to Resident #6 on the morning of 1/22/15. Review of Beta Carotene entry on the January 2015 Medication Administration Record revealed "med not available notified pharmacy" on the following dates: 1/16/14 1/17/14 1/18/14 1/20/14 1/21/14 Review of Beta Carotene entry on the January 2015 electronic Medication Administration Record revealed it was documented as administered on 1/22/14.	D 358		

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D 358	Continued From page 19 C. Review of current FL2 for Resident #4 dated 1/6/15, revealed: -Diagnoses which included dementia-Alzheimer. -An order for Dulcolax suppository 10 mg as needed. Review of Resident Register revealed Resident #4 was admitted to the facility on 1/12/15. Observation of medications on hand for Resident #4 on 1/21/15 at 4:15pm revealed no Dulcolax suppositories available for administration. Per observation and record review, Resident #4 was not interviewable. Telephone interview with staff at the pharmacy on 1/21/15 at 2:45pm revealed they did not know why the Dulcolax suppositories were not dispensed when the other medication was dispensed. Review of personal care records including bowel movements for Resident #1 revealed only 1 bowel movement was documented on 1/22/15 since admission. Interview with the Administrator on 1/23/15 at 1:00pm revealed she did not know why the Dulcolax was delayed in being dispensed nor how the medication aides would administer laxatives as needed if the bowel movement documentation was not accurate. Telephone call to Resident #4's guardian was not successful. D. Review of Resident #3's current FL2 dated 10/30/14 revealed: - Diagnoses included Alzheimer's disease.	D 358		

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D 358	Continued From page 20 - Physician's orders for Seroquel 50mg at bedtime (used to treat bipolar disorder and major depression). Per observation and record review, Resident #3 was not interviewable. 1. Record review on 1/22/15 revealed: - A physician's order dated 12/3/14 to increase Seroquel to 25mg every morning and 50mg at bedtime. Review of Medication Administration Records (MAR's) for December 2014 on 1/22/15 revealed: - Documentation of administration of Seroquel 50mg at bedtime for 12/1/14-12/31/14. - No transcribed entry for Seroquel 25mg every morning. Interview with a 1st shift Medication Aide (MA) on 1/22/15 at 1:30pm revealed she had "no clue" about the 12/3/14 physician's order to increase Seroquel to 25 mg every morning. Interview with the SCUC on 1/22/15 at 1:51pm revealed: - The physician's order dated 12/3/14 to increase Seroquel to 25mg every morning had been "found" by the pharmacy consultant during medication reviews on 1/6/15 and faxed to the pharmacy the same day. - Medication were ordered by the physician through the electronic medication administration record (eMAR) system. - When the physician completed their orders, the orders were printed from the eMar system by her or the MA's and faxed to the pharmacy for processing. - The 12/3/14 order to increase Seroquel "might not have been processed."	D 358		

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D 358	Continued From page 21 Review of MAR's for January 2015 on 1/22/15 revealed: - Entry and documentation of administration of Seroquel 50mg at bedtime for 1/1/15-1/12/15. - Entry and documentation of administration of Seroquel 50mg two tablets (100mg) at bedtime for 1/13/15 and 1/15/15. - Entry and documentation of administration of Seroquel 50mg every morning for 1/13/15, 1/15/15 and 1/16/15. - Entry for Seroquel 25mg every morning with no documentation of administration and stop date of 1/7/15. Interview with a pharmacy representative on 1/22/15 at 1:45pm revealed: - The physician increased the Seroquel order on 1/7/15 to Seroquel 50mg every morning and 50mg two tablets (100mg) at bedtime. - All Seroquel orders were discontinued 1/16/15. Review of January 2015 eMAR revealed staff failed to administer Seroquel 50mg in the morning and 100mg in the evening from January 7, 2015 through January 12, 2015. Interview with Resident #3's consulting physician on 1/22/15 at 3:59pm revealed: - He was driving and did not have Resident #3's record available for immediate review. - Seroquel was most commonly ordered for agitation. - The facility would have contacted him if Resident #3 had experienced any increased agitation. 2. Record Review on 1/22/15 revealed a physician's order dated 1/14/15 for Senna-S 8.6mg daily (used to treat constipation).	D 358		

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D 358	Continued From page 22 Review of MAR's for January 2015 on 1/22/15 revealed documentation Resident #3 had received Senna 8.6mg from 1/20/15 through the current date of 1/21/15. Interview with a pharmacy representative on 1/22/15 at 1:45pm revealed: - An order for Senna 8.6mg dated 1/14/15 had been received from the facility on 1/16/15 and processed by the pharmacy the same day. - Senna 8.6mg would have been available in the facility for administration at 8:00am on 1/17/15. Review of the pharmacy delivery manifest for 1/12/15-1/22/15 revealed Senna 8.6mg had been received in the facility on 1/17/15 at 12:27am. 3. Record review on 1/22/15 revealed a physician's order dated 1/16/15 for Haldol 1mg in the morning and Haldol 5mg at bedtime (used to treat agitation). Review of MAR's for January 2015 revealed: - Documentation that Haldol 1 mg had initially been administered for 8:00am on 1/20/15 and 1/21/15. - Documentation that Haldol 5 mg had initially been administered for 8:00pm on 1/19/15 and 1/20/15. Interview with a pharmacy representative on 1/22/15 at 1:45pm revealed: - The pharmacy had received a physician's order dated 1/16/15 for Haldol 1mg every morning and 5mg every night at bedtime on 1/16/15 and had processed it the same day. - Haldol 1mg tablets would have been available in the facility for administration at 8:00 on 1/17/15. - 5 Haldol 1mg tablets were to be used for the	D 358		

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D 358	Continued From page 23 evening dose. Review of the pharmacy delivery manifest for 1/12/15-1/22/15 revealed Haldol 1mg tablets had been received in the facility on 1/17/15 at 12:27am. Interview with the Administrator on 1/23/15 at 12:55pm revealed she would review the facility's medication system to assure medications were administered timely and as ordered. _____ The Plan of Correction provided by the facility revealed: -The Special Care Unit Coordinator (SCUC) will review all medication administration records and orders to assure all medications are in the facility and and being administered as ordered. -The SCUC will follow upon medications not received with the medication delivery. -When an order is faxed to the pharmacy, the SCUC will maintain confirmation transmittals and will call the pharmacy to inquire about the medications. -The SCUC will monitor twice a week to assure that medications are ordered and administered as prescribed. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 2/23/15.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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	D912		

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D912	Continued From page 24 regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance 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 medications which included Oxycod/Apap, Fentanyl Patches, gabapentin, capsaicin cream, CMPD cream, Brimonidine Solution, beta-carotene, Dulcolax, Seroquel, Haldol, and Senna were administered as ordered for 4 of 6 sampled residents (#2, #3, #4, and #6). Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]	D912		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents received a reasonable response to a request related to the facility contacting the physician for a medication discontinue order. The findings are:	D917		

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D917	Continued From page 25 Based on observation, interview, and record review, the facility failed to assure 1 of 6 sampled residents (#6) received a reasonable response to the request for a prescribed medication (Oxybutynin) to be discontinued by the prescribing physician. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type B Violation).]	D917		