Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045114	A. BUILDING: _____ B. WING _____	07/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS ASSISTED LIVING # 2	1310 HEBRON STREET HENDERSONVILLE, NC 28739

(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 and the Henderson County Department of Social Services conducted an annual survey on July 17, 2015 with an exit conference on July 20, 2015.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the floors, walls, and ceilings in the facility were clean and in good repair. The findings are: A. Observation of resident room #6 on 7/17/15 at 8:15am revealed: -There was cream colored berber style carpet covering the floor of the resident's room. -There was a 2 ft. wide by 6 ft. long gray colored, worn area in the carpet at the entrance door to the room. -There were two stains on the floor beside the resident's bed: a 3 in. wide by 6 in. long stain and a 2 in. wide by 3 in. stain and both were brown in color. -There was a 3 ft wide by 6 ft long area of carpet that was gray in color at the entrance to the residents bathroom. Observation of resident room #5 on 7/17/15 at	C 074	A cleaning schedule has been put into place to insure the facility remains in compliance with the rule. a cleaning task sheet will be placed on back of resident closet door and signed upon completion of task by supervisor. The administrator will monitor weekly and sign the task sheet to reflect monitoring.	To Sept 30, 2015

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 6899 SDHQ11 If continuation sheet 1 of 23

Approved by Charity Steele BSN RN 8/19/15

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C 074	Continued From page 1 8:20am revealed the blue colored carpet outside Resident Room #5 was soiled to a grayish color and heavily worn. Observation of the common hallway from the kitchen leading to resident rooms #2, #3, #5, and #6 and the staff quarters on 7/17/15 at 8:21am revealed the blue colored carpet was heavily worn and soiled to a grayish black color. Observation on 7/17/15 at 8:24am of the carpet in the hallway in where the laundry closet was located revealed the blue colored carpet was heavily worn and soiled to a grayish black color. Observation on 7/17/15 at 8:25am revealed the blue carpet outside resident room #1 in the hallway was heavily worn and soiled to a grayish black color. Observation on 7/17/15 at 8:33am revealed the blue carpet in the facility living room had multiple stains and was heavily worn. Confidential interviews with three residents revealed: -The carpet "does not bother me. I don't pay attention." -"[The carpet] doesn't bother me. I haven't noticed." -One resident hated the carpet and the staff had promised to replace the carpet with hard flooring. Interview with the Administrator on 7/17/15 at 2:20pm and a telephone interview on 7/20/15 at 1:50pm revealed: -It had been a "couple" months, since the carpets had been shampooed throughout the facility. -She had already replaced carpet with hard flooring in several of the residents rooms.	C 074		

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C 074	Continued From page 2 -She would be shampooing the carpets again "tomorrow." -Her plan was to "spot" check all the carpets every 2 weeks for stains. -It was her intention to "deep clean" the carpets throughout the facility every month. B. Observation of resident room #6 on 7/17/15 at 8:15am revealed: -There was a 2 ft. high area of paint which was scuffed on the left door frame as you entered the resident's room. Observation of resident room #5 on 7/17/15 at 8:20am revealed: -There was a 1 ft high area of paint which was scuffed on the left door frame as you entered the resident's room. -There was a 4 in. long black scuff mark on the lower right hand side of the resident's door. Observation of the wall across from resident room #3 on 7/17/15 at 8:22am revealed a 1 ft high by 2 in. wide area of missing paint. Observation of resident room #2 on 7/17/15 at 8:23am revealed a 2 ft. high by 1 in. wide area of scuffed paint on the left and right door frame leading into the resident's room. Observation of the corner closet wall in the hallway off the kitchen on 7/17/15 at 8:24am revealed an area 1 in. wide by 2 ft. high area of chipped paint and sheetrock. Confidential interview with one resident when asked if any condition in the home like scuffed paint mattered to the resident and the resident stated "No."	C 074	The administrator will spot check rooms & common areas to check for cleanliness and needed repairs. monthly. The carpet will be cleaned monthly or sooner if needed. A calender will be signed to record task being completed	~~8/30/15~~ ~~9/4/15~~ Sept 3rd 2015 ~~8/30/15~~ ~~9/4/15~~ Sept 3, 2015

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C 074	Continued From page 3 Interview with the Administrator on 7/20/15 at 3:25pm revealed: -She has planned to repaint the walls and door frames. -Her plan was to install a piece of thick plastic on the walls half way up and install plastic protectors on the corner walls to protect the walls from wheelchair damage once she gets the walls freshly painted. C. Observation of the common bathroom adjacent to resident room #1 on 7/17/15 at 8:25am revealed there was 2 ft. long by 1 ft. wide area of damaged ceiling over the shower which appeared to be water damage. Observation in the resident room across from the washer and dryer closet on 7/17/15 at 3:59pm revealed: -There was a 1 ft. wide by 1 ft. long area of damaged ceiling paint on the outside wall of the resident's room. -There was a 2 ft. wide by 2 ft. long area of peeling, damaged ceiling paint in the left back side of the resident's closet which appeared to be water damage. Interview with the resident residing in the room across from the washer/dryer closet on 7/17/15 at 3:35pm revealed: -The area of water damage in the closet had been there for 6 to 7 months. -The area of water damage in the ceiling on the outside wall had been there about 1 year. -The resident stated staff had been made aware of the areas of water damage in the room. Interview with the Administrator on 7/17/15 at 4:00pm revealed: -She was unaware of the ceiling damage in the	C 074	The repair painting will be completed by 8/30/15 The ceiling, walls & floors will be monitored monthly for needed touch up and repair. A Calender will reflect findings and repairs needed w/ completion date Sign by administrator.	9/30/15 9/30/15

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C 074	Continued From page 4 resident room across from the washer/dryer closet. -"I just had an area [of ceiling repaired] over the dining room table fixed and the roof repaired." -The resident who resided in the room across from the washer/dryer closet "was here when [the ceiling and roof were repaired in the dining room] and didn't say anything about [the ceiling in their room] having an issue."	C 074		
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 Novolog insulin, lisinopril, Toprol XL, and Lasix were administered as ordered for 2 of 3 sampled residents (Resident #1 and #3). The findings are: A. Review of Resident #1's current FL2 dated 12/11/14 revealed: -Diagnoses included: Insulin Dependent Diabetes Mellitus, Chronic Pain Syndrome, and hypothyroidism.	C 330	C330 - It will be the administrative responsibility to collect all Dr orders and follow through until order is accurate and placed on Quick Mar. A tracking sheet has been implemented and placed on the Physician order sheet that is sent to all appointment. (See Attached) Sept 3rd, '15	

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C 330	Continued From page 5 -An order for Lantus insulin (used to control blood sugar over 24 hours) 28 units at bedtime. -An order for Novolin R insulin (fast acting insulin used to control blood sugar) 9 units with breakfast and lunch. -An order for Novolin R insulin 5 units with dinner. 1. Review of an Endocrinologist's order for Resident #1 dated 3/23/15 revealed: -Blood glucose (BG) testing 4 times daily before every meal and at bedtime. -An order for Lantus (used to control blood sugar over 24 hours) insulin 28 units at bedtime. -An order for Novolog insulin (fast acting insulin used to control blood sugar) 12 units with breakfast. a. Continued review of a physician's order for Resident #1 dated 3/23/15 revealed: -An order for Novolog insulin per sliding scale pre: breakfast, lunch, and supper: 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=5 units, 351-400=7 units. Review of Resident #1's March 2015 Electronic Medication Administration Record (EMAR) revealed: -An entry for "Regular insulin" per sliding scale pre: breakfast 7:30am, lunch 11:30am, and supper 4:30pm: 151-200=2 unit, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. -There were 14 occurrences out of 14 opportunities where Regular insulin was documented as administered instead of Novolog insulin (from 3/23/15 to 3/29/15) and Regular insulin was administered in incorrect amounts. -For example, on 3/24/15 at 4:30pm BG 325; received 8 units and should have received 5 units.	C 330	C330 If a order is received via fax the tracking sheet will be placed on order and the administrator will follow thrugh with all steps. If clarification is need the administrator will complete and document on medication track form	Sept 3, 15

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C 330	Continued From page 6 -On 3/25/15 at 11:30am BG 253; received 6 units and should have received 3 units. -On 3/28/15 at 4:30pm BG 300; received 6 units and should have received 3 units. Review of Resident #1's April 2015 EMAR revealed: -An entry for Novolog insulin per sliding scale pre: breakfast 7:30am, lunch 11:30am, and supper 4:30pm: 151-200=2 unit, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. -There were 59 occurrences out of 64 opportunities where sliding scale Novolog insulin was documented as administered in incorrect amounts. -For example, on 4/5/15 at 4:30pm BG 350; received 8 units and should have received 5 units. -On 4/11/15 at 7:30am BG 290; received 6 units and should have received 3 units. -On 4/22/15 at 11:30am BG 274; received 6 units and should have received 3 units. Review of Resident #1's May 2015 EMAR revealed: -An entry for Novolog insulin per sliding scale pre: breakfast 7:30am, lunch 11:30am, and supper 4:30pm: 151-200=2 unit, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. -There were 68 occurrences out of 68 opportunities where sliding scale Novolog insulin was documented as administered in incorrect amounts. -For example, on 5/4/15 at 7:30am BG 268; received 6 units and should have received 3 units. -On 5/11/15 at 4:30pm BG 214; received 4 units and should have received 2 units.	C 330	C330 The administrator will monitor insulin and print CBG MAR and check for accuracy. Weekly for 1 month Bi-weekly for 1 month then monthly. The pharmacy review will be printed out and emailed to Administrator ← me any clarifications needed.	Sept 3rd 11 9/15/11

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C 330	Continued From page 7 -On 5/20/15 at 11:30am BG 386; received 9 units and should have received 7 units. Review of Resident #1's June 2015 EMAR revealed: -An entry for Novolog insulin per sliding scale pre: breakfast 7:30am, lunch 11:30am, and supper 4:30pm: 151-200=2 unit, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. -There were 60 occurrences out of 60 opportunities where sliding scale Novolog insulin was documented as administered in incorrect amounts. -For example, on 6/2/15 at 7:30am BG 298; received 9 units and should have received 3 units. -On 6/10/15 at 11:30am BG 217; received 4 units and should have received 2 units. -On 6/21/15 at 4:30pm BG 156; received 2 units and should have received 1 unit. Review of Resident #1's July 2015 EMAR revealed: -An entry for Novolog insulin per sliding scale pre: breakfast 7:30am, lunch 11:30am, and supper 4:30pm: 151-200=2 unit, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. -There were 23 occurrences out of 23 opportunities (from 7/1/15 through 7/16/15) where sliding scale Novolog insulin was documented as administered in incorrect amounts. -For example, on 7/4/15 11:30am BG 346; received 8 units and should have received 5 units. -On 7/9/15 at 4:30pm BG 330; received 8 units and should have received 5 units. -On 7/14/15 at 11:30am BG 345; received 8 units and should have received 5 units.	C 330		

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C 330	Continued From page 9 -"But sometimes they don't enter the orders correctly." -Often the medication aides would have to go into the EMAR system and "fix" entries. -She always checked the same day the orders were faxed to the pharmacy to ensure the orders were entered correctly by the pharmacy. -If there was a problem with an order, she had rights to go into the EMAR system and correct the entry. -All medication orders were checked monthly by one of the supervisors. -She did not know how the sliding scale order changes "...got missed." Telephone interview with the facility pharmacy on 7/20/15 at 11:25am revealed: -On 3/23/15, the pharmacy received a faxed order from Resident #1's physician's office. -The order faxed to the pharmacy only outlined the required doses of scheduled Novolog insulin at breakfast , lunch, and supper. -The pharmacy had never received a copy of the sliding scale insulin order dated 3/23/15. Interview with the Administrator on 7/20/15 at 3:25pm revealed: -Resident #1 had seen the Endocrinologist today. -The resident's A1C (blood test used to determine the resident's average blood sugar levels over the past 3 months) had come down, so the physician had continued the sliding scale insulin orders the facility had been administering. Review of a physician's order for Resident #1 dated 7/20/15 revealed: -"We have been giving the wrong sliding scale since last order change." -Physician responded "Not a problem-in fact, I am going to continue the 2-4-6-8-10 sliding scale you	C 330		

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C 330	Continued From page 8 Interview with the Administrator on 7/17/15 at 2:20pm revealed: -She had contacted the facility pharmacy and the pharmacy still had the sliding scale insulin order from Resident #1's 8/4/14 FL2. -The pharmacy had not received a copy of the physician order dated 3/23/15 or "when we clarified [insulin] orders with the physician on 6/16/15." -On the order sheet received from the physician from the 3/23/15 visit, there was documentation that the physician's office had faxed over the new sliding scale insulin order to the pharmacy. -The pharmacy had received the scheduled insulin orders for premeal breakfast, lunch, and supper order, however had not received the Novolog sliding scale insulin order. -She would immediately contact Resident #1's physician to determine the correct current order for the sliding scale insulin and make sure the pharmacy had a copy and the changes were made to the resident's EMAR. -Resident #1 had a routine appointment scheduled with her Endocrinologist on 7/20/15, so any medication issues could be addressed during the appointment. Telephone interview with a Supervisor at the facility on 7/20/15 at 11:00am revealed: -She routinely administered medications to the residents. -She stated she had been using the sliding scale insulin scale from the physician's order dated 8/4/14 to medicate Resident #1. -When a resident returned from the hospital or a physician's office, staff were expected to fax all new orders to the facility pharmacy. -The pharmacy was supposed to enter all the new orders into the EMAR system.	C 330		

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C 330	Continued From page 10 are using." Attempted telephone interview on 7/20/15 at 11:55am with Resident #1's Endocrinologist had not been returned by exit. b. Review of a physician's order for Resident #1 dated 3/23/15 revealed: -An order for Novolog insulin per sliding scale bedtime: 151-200=none, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=5 units. Review of Resident #1's March 2015 EMAR revealed: -An entry for Regular insulin per sliding scale bedtime: 151-200=none, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, greater than 400 call MD. -There were 6 occurrences out of 7 opportunities where Regular insulin was documented as administered instead of Novolog and it was administered in incorrect amounts. -For example, on 3/23/15 at 8pm BG 300; received 4 units and should have received 2 units. -On 3/25/15 at 8pm BG 303; received 6 units and should have received 3 units. -On 3/26/15 at 8pm BG 249; received 2 units and should have received 1 unit. Review of Resident #1's April 2015 EMAR revealed: -An entry for Novolog bedtime sliding scale: No scale was documented on the printed EMAR. -There were 10 occurrences out of 10 opportunities where sliding scale Novolog insulin was documented as administered in incorrect amounts. -For example, on 4/2/15 at 8pm BG 290; received	C 330		

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C 330	Continued From page 11 4 units and should have received 2 units. -On 4/16/15 at 8pm BG 295; received 4 units and should have received 2 units. -On 4/25/15 at 8pm BG 204; received 2 units and should have received 1 unit. Review of Resident #1's May 2015 EMAR revealed: -An entry for Novolog bedtime sliding scale: No scale was documented on the printed EMAR. -There were 13 occurrences out of 13 opportunities where sliding scale Novolog insulin was documented as administered in incorrect amounts. -For example, on 5/4/15 at 8pm BG 215; received 2 units and should have received 1 unit. -On 5/12/15 at 8pm BG 288; received 4 units and should have received 2 units. -On 5/19/15 at 8pm BG 275; received 4 units and should have received 2 units. Review of Resident #1's June 2015 EMAR revealed: -An entry for Novolog bedtime sliding scale: No scale was documented on the printed EMAR. -There were 16 occurrences out of 16 opportunities where sliding scale Novolog insulin was documented as administered in incorrect amounts. -For example, on 6/7/15 8pm BG 238; received 2 units and should have received 1 unit. -On 6/13/15 at 8pm BG 339; received 6 units and should have received 3 units. -On 6/24/15 at 8pm BG 380; received 8 units and should have received 5 units. Review of Resident #1' a June 2015 EMAR revealed: -An entry for Novolog bedtime sliding scale: No scale was documented on the printed EMAR.	C 330		

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C 330	Continued From page 12 -There were 8 occurrences out of 8 opportunities (from 7/1/15 through 7/15/15) where sliding scale Novolog insulin was administered in incorrect amounts. -For example, on 7/3/15 at 8pm BG 333; received 6 units and should have received 3 units. -On 7/12/15 at 8pm BG 217; received 2 units and should have received 1 unit. -On 7/15/15 at 8pm BG 289; received 4 units and should have received 2 units. Interview with the Administrator on 7/17/15 at 2:20pm revealed: -She had contacted the facility pharmacy and the pharmacy still had the sliding scale insulin order from Resident #1's 8/4/14 FL2. -The pharmacy had not received a copy of the physician order dated 3/23/15 or "when we clarified [insulin] orders with the physician on 6/16/15." -On the order sheet received from the physician from the 3/23/15 visit, there was documentation that the physician's office had faxed over the new sliding scale insulin order to the pharmacy. -The pharmacy had received the scheduled insulin orders for premeal breakfast, lunch, and supper order, however had not received the Novolog sliding scale insulin order. -She would immediately contact Resident #1's physician to determine the correct current order for the sliding scale insulin and make sure the pharmacy had a copy and the changes were made to the resident's EMAR. -Resident #1 had a routine appointment scheduled with her Endocrinologist on 7/20/15, so any medication issues could be addressed during the appointment. Telephone interview with a Supervisor at the facility on 7/20/15 at 11:00am revealed:	C 330		

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	FCL045114	A. BUILDING: _____ B. WING _____	07/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 330	Continued From page 13 -She routinely administered medications to the residents. -She stated she had been using the sliding scale insulin scale from the physician's order dated 8/4/14 to medicate Resident #1. -When a resident returned from the hospital or a physician's office, staff were expected to fax all new orders to the facility pharmacy. -The pharmacy was supposed to enter all the new orders into the EMAR system. -"But sometimes they don't enter the orders correctly." -Often the medication aides would have to go into the EMAR system and "fix" entries. -She always checked the same day the orders were faxed to the pharmacy to ensure the orders were entered correctly by the pharmacy. -If there was a problem with an order, she had rights to go into the EMAR system and correct the entry. -All medication orders were checked monthly by one of the supervisors. -She did not know how the sliding scale order changes "...got missed." Telephone interview with the facility pharmacy on 7/20/15 at 11:25am revealed: -On 3/23/15, the pharmacy received a faxed order from Resident #1's physician's office. -The order faxed to the pharmacy only outlined the required doses of scheduled Novolog insulin at breakfast , lunch, and supper. -The pharmacy had never received a copy of the sliding scale insulin order dated 3/23/15. Interview with the Administrator on 7/20/15 at 3:25pm revealed: -Resident #1 had seen the Endocrinologist today. -The resident's A1C (blood test used to determine the resident's average blood sugar levels over the	C 330		

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C 330	Continued From page 14 past 3 months) had come down, so the physician had continued the sliding scale insulin orders the facility had been administering. Review of a physician's order for Resident #1 dated 7/20/15 revealed: -"We have been giving the wrong sliding scale since last order change." -Physician responded "Not a problem-in fact, I am going to continue the 2-4-6-8-10 sliding scale you are using." Attempted telephone interview on 7/20/15 at 11:55am with Resident #1's Endocrinologist had not been returned by exit. c. Review of a physician's order for Resident #1 dated 3/23/15 revealed: -An order for Novolog insulin 9 units with lunch. -An order for Novolog insulin 14 units with supper. -An order for BG less than 50: treat low BG, delay injection until immediately after meal. -An order for BG 51-70: Immediately eat. Take injection just before eating. Reduce insulin by 2 units. -An order for BG 71-150: Take prescribed dose of insulin. Review of Resident #1's April 2015 Electronic Medication Administration Record (EMAR) revealed: -At 11:30am, there were 12 occurrences out of 27 opportunities the wrong dose of insulin was documented as administered (4/1/15 BG 189 14 units received, 9 units required; 4/14/15 BG 121 0 units received, 9 units required; 4/27/15 BG 206 4 units received, 9 units required.) -At 4:30pm, there were 6 occurrences out of 27 opportunities the wrong dose of insulin was	C 330		

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C 330	Continued From page 15 documented as administered (4/9/15 BG 269 3 units received, 14 units required; 4/18/15 BG 243 4 units received, 14 units required; 4/27/15 BG 187 2 units received, 14 units required.) Review of Resident #1's May 2015 EMAR revealed: -At 11:30am, there were 10 occurrences out of 20 opportunities the wrong dose of insulin was documented as administered (5/3/15 BG 159 2 units received, 9 units required; 5/11/15 BG 142 0 units received, 9 units required; 5/19/15 BG 216 4 units received, 9 units required.) -At 4:30pm, there were 11 occurrences out of 21 opportunities the wrong dose of insulin was documented as administered (5/1/15 BG 241 4 units received, 14 units required; 5/11/15 BG 214 4 units received, 14 units required; 5/20/15 BG 97 0 units received, 14 units required.) Interview with the Administrator on 7/20/15 at 3:25pm revealed: -Resident #1 had seen the Endocrinologist today. -The resident's A1C (blood test used to determine the resident's average blood sugar levels over the past 3 months) had come down. -There had been no changes made to the resident's scheduled insulin orders. Attempted telephone interview on 7/20/15 at 11:55am with Resident #1's Endocrinologist had not been returned by exit. B. Review of Resident #3's current FL2 dated 4/28/15 revealed: -Diagnoses included: Type II Diabetes, Coronary Artery Disease, and Cardiac Arrhythmia. -Blood pressure checks monthly -Lisinopril (used to control blood pressure) 2.5mg daily	C 330		

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C 330	Continued From page 16 -Toprol XL (used to control blood pressure and heart rate) 25mg daily -Lasix (used to reduce excessive fluid accumulation) 20mg 3 tabs daily 1. Review of a physician's order for Resident #3 dated 6/18/15 revealed hold lisinopril for systolic blood pressure 110 or below. Review of Resident #3's June 2015 Electronic Medication Administration Records (EMAR) revealed: -A blood pressure was documented on 6/15/15 of 148/78 (Normal blood pressure is considered 120/80 according to the National Institute of Health.) -Daily blood pressures were not documented. -Lisinopril was documented as administered daily for 30 occurrences out of 30 opportunities. Review of Resident #3's July 2015 EMAR revealed: -A blood pressure was documented on 7/15/15 of 146/86. -Daily blood pressures were not documented. -Lisinopril was documented as administered daily for 17 occurrences out of 17 opportunities. Observation of Resident #3's lisinopril on the medication cart on 7/17/15 at 1:35pm revealed there was no parameter for a blood pressure check on the label for the medication. Review of a physician's order for Resident #3 dated 7/20/15 revealed: -Patient is currently doing well in terms of blood pressure control. -If systolic blood pressure is less than 110 hold all blood pressure medications and alert the primary care provider.	C 330		

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C 330	Continued From page 17 -If diastolic blood pressure is less than 55 hold all blood pressure medications and alert the primary care provider. -Due to current stable blood pressure, patient does not need daily blood pressure checks. -Blood pressure can be reviewed once a month. Refer to interview with the Administrator on 7/17/15 at 1:50pm. Refer to interview with Resident #3 on 7/17/15 at 2:05pm. Refer to telephone interview with the Supervisor on 7/20/15 at 11:00am. Refer to telephone interview with Resident #3's physician on 7/20/15 at 11:20am. 2. Review of a physician's order for Resident #3 dated 6/18/15 revealed hold Toprol XL for systolic blood pressure 110 or below or heart rate less than 55. Review of Resident #3's June 2015 EMAR revealed: -A blood pressure was documented on 6/15/15 of 148/78. -Daily blood pressures were not documented. -Daily heart rates were documented with a range of 68-86. -Toprol XL was documented as administered daily for 30 occurrences out of 30 opportunities. Review of Resident #3's July 2015 EMAR revealed: -A blood pressure was documented on 7/15/15 of 146/86. -Daily blood pressures were not documented. -Daily heart rates were documented with a range	C 330		

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C 330	Continued From page 18 of 68-80. -Toprol XL was documented as administered daily for 17 occurrences out of 17 opportunities. Observation of Resident #3's Toprol XL on the medication cart on 7/17/15 at 1:35pm revealed there was no parameter for a blood pressure check on the label for the medication. Review of a physician's order for Resident #3 dated 7/20/15 revealed: -Patient is currently doing well in terms of blood pressure control. -If systolic blood pressure is less than 110 hold all blood pressure medications and alert the primary care provider. -If diastolic blood pressure is less than 55 hold all blood pressure medications and alert the primary care provider. -Due to current stable blood pressure, patient does not need daily blood pressure checks. -Blood pressure can be reviewed once a month. Refer to interview with the Administrator on 7/17/15 at 1:50pm. Refer to interview with Resident #3 on 7/17/15 at 2:05pm. Refer to telephone interview with the Supervisor on 7/20/15 at 11:00am. Refer to telephone interview with Resident #3's physician on 7/20/15 at 11:20am. 3. Review of a physician's order for Resident #3 dated 6/18/15 revealed hold Lasix for systolic blood pressure less than 110. Review of Resident #3's June 2015 EMAR	C 330		

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C 330	Continued From page 19 revealed: -A blood pressure was documented on 6/15/15 of 148/78. -Daily blood pressures were not documented. -Lasix was documented as administered daily for 30 occurrences out of 30 opportunities. Review of Resident #3's July 2015 EMAR revealed: -A blood pressure was documented on 7/15/15 of 146/86. -Daily blood pressures were not documented. -Lasix was documented as administered daily for 17 occurrences out of 17 opportunities. Observation of Resident #3's Lasix on the medication cart on 7/17/15 at 1:35pm revealed there was no parameter for a blood pressure check on the label for the medication. Review of a physician's order for Resident #3 dated 7/20/15 revealed: -Patient is currently doing well in terms of blood pressure control. -If systolic blood pressure is less than 110 hold all blood pressure medications and alert the primary care provider. -If diastolic blood pressure is less than 55 hold all blood pressure medications and alert the primary care provider. -Due to current stable blood pressure, patient does not need daily blood pressure checks. -Blood pressure can be reviewed once a month. Refer to interview with the Administrator on 7/17/15 at 1:50pm. Refer to interview with Resident #3 on 7/17/15 at 2:05pm.	C 330		

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C 330	Continued From page 20 Refer to telephone interview with the Supervisor on 7/20/15 at 11:00am. Refer to telephone interview with Resident #3's physician on 7/20/15 at 11:20am. Interview with the Administrator on 7/17/15 at 1:50pm revealed: -"When I took [Resident #3's name] to the doctor in June" the resident had an order for monthly blood pressure checks. -During the visit, "I was telling [Resident #3's physician's name] we needed a parameter [for the blood pressures], but [the physician] seemed confused, because the blood pressures were fine and we only had an order for monthly blood pressures." -"We have only been doing the blood pressures monthly." -"The doctor was aware we were only checking the blood pressures monthly." -There was an entry in Resident #3's EMAR to "trigger a blood pressure...to be taken" when the lisinopril was being administered. Interview with Resident #3 on 7/17/15 at 2:05pm revealed: -Staff checked her blood pressure once a month. -The resident had just seen her physician "last Monday" and her blood pressure was 112/70. -"The only time I get dizzy is when I lay down and turn over." -"The ear doctor said as you get older ear ringing is more normal." Telephone interview with the Supervisor on 7/20/15 at 11:00am revealed: -She was one of three Supervisor's who administered medications to Resident #3.	C 330		

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C 330	Continued From page 21 -She checked Resident #3's blood pressure weekly. -She did not check Resident #3's blood pressure daily before administering the resident's scheduled medications. Telephone interview with Resident #3's physician on 7/20/15 at 11:20am revealed: -"We see [the resident] every 3 to 6 months." -The blood pressure is stable. -There is no need to check the blood pressure daily. A plan of protection was submitted on 7/17/15 and included: -The Administrator will do a complete chart audit on all the resident records to ensure all medication orders are correct and medication was dispensed correctly. -Daily blood pressure monitoring has been added to the EMAR for Resident #3. -The sliding scale insulin orders for Resident #1 have been verified with the physician and the current order faxed to the facility pharmacy. -Medications will be on hand and given as ordered. -The Administrator will monitor all new orders the day of the resident's appointment and call the pharmacy to ensure they have received any new orders. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 3, 2015.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights	C 912		

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C 912	Continued From page 22 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. 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 Novolog insulin, lisinopril, Toprol XL, and Lasix were administered as ordered for 2 of 3 sampled residents (Resident #1 and #3). [Refer to Tag 0330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation).]	C 912		

Medication tracking form:

Date/time order was received at facility:_____

Who received order:_____

Date/time faxed to pharmacy:_____

Date/ time Quick Mar was reviewed to see if new orders are current and correct_____

Date/time order was faxed to Administrator:_____

After 3 hours of faxing order to pharmacy and checking QuickMar and orders are not entered, call pharmacy (whom did you speak to_____)

If after 6pm M-F or weekends call on call pharmacy if meds are needed and Administrator

Date/time orders are complete and accurate_____

Willow Springs Assisted Living
1310 Hebron Street
Hendersonville NC 28739
Phone/fax 828-692-4500

DATE		PHYSICIAN'S ORDER
		Read – Back ALL Verbal/Telephone Orders

Resident:_____

Physician:_____

PHYSICIAN'S ORDER

Willow Springs Assisted Living
1310 Hebron Street
Hendersonville NC 28739
Phone/fax 828-692-4500