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| BROOKDALE HIGH POINT NORTH AL (NC) | 1568 SKEET CLUB ROAD HIGH POINT, NC 27265 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a Follow Up Survey on January 5, 6, 7, 8, with an exit conference via telephone on January 11, 2016. | D 000 | | |
| D 137 | 10A NCAC 13F .0407(a)(5) Other Staff Qualifications<br><br>10A NCAC 13F .0407 Other Staff Qualifications<br>(a) Each staff person at an adult care home shall:<br>(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 7 sampled staff (Staff C and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256.<br><br>The findings are:<br><br>1. Review of Staff C's personnel record revealed:<br>-Staff A was hired as a housekeeper on 2/15/06.<br>-Her job responsibilities included providing cleaning services throughout the facility and residents' rooms.<br>-There was no documentation of a HCPR check.<br><br>Interview on 1/5/16 at 11:30 am and on 1/7/16 at 3:00pm with Staff C revealed:<br>-She worked at the facility for 10 years.<br>-She worked first shift. | D 137 | | |

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| D 137 | Continued From page 1 | D 137 | | |

-Her duties included sweeping, moping, dusting, and taking the trash out of residents' rooms.
-She was unaware what a HCPR was and did not know if one had been completed prior to her employment.

Observation on 1/5/16 between 11:00 am and 11:30 am revealed Staff C was cleaning, sweeping and dusting in a resident's room while the resident was in the room.

A HCPR check was done on 1/6/16, and revealed no substantiated findings.

Refer to the interview on 1/6/16 at 11:40 am with the Administrator.

Refer to the interview on 1/6/16 at 12:00 pm with the Business Office Coordinator.

2. Review of Staff G's personnel record revealed:
-Staff G was hired as a dietary aide on 2/25/15.
-Her job responsibilities included assisting the lead cook in preparing meals and serving the residents' meals.
-There was no documentation of a HCPR check.

Interview on 1/7/16 at 2:45 pm with Staff G revealed:
-She had worked in the facility as a Dietary Aide for almost a year.
-She worked second shift.
-Her duties included assisting the lead cook as well as serving the meals and beverages to the residents.
-She was unaware what a HCPR was and did not know if one had been completed prior to her employment.

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| D 137 | Continued From page 2<br>A HCPR check was done on 1/6/16, and revealed no substantiated findings.<br><br>Refer to interview on 1/6/16 at 11:40 am with the Administrator.<br><br>Refer to the interview on 1/6/16 at 12:00 pm with the Business Office Coordinator.<br><br>Interview on 1/6/16 at 11:40 am with the Administrator revealed:<br>-She was responsible for day to day operations of the facility.<br>-She was aware a HCPR check was to be completed on all employees upon hire.<br>-She relied on the Business Office Coordinator (BOC) to obtain and review staff records for HCPR.<br>-A new BOC had started her position in October 2015.<br>-The HCPR would be run today for Staff C and G.<br><br>Interview on 1/6/16 at 12:00 pm with the Business Office Coordinator revealed:<br>-She had been employed as the BOC for 2 months.<br>-Her duties included obtaining HCPR for staff upon hire.<br>-She was unaware the housekeeping staff and dietary aides required a HCPR check upon hire.<br>-She was unaware that the HCPR checks were to be obtained for all staff.<br>-She thought the previous BOC had completed the HCPR check on Staff C and G prior to her taking the position.<br>-She would immediately run a HCPR on Staff C and G. | D 137 | | |

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| D 137 | Continued From page 3<br>The facility provided the following Plan of Protection on 1/7/16 as follows.<br>-Beginning immediately, all staff records will be reviewed to ensure HCPR check is completed.<br>-A tracking system will be implemented to included HCPR compliance by the BOC and reviewed by the ED weekly for one month and monthly thereafter.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2016. | D 137 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Follow-up, Standard Deficiency<br><br>Deficient Practice continues<br><br>Based on observation, interview, and record review, the facility failed to assure documentation of implementation of physician's orders for 1 of 5 sampled residents (Resident #5) related to applying and removing TED hose (Thrombo Embolic Derrent) and oxygen administration. | D 276 | | |

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| D 276 | Continued From page 4<br><br>The findings are:<br><br>Review of Resident #5's current FL2 dated 08/21/15 revealed:<br>-Diagnoses of rapid atrial fibrillation, chronic obstructive pulmonary disease (COPD), carpel tunnel syndrome, hypertension, osteoporosis, hyperlipidemia, and restless leg syndrome.<br><br>Review of the Resident Register in Resident #5's record revealed the resident was admitted to the facility on 08/24/15.<br><br>1. Review of Resident #5's record revealed:<br>-An order dated 10/08/15 from the Nurse Practitioner (NP) for the "HHN (Home Health Nurse) to observe and assess for BLE edema"<br>-The order included "Ted hose, on QAM, off QHS."<br>-The resident was measured for the TED hose on 10/13/15.<br><br>Review of Resident #5's Personal Service and Care Plan signed by the physician on 09/29/15 revealed:<br>-The resident needed extensive assistance with ambulation, dressing, and transferring.<br>-The resident needed supervision assistance with toileting, personal hygiene, and grooming.<br>-Ted Hose were not documented on the Care Plan.<br>-The Care Plan had not been updated to include the TED hose ordered on 10/08/15.<br><br>Review of the HHN Registered Nurse (RN), notes in Resident #5's record revealed:<br>-The RN visited observe and assess Resident #5 for edema.<br>-The RN noted observations on the following: | D 276 | | |

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-10/20/15 the SN assessed Resident #5 as having edema, no TED hose on. "Staff was educated on applying Ted Hose during the day."
-10/23/15 SN observed "1+ edema" to bilateral lower extremities.
-10/26/15 SN observed "2+ edema, no Ted Hose on."
10/29/15 SN observed 1+ edema and pitting to bilateral extremities, "no compression hose on."
-11/12/15 SN observed Resident #5 had "2+ edema", and did not have on her Ted Hose. A "discipline discharge," RN services were discontinued.

Review of Resident #5's October 2015 Medication Administration Records (MARs) revealed TED hose was not documented on the MAR.

Review of Resident #5's November and December 2015 MARs revealed:
-Ted Hose was printed on the MAR, on at 8:00 am, and off at 8:00 pm.
-Staff initialed the MARs for applying TED hose daily at 8:00 am, and initialed for removing TED hose daily at 8:00 pm for 30 days in November 2015, and for 31 days in December 2015.

Review of Resident #5's January 2016 MARs revealed;
-Ted Hose was printed on the MAR, on at 8:00 am, and off at 8:00 pm.
-Staff initialed the MAR for the applying of TED hose daily at 8:00 am on January 1, 2, 3, 4, and 5, 2016. Staff circled initials at 8:00 am on January 6, 2016.
-No reason was documented on the MAR why staff circled their initials.
-Staff initialed the MAR for removing Resident #5's TED hose daily at 8:00 pm on January 3 and

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| D 276 | Continued From page 6<br>4, 2016.<br>-There was no staff documentation on the MAR to show Resident #5's Ted Hose was removed at 8:00 pm on January 1, 2, and 5, 2016.<br><br>Review of the Licensed Health Professional Support (LHPS) Evaluation dated 12/08/15 revealed:<br>-The Registered Nurse (RN) preparing the document marked the task of oxygen therapy and transferring.<br>-The RN did not document TED hose as a LHPS marked task.<br><br>Observation on 01/05/16 at 10:30 am of Resident #5 revealed:<br>-The resident was in her room sitting in a reclining chair, asleep.<br>-The resident's legs were reclined off the floor, approximately 2 feet in the air.<br>-The resident had on black and white tweed wool socks that were 3 inches above the ankle.<br>-The socks appeared lose with no firmness or tightness.<br><br>Observation on 01/06/15 at 1:34 pm of Resident #5 revealed:<br>-The resident was in her room, in a recliner, asleep.<br>-The resident's feet were reclined off the floor, approximately 2 feet.<br>-The resident had on white socks with elastic that stopped above the ankle.<br><br>Observation on 01/06/16 at 1:43 pm of Resident #5's feet and legs revealed:<br>-It could not be determine if there was swelling in the resident's feet.<br>-The Personal Care Aide assisted with removing the resident's socks. | D 276 | | |

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-Resident #5's feet had mild edema below the ankle with a visible imprint of the sock material that was caused by the elastic in the socks.

Observation on 01/06/15 at 1:44 pm with the Personal Care Aide (PCA) searching Resident #5's chest of drawer for TED hose revealed:
-No beige TED hose were found in the resident's drawers.
-The resident had a white pair of TED hose with a light blue trim around the toe opening.

Interview on 01/06/15 at 1:45 pm with Resident #5 revealed:
-The resident stated she had gotten the white TED hose from the hospital, but had never worn them at the facility.
-Resident #5 stated she had two pair of beige TED hose, and did not know where they were.

Interview on 01/06/16 at 9:15 am with a first shift Medication Aide revealed:
-She did not apply Resident #5's TED hose, that was done by the Personal Care Aides (PCAs) staff.
-She documented on the MARs that she observed the TED hose on the Resident.
-She had not seen Resident #5 TED hose in a month, "beige ones."
-She did not tell the Health and Wellness Nurse, and she still documented on the MARs.
-"Everybody knows she does not wear them."
-The resident always refused or complained about the TED hose and wanted them off, they were put on.
-She was not sure if anyone had made the physician aware Resident #5 did not wear her Ted Hose.

Interview on 01/05/16 at 10:37 am with Resident

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| D 276 | Continued From page 8<br><br>#5 revealed:<br>-Her feet were swollen, so she kept them up off the floor.<br>-Her feet felt tight and often swell.<br>-The resident could not think of a cause or healthcare issued that caused the tightness or swelling in her feet other than exercising.<br><br>Interview on 01/06/16 at 1:38 pm with Resident #5 revealed:<br>-When asked by the surveyor if she had TED hose, Resident #5 said, "it had been a month since staff put her TED hose on."<br>-She was ordered TED hose to help with the tightness and swelling in her feet.<br>-She had two beige pair of TED hose, that she had forgot about.<br>-Her feet felt tight, that's how she knew they were swollen.<br>-She was unable to recall if she asked staff to put the TED hose on her.<br>-She was unable to ambulate, transfer, or dress herself without staff hands on assistance.<br>-The facility staff laid her clothes out at night, and in the morning a staff person assisted with getting dressed.<br>-She thought the TED hose were not put on because they were not laid out with her clothes.<br>-The facility had a lot of new staff, and she blamed herself for forgetting to tell staff about the TED hose.<br><br>Interview on 01/06/16 at 1:45 pm with the first shift PCA revealed:<br>-She had worked at the facility for one month.<br>-She had assisted Resident #5 with getting dressed this morning.<br>-The resident's clothes were already laid out, she assisted the resident with putting the clothes on.<br>-No one at the facility told her that Resident #5 | D 276 | | |

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was to wear TED hose.
-She had not seen the resident wearing the TED hose since she started working at the facility.
-When she started working at the facility she shadowed another PCA, staff person, that told her the needs of each resident.
-Some residents told her what they needed her to do for them.
-She was unaware if Resident #5 had a Care Plan and where the document was located.
-Until today she was unaware Resident #5 had TED hose

Interview on 01/06/16 at 2:55 pm with a second Medication Aide on the first shift revealed:
-She circled her initials this morning because she observed Resident #5 was not wearing her TED hose.
-She was unaware she needed to document why she circled her initials.
-She worked on January 2, 3, and 4th, and was sure she had observed Resident #5 wearing her TED hose.
-Being honest, she was unable to recall if the resident had her TED hose on.

Interview on 01/06/16 at 3:20 pm with pharmacy used to fill Resident #5's medications revealed:
-They received an order for Resident #5's TED hose on 10/13/15.
-They dispensed a pair of beige Ted Hose on that date.
-On 10/27/15 they dispensed to Resident #5 another pair of beige Ted Hose.

Interview on 01/06/15 at 3:10 pm with the RN that prepared the LHPS evaluation revealed:
-She was not the nurse that regularly did the LHPS evaluations at the facility.
-The facility RN had quit and she was called in to

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complete the LHPS evaluation.
-When she arrived at the facility on 12/08/15, staff gave her a list of residents with LHPS tasks, but did not document the task on the list.
-She visually observed Resident #5, but the resident was not wearing TED hose.
-She wrote down the tasks observed when she visited the resident.

Interview on 01/06/16 at 4:30 pm with the second shift PCA revealed:
-She was responsible for taking off Resident #5's TED hose at bedtime.
-She was unable to remember the last time she saw Resident #5's TED hose on, "she does not wear them."
-She had told the Medication Aide, but was not sure if anyone made the resident's physician aware.
-"Everyone knows she does not wear the TED hose."
-They had "stand-up" meetings every morning, and Resident #5's not wearing her TED hose was never discussed in the meetings that she attended.

Interview on 01/07/16 at 10:16 am with the Nurse Practitioner (NP) revealed:
-She visited the facility weekly, on Thursdays, and no one at the facility had informed her that Resident #5 was not wearing TED hose.
-She was not sure, but thought she ordered the TED hose at the resident's request, due to complaining about swelling in her legs and feet.
-She last saw Resident #5 in October 2015.
-She would check into the matter today.

The RN was not available for interview prior to exiting the survey.

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| D 276 | Continued From page 11<br><br>2. Review of Resident #5's current FL2 dated 08/21/15 revealed diagnosis included COPD, and an order for oxygen continuous at 2 liters per minute.<br><br>Review of Resident #5's Services and Care Plan dated 09/29/15 revealed:<br>-"Other chronic condition management, resident has Chronic Obstructive Pulmonary Disease, resident uses oxygen."<br><br>Observation on 01/05/16 at 10:35 am of Resident #5 revealed:<br>-The resident was in her room sitting in a recliner.<br>-The resident's legs were reclined up, two feet off the floor.<br>-The resident was asleep.<br>-There was an oxygen concentrator observed placed against the wall behind the resident's recliner.<br>-The oxygen concentrator was on, making a loud roaring noise.<br>-The clear tubing that came from the oxygen concentrator was curled in a circular pattern on the floor.<br>-The resident was not wearing the nasal cannula in her nose.<br>-The nasal piece of the cannula was observed in the resident's trash can.<br>-The concentrator was set at 2 liters per minute.<br><br>Second observation 01/05/16 at 10:40am of Resident #5 revealed:<br>-When asked why she was not wearing her oxygen the resident used her arm to reach down aimlessly toward the floor trying to pick up the oxygen tubing.<br>-The resident grabbed the tubing from the piled circle of tubing, and pulled it until the nasal part of the cord came out of the trash can. | D 276 | | |

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| D 276 | Continued From page 12<br>-Resident #5 put the nasal cannula in her nose and around her ears.<br>-The concentrator was set on 2 liters per minute.<br><br>Observation on 01/06/15 at 1:34 pm of Resident #5 revealed:<br>-The oxygen concentrator was on and could be heard roaring upon entrance to the resident's room.<br>-The resident was asleep in the recliner.<br>-The tubing coming from the oxygen concentrator was twisted in circles on the floor, part of the cord oxygen tubing was underneath a bag that was sitting on the floor, with the nasal part of the cannula underneath the side of the resident's bed.<br>-Resident #5 did not appear to be in any distress or have difficulty breathing.<br><br>Second observation on 01/06/16 at 1:46 pm of the Resident #5 awake revealed:<br>-When asked why she did not wear her oxygen.<br>-The resident used her arm to reach down aimlessly toward the floor trying to pick up the oxygen tubing.<br>-The resident used her fingers to try and pick up the oxygen tubing, but was unable to reach it because a bag was sat on the tubing.<br>-The resident asked the survey to lift the purse so she could reach the oxygen tubing.<br>-Once the purse was lifted off the oxygen tubing the resident was able to grab the oxygen tubing.<br>-The resident pulled the tubing to the oxygen dragging the nasal cannula across the floor.<br>-The resident put the nasal end of the cannula in her nose and over her ears.<br><br>Interview on 01/06/16 at 1:46 pm with Resident #5 revealed:<br>-She was unaware why she had to wear the | D 276 | | |

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oxygen continuously.
-Prior to coming to the facility in August 2015 she used oxygen only at night.
-One day, a few months ago the medication aide came to her room and told her she had to wear the oxygen during the daytime, but did not tell her why.
-She could not recall a diagnoses that related to her need for the oxygen.

Review of Resident #5's Personal Service and Care Plan signed by the physician on 09/29/15 revealed:
-The resident needed extensive assistance with ambulation, dressing, and transferring.
-The resident needed supervision assistance with toileting, personal hygiene, and grooming.
-Oxygen therapy was not documented on the Care Plan.

Second interview on 01/06/16 at 1:46 pm with Resident #5 revealed:
-When staff bought her back from the bathroom or from meals they always left the room and forgot to put her oxygen back on.
-She usually falls asleep right away and did not put the oxygen on.

-Interview on 01/06/15 at 1:48pm with a Personal Care Aide revealed:
-She had worked at the facility for a month.
-She assisted Resident #5 to meals and to the bathroom.
-She did not give the oxygen nasal cannula back to Resident #5 because she thought the resident would put the nasal cannula on herself.
-She was unaware the resident's purse was put on the oxygen tubing and the resident was unable to grab the hose herself.
-She had not been told to assist the resident with

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| D 276 | Continued From page 14<br>putting the oxygen on or to ensure the resident herself put the oxygen back on.<br><br>Interview on 01/06/16 at 4:55 pm with the Health and Wellness Director (HWD) revealed:<br>-No one was responsible for cleaning Resident #5's oxygen concentrator.<br>-If there was a problem the company that delivers the machine was called.<br>-She was unaware staff did not assist Resident #5 with putting her oxygen back on.<br>-The PCA on duty today assisting Resident #5 had only worked at the facility for one month, but was trained by another PCA.<br>-The PCA should have been made aware of the specific task to assist Resident #5.<br>-The facility did not have a system in place to ensure PCAs provided healthcare services to residents. | D 276 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record. | D 344 | | |

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| D 344 | Continued From page 15<br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO STANDARD DEFICIENCY<br><br>Based on these findings, standard deficiency continues.<br><br>Based on observation, interview, and record review, the facility failed to assure contact with the resident's physician for clarification of medication orders for 2 of 5 sampled residents (Residents #1 and #4) with an order for Oxybutynin and Myrebetriq; and for not clarifying medication dosage and administration times Vitamin C, Vitamin E, Stool softener, and Fish oil.<br><br>The findings are:<br><br>A. Review of Resident #4's current FL2 dated 08/22/15 revealed:<br>-Diagnoses included hypertension, Polyneuropathy, small vessel disease, cerebrovascular, coronary atherosclerosis, cardia dysrhythmia's, and benign neoplasm of cranial nerve, degenerative cervical disease, and osteoarthrosis.<br><br>Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 08/28/15.<br><br>Review of Resident #4's record revealed the following sequence of medication orders and changes:<br>-On 08/29/15 the physician ordered Vesicare 10mg once daily (used to treat overactive bladder), and referred Resident #4 to a urology specialist.<br>-On 09/16/15 the pharmacy sent a therapeutic interchange request to Resident #4's physician to discontinue Vesicare 10mg due to the resident | D 344 | | |

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experiencing side effects. The pharmacy also faxed a copy to the facility.
-On 09/30/15 the pharmacy sent another therapeutic interchange request to Resident #4's physician with the same comments, and faxed a copy to the facility.
-On 10/05/15 the physician responded back and signed the order to discontinue Vesicare 10mg and administer Oxybutynin (treat overactive bladder).
-On 10/13/15 Resident #4 went to see the urologist.
-He wrote an order that read "Vesicare was not helpful by," discontinue and start Mirabegron (Myrebetriq) 50mg daily (used to treat over active bladder).

Review of Resident #4's October 2015 MAR revealed:
-Vesicare 10mg was printed on the MAR.
-Staff hand wrote "Dc' d 10/05/15," on the MAR.
-On 10/05/15 staff wrote Oxybutynin 10mg once daily on the MAR at 9:00 am.
-On 10/13/15 staff wrote Myrebetriq 50mg once a day on the MAR at 9:00 am.
-In October 2015, staff documented the administration of both Oxybutynin 10 mg and Myrebetriq 50mg for 16 days without clarifying the order with the resident's physician or the urologist.
-The order needed to be clarified because the urologist was unaware of the therapeutic interchange of Vesicare with the Oxybutynin.

Review of Resident #4's November 2015 MAR revealed:
-Oxybutynin 10mg once daily was printed on the MAR at 9:00 am.
-Myrebetriq 50mg once daily was printed on the MAR at 9:00 am.

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| D 344 | Continued From page 17<br>-In November 2015, staff documented the administration of both Oxybutynin 10 mg and Myrebetriq 50mg for 30 days without clarifying the order with the resident's physician or the urologist.<br>-The order needed to be clarified because the urologist was unaware of the therapeutic interchange of Vesicare with the Oxybutynin.<br><br>Review of Resident #4's December 2015 MAR revealed:<br>-Oxybutynin 10mg once daily was printed on the MAR at 9:00 am.<br>-Myrebetriq 50mg once daily was printed on the MAR at 9:00 am.<br>-In December 2015, staff documented the administration of both Oxybutynin 10 mg and Myrebetriq 50mg for 31 days without clarifying the order with the resident's physician or the urologist.<br>-The order needed to be clarified because the urologist was unaware of the therapeutic interchange of Vesicare with the Oxybutynin.<br><br>Review of Resident #4's January 2016 MAR revealed:<br>-Oxybutynin 10mg once daily was printed on the MAR at 9:00 am.<br>-Myrebetriq 50mg once daily was printed on the MAR at 9:00 am.<br>-In January 2016, staff documented the administration of both Oxybutynin 10 mg and Myrebetriq 50mg for 7 days without clarifying the order with the resident's physician or the urologist.<br>-The order needed to be clarified because the urologist was unaware of the therapeutic interchange of Vesicare with the Oxybutynin.<br><br>Observation on 01/07/16 at 11:15 am of Resident | D 344 | | |

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#4's medications on hand at the facility revealed:
-Myrebetriq 50mg was available for administration.
-Oxybutynin was available for administration.
-Both medications were being administered daily.

Interview on 01/07/16 at 8:35 am with the urology specialist revealed:
-He was unaware the pharmacy did a therapeutic interchange that discontinued Vesicare and started Oxybutynin.
-This was the first time he had heard of the switch in medications.
-He did not want Resident #4 to be administered both Myrebetriq and Oxybutynin.
-Had he known of the switch in the medications he would have discontinued the Oxybutynin.
-He will send an order to discontinue Oxybutynin today.

Interview on 01/07/16 at 3:45 pm with the Medication Aide (MA) that worked both the first and second shift revealed:
-It was the facility's protocol when new or changed medication orders were received the MA on duty was to document the order on the MAR and fax the order to the pharmacy.
-If medication orders were unclear or duplicated, the order should be clarified with the Resident's physician.
-She is not sure why this process was not followed with Resident #4's Myrebetriq.
-The resident should not have received both medications until the order was clarified.

Interview on 01/06/16 at 3:42 pm with the pharmacist at the pharmacy used to fill Resident #4's medications revealed:
-They requested the therapeutic interchange of discontinuing Vesicare, and starting Oxybutynin

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because facility staff told them the resident was having side effects.
-The request for therapeutic interchange was signed the primary care physician on 10/05/15.
-The Oxybutynin was filled on 10/15/15, they dispensed 30 tablets to the facility.
-The Oxybutynin was refilled at the facility staff request on 11/05/15 and 12/07/15.
-They received an order dated 10/13/15 for Myrebetriq 10mg and dispensed 30 tablets to the facility.
-They received a refill request from facility staff and dispensed 30 tablets of Myrebetriq 10mg on 11/06/15 and 11/30/15.

Interview on 01/08/16 at 9:33 am with the pharmacist responsible for quarterly drug regimen review revealed:
-He visited the facility monthly to do drug regimen reviews.
-He recalled doing a recommendation sheet to the facility on 12/07/15, stating they needed to clarify the Oxybutynin and Myrebetriq as both medications were potentially duplicate therapy.
-He emailed the recommendation to the Health and Wellness Director on 12/07/15.

Interview on 01/08/16 at 2:20 pm with the Health and Wellness Director (HWD) revealed:
-She recalled getting the email from the pharmacy, but was unaware if she viewed the recommendation to clarify Resident #4's Myrebetriq and Oxybutynin.
-She was unable to recall what she did with the document.
-It was the facility's protocol when a resident returned with new orders or changed orders that were not clear, staff must contact the resident's physician to clarify the orders.
-She was not sure why the two orders for

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Resident #4 were not clarified with the resident's physician.

Interview on 01/11/16 at 1:35 pm with a nurse at Resident #4's Primary care physician office revealed:
-She talked with the physician regarding Resident #4's Oxybutynin and Myrebetriq.
-The physician stated no one at the facility called to clarify the medication orders.
-The physician had not received any pharmacy recommendation questioning clarification due to potential duplicate medication therapy.
-This was the first time this was revealed.
-The facility staff should have followed-up with the urologist because he was the specialist treating the resident for that specific healthcare condition.

B. Review of Resident #1's current FL2 dated 09/30/15 reveled diagnoses included congestive heart failure, hypoxemia, coronary pulmonary disease, muscle weakness, pseudomonas, and a history of urinary tract infections.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/13/15.

Review of Resident #1's record revealed a request from the facility dated 11/12/15 to the Nurse Practitioner (NP) revealed:
-"Resident (Resident #1) has vitamins she would like to self administer 1. Vitamin C (used for growth and repair of tissues in all parts of the body) 2. Vitamin E (used to slow the progression of atherosclerosis) 3. Stool softener (used for constipation) 4. Fish oil (used to help lower the production triglycerides)."
-The NP wrote: "ok to self administer above medications."

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| D 344 | Continued From page 21<br><br>Review of Resident #1's November 2015 MARs revealed:<br>-Staff hand wrote the vitamins and stool softener on the MARs.<br>-Staff wrote "self" beside each vitamin and stool softener.<br><br>The vitamins and stool softener were not documented on the December 2015 and January 2016 MARs.<br><br>Review of Resident #1's record revealed no follow-up with the NP to clarify the dose amount,administration quantity (1 or 2 tablets), and administration times with the NP.<br><br>Observation on 01/07/16 at 11:34 am of medications in Resident #1's room revealed:<br>-The following medications were identified in Resident #1's top Chest-of-drawer.<br>-Stool softener 100mg liquid gel caps, quantity 400 tablets.<br>-Fish oil tablets 1000mg total Omega-3 fatty acids, quantity 400 tablets per container, total (2 containers), and Fiber capsules, 320 capsules per container.<br><br>Interview on 01/07/16 at 11:38 am with Resident #1 revealed:<br>-She took the above supplements prior to moving into the facility, but she had been too busy to organize her pill container.<br>-She had not taken the supplements since she moved into the facility.<br><br>Interview on 01/07/16 at 10:40 am with the NP revealed:<br>-Facility staff faxed her a request asking for an order for Resident #1 to self-administer her | D 344 | | |

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| D 344 | Continued From page 22<br>supplements (vitamin C, vitamin E, stool softener, and fish oil).<br>-She did not think to write dosage and administration times because usually when staff asked for an order allowing a resident to self-administer their own medications, there were existing orders for the medication.<br>-No one at the facility called to clarify dosage, administration times or quantity of Resident #1's supplements.<br>-She would write an order today for the supplements.<br>-She was also not sure she wanted Resident #1 to self-administer her own supplements.<br>-Resident #1 was alert, but had periods of forgetfulness.<br><br>Interview on 01/07/16 at 10:01 am with the Health and Wellness Director revealed:<br>-Resident #1 had orders to self-administer her vitamin C, vitamin E, fish oil, stool softener, and Vitamin B12.<br>-She did an evaluation on the resident to ensure she was capable of self-administering the supplements.<br>-She asked the Medication Aide (MA) on duty to fax the physician a request allowing Resident #1 to self-administer supplements.<br>-The MA was aware Resident #1 did not currently have orders for the supplements, she was unsure why the MA did not ask the NP for an order.<br>-She went to Resident #1's room to do a medication self-administration evaluation, and she asked the MA to fax the NP for an order.<br>-She did not specifically tell the MA to get an order with the supplement name, dosage, administration times, and quantity, but she presumed the MA would know to do that.<br>-The MA verbally told her that she obtained the order. | D 344 | | |

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-She did not think anymore about the order for Resident #1's supplements.
-The order was filed in the resident's record.
-She had not been in Resident #1's room to view the supplements.
-She was sure no one at the facility had clarified Resident #1's vitamin C, vitamin E, stool softener, and fish oil with the NP.
-She thought it would be best if the facility administered all Resident #1's medications.

The MA who wrote the request to the NP allowing Resident #1 to self-administer vitamin C, vitamin E, stool softener, and fish oil was not available for interview.

Interview on 01/07/16 at 1:48 pm with Resident #1's family member revealed:
-She was unaware Resident #1 had an order to self-administer her supplements.
-She did not ask for an order for Resident #1 to self-administer supplements.
-Resident #1 was alert cognitively with some things, but not all the time.
-The resident probably should not be self-administering her own supplements because she noticed Resident #1 had signs of dementia forgetting current events and only remembering the past.
-She was unaware the facility got orders for the resident to self-administer the supplements.
-She visited the facility and bought the vitamin C, vitamin E, fish oil, and stool softener to the resident and left them in the room.
- She told the HWD and a MA the supplements were in the resident's room, mainly because she wanted them to know what was in the room.
-She did not want Resident #1 to self-Administer her own medications.
-No one at the facility had asked her if she

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| D 344 | Continued From page 24<br>wanted Resident #1 to self-administer the supplements. | D 344 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE B VIOLATION<br><br>Based on these findings, the previous Type B Violation was not abated.<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered or discontinued as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Residents #1 and #4) with orders for Anastrozole and Vitamin B12.<br><br>The findings are:<br><br>A. Review of Resident #4's current FL2 dated 08/22/15 revealed:<br>-Diagnoses included hypertension, Polyneuropathy, small vessel disease, cerebrovascular, coronary atherosclerosis, cardia dysrhythmia's, and benign neoplasm of cranial nerve, degenerative cervical disease, and osteoarthrosis. | D 358 | | |

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| D 358 | Continued From page 25<br>-Medication orders included Anastrozole 1mg once daily (used to treat breast cancer in women).<br><br>Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 08/28/15.<br><br>Review of Resident #4's record revealed an order from the oncology/hematology physician dated 09/28/15 to "stop Anastrozole."<br><br>Review of a printed medication list from the urologist revealed Resident #4's discontinued medications included Anastrozole 1mg.<br><br>Review of Resident #4's October 2015 Medication Administration Record (MARs) revealed:<br>-Anastrozole 1mg tablet every day at 9:00 am was printed on the MAR.<br>-On 10/01/15 staff hand wrote on the MAR "D/C 10/01/15."<br><br>Review of Resident #4's November and December 2015, and January 2016 MARs revealed:<br>-Anastrozole 1mg every day at 9:00 am was printed on the MAR.<br>-Staff documented the administration of Anastrozole 1mg at 9:00 am for 30 days in November 2015; for 31 days in December 2015; and for 7 days in January 2016, including this morning January 7, 2016.<br><br>Observation on 01/06/16 at 4:38 pm of Resident #4's medications on hand at the facility revealed:<br>-Anastrozole 1mg was available for administration.<br>-According to the pre-printed pharmacy label the | D 358 | | |

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medication was last filled on 12/07/15 for a quantity of 30 dosages.

Interview on 01/06/16 at with the contract pharmacist used to fill Resident #4's medications revealed:
-They had an order dated 08/29/15 for Anastrozole 1mg every day.
-They had not received orders to discontinue the medication.
-The facility staff requested refills each month.
-They dispensed Anastrozole 1mg on 12/07/15 for quantity of 30; on 11/10/15 they dispensed a quantity of 30; and on 08/29/15 they dispensed a quantity of 30.
-If the facility had an order to discontinue the medication they should fax it to the pharmacy.
-If the medication was stopped and the resident continued to take the medication there may not be any obvious side effects due to the Resident being on the medication for 5 years.
-Based on previous research the medication had a usage life of 5 years, and there were some studies to show what would happen if the medication was continued past the 5 years.
-He would suggest possibly having the resident's liver enzymes checked.

Interview on 01/07/16 at 11:10 am with the oncology physician's nurse revealed:
-Resident #4 was 5 year breast cancer survivor, which was the limited time usage for the Anastrozole medication.
-The nurse was not sure of harmful side effects because the resident continued to take the medication, but said that was the life usage of the medication.
-The facility staff should have pulled that medication off the cart on 09/28/15, which was the date the medication was discontinued.

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| D 358 | Continued From page 27<br><br>Interview on 01/07/16 at 11:55 am with Resident #4 revealed:<br>-She was a breast cancer survivor.<br>-She last visited the oncologist in September 2015.<br>-She was aware the oncologist stopped the medication that she had been taken for 5 years, and she verbally told that to facility staff and gave them the order.<br>-She was unaware if staff still administered to her the Anastrozole, because she did not know what the pill looked like.<br>-She always count her pills because sometimes staff did not give her all her medications.<br>-She was aware she got 3 pills before breakfast, 4 pills at 9:00 am, and 5 pills in the evening.<br>-The count of her pills have not changed since she came to the facility.<br><br>Interview on 01/06/16 at 5:25 pm with the Health and Wellness Director (HWD) revealed:<br>-When Resident #4 returned from her physician's visit in September 2015, the staff on duty should have immediately faxed the order to stop Anastrozole to the pharmacy, and documented the medication on the MARs.<br>-She saw where staff wrote "D/C on 10/01/15" on the October MAR, but someone started back administering the medication in November 2015.<br>-She was unsure why staff would start back administering the medication.<br>-No one reviewed behind medication aides to ensure they followed the facility's protocol.<br>-If staff was not sure about the order they should have contacted the resident's physician.<br>-However the order clearly states "stop Anastrozole."<br>-Medication Aides (MA) were to check MARs with orders on the 12th and 13th of each month. | D 358 | | |

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-The Resident Care Coordinator (RCC) was to check behind the MA.
-Currently, the facility did not have a RCC, so no one was checking behind the MAs.

Interview on 01/07/16 at 3:45 pm with the first shift Medication Aide revealed:
-It was the facility's protocol that if a medication was discontinued, the staff receiving the order was to document the order on the MAR and fax a copy to the pharmacy.
-The medication should be pulled off the medication cart.
-If the medication order was not clear or conflicting the MA was to contact the resident's physician to clarify the order.
-The MA was to flag the MAR to draw attention to oncoming staff that there was a pending order clarification, so the staff would continue to follow-up.
-Once the order was clarified and the right medication received the flag was removed.
-The Resident Care Coordinator (RCC) was to check behind the MA to ensure proper protocol was followed.
-She was unaware of Resident #4's order to stop Anastrozole, and did not know how the order was over looked and staff continued to administer the medication to the resident since September 2015.

Interview on 01/08/16 at 9:33 am with the pharmacist that completed the facility's quarterly drug reviews revealed:
-He visited the facility on 12/07/15, and did a drug regiment review for Resident #4.
-He did not recall seeing the order to stop Anastrozole.
-He did look at the FL2s and current orders, however if the order was not filed, or not with the other medication orders he might have missed

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| D 358 | Continued From page 29<br>seeing the order to stop Anastrozole.<br><br>B. Review of Resident #1's current FL2 dated 09/30/15 revealed:<br>-Diagnoses included congestive heart failure, pseudomonas, and muscle weakness.<br><br>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/13/15.<br><br>Review of Resident #1's record revealed an order dated 10/20/15 for vitamin B12 1,1000mcg once daily (used to treat B12 deficiency and/or anemia).<br><br>Review of Resident #1's October, November, and December 2015 Medication Administration Records (MARs) revealed:<br>-Vitamin B12 1,1000mcg take 1 tablet by mouth every day was printed on the MARs to be administered at 8am.<br>-"Self" was printed on the MARs beside the Vitamin B12, and staff also hand wrote "self" using large letters.<br>-There was no documentation of the administration of vitamin B12 to Resident #1.<br><br>Review of a laboratory report dated 10/14/15 in Resident #1's record revealed a vitamin B12 deficiency result of 166. The normal reference range of a vitamin B12 level was 211-911.<br><br>Observation on 01/07/16 at 9:55 am of Resident #1's medications on hand in the medication cart revealed there were no vitamin B12 supplements available for Resident #1.<br><br>Interview on 01/07/16 at 9:58 am with the first shift Medication Aide (MA) revealed: | D 358 | | |

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| D 358 | Continued From page 30<br>-Resident #1 did not have vitamin B12 supplement on the medication cart.<br>-She never administered the vitamin B12 supplement to Resident #1.<br>-According to the MARs the resident self-administered the medication daily.<br>-The medication must be in the resident's room.<br><br>Interview on 01/07/16 at 10:01 am with the Health and Wellness Director revealed:<br>-Resident #1's vitamin B12 was to be self-administered by the resident.<br>-The resident should have the medications in her room.<br>-A search of Resident #1's room by the MA revealed there were no vitamin B12 supplements in the residents room.<br>-A few months ago she verbally told a MA to ask the NP for an order allowing Resident #1 to self-administer her own vitamins.<br>-She searched Resident #1's record today and did not see an order for the resident to self-administer vitamin B12.<br>-She also just noticed the MA wrote on the MAR the resident was to self-administer the vitamin B12.<br>-Based on what she just observed, she was unsure when Resident #1's vitamin B12 was last administered.<br>-She was unaware until today that Resident #1 was not receiving vitamin B12.<br>-MARs and medications on hand, on the medication cart were checked the 12th and 13th of each month by the MAs, mostly third shift staff.<br>-Medications that were self-administered by the resident were not checked.<br>-The Resident Care Coordinator (RCC) was to check behind staff, but currently the facility did not have a RCC. | D 358 | | |

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| D 358 | Continued From page 31<br><br>Observation on 01/07/16 at 11:34 am of medications in Resident #1's room revealed no vitamin B12 supplement was observed in the resident's room.<br><br>Interview on 01/07/16 at 11:38 am with Resident #1 revealed:<br>-She did not have vitamin B12 supplement in her room.<br>-She thought the facility administered the medication with other morning medications.<br>-The vitamin B12 was an oblong pink pill and it used to be in with her other medications.<br>-Lately, she did not pay attention to see if the vitamin B12 was administered.<br>-She was mostly concerned about Lyrica, so she watched for that pill.<br><br>Interview on 01/07/16 at 10:06 am with the pharmacy used to fill Resident #1's medications revealed:<br>-The pharmacy had an order for Resident #1's vitamin B12 1000mcg once daily dated 10/20/15.<br>-The pharmacy did not have an order to discontinue the medication.<br>-The pharmacy received an order on 11/06/15 for Resident #1 to self-administer all her medications, so the word "self" was printed on the MARs beside the medications.<br>-Facility staff had informed the pharmacy to remove the word "self" from some medications that were not self-administered by the resident.<br>-The pharmacy also received notice that Resident #1 was going to start mail ordering her medications to get them in a larger quantity at a reduced price.<br>-The facility staff requested vitamin B12 1000mcg refills on 10/20/15 and 11/19/15.<br>-Each time they dispensed a quantity of 30 tablets. | D 358 | | |

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-No one had requested refills of the vitamin B12 since 11/19/15, so the resident should have ran out around December 20, 2015.

Interview on 01/07/16 at 10:40 am with the Nurse Practitioner revealed:
-She was unable to recall having an order for Resident #1 to self-administer her vitamin B12 supplement.
-She visited the facility almost weekly, usually on a Thursday, and no one at the facility asked her about an order for Resident #1 to self-administer her vitamin B12 supplement.
-Resident #1 did have an existing order for vitamin B12 1000mcg every day, but to self-administer.
-She did not show the order was stopped, changed, or allowed the resident to self-administer the medication.
-She will order Resident #1 a new vitamin B12 level today.
-She was unsure she wanted Resident #1 to self-administer her vitamin B12 supplement.
-Resident #1 was alert, but had periods of forgetfulness.

Interview on 01/07/16 at 1:48 pm with Resident #1's family member revealed:
-Resident #1 was hospitalized prior to coming to the facility in September 2015, with congestive heart failure.
-The laboratory tests that were done while the resident was in the hospital showed the resident had a vitamin B12 deficiency.
-The resident was given vitamin B12 in the hospital and when discharged was put on vitamin B12.
-It was very important Resident #1 vitamin B12 was administered daily.
-No one at the facility had called to inform her

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| D 358 | Continued From page 33<br>Resident #1 was out of the vitamin B12.<br>_____<br>The facility provided the following Plan of Protection on 01/07/16:<br>-A review of all resident charts will be done from September 2015 to present to assure appropriate follow through of medication orders.<br>-All charts will be reviewed and corrections done by January 15, 2016.<br>-All associates will be trained in the process of receiving new orders and appropriate follow through.<br>-Going forward over the next 30 days any paperwork received will be processed by the HWD or designee to review when in the community.<br>-Nursing staff will do random chart audits to assure appropriate follow through.<br><br>THE FACILITY PROVIDED A DATE OF CORRECTION ON JANUARY 7, FOR JANUARY 11. | D 358 | | |
| D 371 | 10A NCAC 13F .1004(n) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews the facility failed to assure medications that fell on the floor were not administered to 1 of | D 371 | | |

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| D 371 | Continued From page 34<br>5 residents (#1) in accordance with infection control measures.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 09/30/15 revealed diagnoses included congestive heart failure, hypoxemia, coronary pulmonary disease, muscle weakness, pseudomonas, and a history of urinary tract infections.<br><br>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/13/15.<br><br>Observation on 01/05/16 from 10:00 am to 10:50 am during the initial tour of the facility revealed:<br>-Resident #1 was in her room sitting in a lounge chair.<br>-On the window ledge was observed a small medication cup with 7-8 tablets.<br>-Observed on the floor underneath the resident's foot stool was a small orange colored tablet with no writing on one side, and writing on the other side of the tablet was "Crestor 5."<br>-The medications in the cup were later identified as K-Dur (used to treat potassium high or low in the blood) 20MEQ; Propranolol (used to treat anxiety/depression) 20mg; Amlodipine (used to slow blood related to coronary artery disease) 2.5mg; Aspirin (assist with blood flow heart disease) 325mg; and Furosemide (used to reduce fluid retention) 20mg.<br><br>Interview on 01/05/16 at 10:55 am with Resident #1 revealed:<br>-She had not taken her morning medications.<br>-The resident said the Medication Aide (MA) did not bring her Lyrica.<br>-She refused to take the rest of her medications | D 371 | | |

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without Lyrica.
-The MA left the room to go get the Lyrica, and left the medications with the resident.
-The MA had been gone for about 15 minutes and would return soon.
-The resident said she had neuropathy with little feelings in her left hand.
-She was a little shaky and dropped all the medications on the floor.
-She pulled her call bell for staff help as she was unable to bend to pick-up the medications.
-One of the Personal Care Aides (PCA) came to her room and picked up all the medications.
-The PCA gave her back the cup of medications.
-It was suggested to the resident not to take the medications because they had fallen on the floor.
-Resident #1 stated "the floor was clean, if it was not clean I would not take them."
-Resident #1 said it was not the first time the MA had forgot to bring her Lyrica that happened often.
-It was the first time she dropped the medications on the floor.

Second interview on 01/05/16 at 3:05 pm with Resident #1 revealed:
-The MA and the PCA both came to her room together, both staff counted the pills in her cup, then the MA gave her the medication.
-The MA did not say anything to her about the medication falling on the floor.
-The MA did not say she should not take the medication because it fell on the floor.

Interview on 01/05/16 at 11:10 am with the first shift MA revealed:
-She had just given Resident #1 her medications.
-When asked was she aware the medications fell on the floor, she stated no one told her.
-She was aware if medications fell on the floor

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they should be discarded.
-It was the facility policy to stay in the room with the resident while they were taking their medications.
-This morning she counted Resident #1's medications and did not think she missed putting any medications in the cup.
-Resident #1 counted her medications to make sure nothing was missing.
-The resident also knew what most of her medications looked like.
This morning the resident identified the Lyrica was missing and refused to take her other medications until she received the Lyrica.
-She left Resident #1's medications in the room because she planned to come right back, however other residents had needs and it took longer than she had planned.

Second interview on 01/05/16 at 2:55 pm with the first shift MA revealed:
-She apologized for not telling the truth earlier.
-When she bought the Lyrica to Resident #1, the resident refused to hand her the cup.
-The resident took the tablets and swallowed them.
-The PCA told her that Resident #1's medications had fallen on the floor.
-She did not tell the resident to discard the medications, but administered the medications to the resident.
-She was busy and did not say anything to management about what happened.
-I know that facility's policy is to discard tablets that drop on the floor, but "the resident would not let me have the tablets."

Interview on 01/05/16 at 2:45 pm with the PCA revealed:
-She worked at the facility for ten years as a PCA.

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| D 371 | Continued From page 37 | D 371 | | |

-Earlier Resident #1 put her call light on and when she answered, the resident asked her to pick-up the pills that fell on the floor.
-She told the resident not to take the medication, but to wait for the MA to come back.
-She told Resident #1 to make sure she told the MA the medication fell on the floor. The resident promised and she left the room.
-She went to find the MA and told her about the medication falling onto the floor.
-The MA counted the medication and gave them to the resident anyway.

Interview on 01/05/16 at 11:40 am with the Health and Wellness Director revealed:
-She was unaware Resident #1's medications had fallen on the floor, and the MA administered the medications to the resident.
-That was not according to the facility's policy.
-The MA should have discarded the medication, and re-administered uncontaminated medication to Resident #1.
-In this situation the facility would have paid the cost of the medication for Resident #1.

Review of the facility's policy for disposing of non-controlled medications revealed:
-If a medication is on the floor the staff should place the medication in an envelope with the resident's name.
-The name of the medication, date, time, and reason for disposal.
-Staff was to temporarily store the envelope in a designated locked secure area for disposal, separate from current medication.
-The next time the nurse was available to dispose of the medications he/she would dispose of the medication in the presence of a witness.
-Facility had annual infection prevention procedures, as well as updated in-services to

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| D 371 | Continued From page 38<br>ensure non-infectious procedures were followed. | D 371 | | |
| D 410 | 10A NCAC 13F .1010(c) Pharmaceutical Services<br><br>10A NCAC 13F .1010 Pharmaceutical Services (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure the provision of pharmaceutical services to meet the needs of residents including procedures to assure the accurate ordering, receiving, and administering of all prescribed medications to 1 of 5 sampled residents' (Resident # 3) whose medications were not administered as ordered due to the medications being unavailable at the facility.<br><br>The findings are:<br><br>Review of Resident #3's current FL2 dated 8/26/15 revealed:<br>-Diagnoses included dementia, congested heart failure and diabetes.<br>-Medication orders included Donepezil (used to improve cognition and behaviors in dementia patients) 10 mg at bedtime and Melatonin (regulation of sleep pattern) 3 mg at bedtime.<br><br>A. Review on 1/6/16 at 4:00 pm of Resident #3's pharmacy generated Medication Administration | D 410 | | |

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| D 410 | Continued From page 39 | D 410 | | |

Record (MAR) for the month of January 2016 revealed:
-A transcription entry for Donepezil 10 mg take one tablet at bedtime.
-No documentation of administration on 1/3, 1/4, and 1/5, 2016, that Donepezil 10 mg was not administered as ordered.
-Documentation on the of back of the MAR on 1/5/16 at 8:00 pm that Donepezil "awaiting pharmacy ".
-No other documentation was recorded on the back of the MAR for 1/3/16 or 1/4/16.

Observation on 1/6/16 at 9:30 pm of medications on hand for Resident #3 revealed:
-There was no Donepezil 10 mg found in Resident #3's current medications.
-There was no Donepezil available in the facility overstock for Resident #3.

B. Review on 1/6/16 at 4:00 pm of Resident #3's pharmacy generated MAR for the month of January 2016 revealed:
-A transcription entry for Melatonin 3mg take one tablet at bedtime.
-No documentation on 1/3, 1/4, and 1/5, 2016 that Melatonin 3 mg was administered as ordered.
-Documentation on the back of the MAR on 1/5/16 at 8:00 pm Melatonin "awaiting pharmacy".

Observation on 1/6/16 at 9:30 am of medications on hand for Resident #3 revealed:
-There was no Melatonin 3 mg found in Resident #3's current medications.
-There was no Melatonin 3 mg available in the facility overstock for Resident #3.

Interview on 1/6/15 at 1:40 pm with a first shift Medication Aide (MA) revealed:

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| D 410 | Continued From page 40<br>-She had worked on 1/5/16 day shift.<br>-She was unaware the Donepezil and the Melatonin were not administered to Resident #3 on 1/3, 1/4 or 1/5, 2016, because they were administered at night not on day sift.<br>-When a resident got low on medication, the MAs were to scan the request for refills to the pharmacy.<br>-She requested refills of medication when the residents had 7 or 8 pills left in the pharmacy generated punch card.<br>-It was the MA's responsibility to scan the refill request to the pharmacy.<br>-It was the MA's responsibility to document on the back of the MAR the reason Resident #3 had not received her medication.<br>-The MAs did a shift to shift report before starting their shift.<br>-The prior shift had not mentioned Resident #3 was out of Donepezil or Melatonin.<br>-She was unaware if the facility nurse reviewed or audited refill orders when faxed to the pharmacy.<br>-She relied on the MAs on all other shifts to order refills of medication that were given on their shifts.<br><br>Interview on 1/6/16 at 2:00 pm with Resident #3's family member revealed:<br>-He lived at the facility with Resident #3.<br>-He was unaware what medications Resident #3 had taken.<br>-He relied on the facility staff to administer the medications to Resident #3.<br>-He was unaware the facility had not administered the Donepezil or the Melatonin to Resident #3 on 1/3, 1/4, 1/5, 2016.<br>-He expected the facility to follow the physican orders and administer the medications to Resident #3. | D 410 | | |

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| D 410 | Continued From page 41<br><br>Telephone interview on 1/6/16 at 2:45 pm with Resident #3's pharmacy revealed:<br>-They were unaware Resident #3 had been out of Donepezil 10 mg and the Melatonin 3 mg for three days until 1/6/16.<br>-The facility had called the pharmacy on 1/6/16 and informed them Resident #3 had been out of medications.<br>-The last fill date on the Donepezil 10 mg was 11/30/15 and they had dispensed a 30 day supply.<br>-The last fill date on the Melatonin 3 mg was 12/3/15 and they had dispensed a 30 day supply.<br>-They relied on the facility to communicate with them either by fax or telephone when a resident was low on medications.<br>-The pharmacy did not offer automatic refill for Resident #3's medications.<br><br>Interview on 1/6/16 at 3:30 pm with second shift MA revealed:<br>-She was unaware the Melatonin and the Donepezil were not available for administration to Resident #3 until 1/5/16.<br>-She had not administered the Donepezil or the Melatonin to Resident #3 at bedtime on 1/5/16.<br>-She had informed third shift the medications were not available in the facility for Resident #3 on 1/5/16.<br>-She had written on a facility 24 hour report form that Resident #3 needed a pharmacy request for Donepezil and Melatonin on 1/5/16 during her second shift.<br>-She had relied on the first shift MA to fax the request to pharmacy on 1/6/16.<br>-She was unaware if the third shift MA informed the first shift MA to fax a request to pharmacy for Resident #3's Donepezil and Melatonin.<br>-She was unaware if the faxed pharmacy orders were reviewed or audited by the facility nurse. | D 410 | | |

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| D 410 | Continued From page 42<br><br>Observation on 1/6/16 at 3:40 pm revealed a 24 hour report form with documentation from the second shift MA, Resident #3 needed Donepezil and Melatonin refilled "send fax to pharmacy".<br><br>Interview on 1/6/15 at 3:50 pm with the facility Health and Wellness Director (HWD) revealed:<br>-She was responsible for the day to day operations of the nursing staff.<br>-She relied on the MAs to fax pharmacy or call pharmacy if a resident was low on medications.<br>-The policy was after the third missed dose of medications the physican was to be notified.<br>-The MAs were responsible for contacting the physican.<br>-The MA Supervisor in Charge (SIC) was responsible for review all the orders and the pharmacy fax.<br>-The facility did not usually keep a copy of the pharmacy fax requesting medications refills.<br>-She was not sure why the MA had not notified the pharmacy Resident #3 was out of Donepezil and Melatonin.<br><br>Review on 1/7/15 of the facility policy on Medications and Treatments revealed the policy is for all current ordered medcations to be available for the residents.<br><br>Telephone interview on 1/6/16 at 4:50 pm with a Registered Nurse at Resident #3's physican office revealed:<br>-The office was not made aware Resident #3 was out of Donepezil or Melatonin.<br>-The office had a 24/7 on call service for all residents' needs and the facility could call anytime.<br>-The physican would expect the facility to call if Resident #3 did not have her medications for 3 | D 410 | | |

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| D 410 | Continued From page 43<br>days.<br>-The physician relied on the facility to notify them if Resident #3 needed medications or a prescriptions for refilled.<br><br>Observation on 1/6/16 at 4:00 pm revealed pharmacy delivered Melatonin 3 mg and Donepezil 10 mg to the facility for Resident #3. | D 410 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews and record reviews, 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 rule and regulations related to health care personnel registry and medication administration.<br><br>A. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 7 staff (Staff C and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256. [Refer to Tag 137 10A NCAC 13F .0407 (5) Other Staff Qualifications (Type B Violation)].<br><br>B. Based on observations, interviews, and record | D912 | | |

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| D912 | Continued From page 44<br>reviews, the facility failed to ensure medications were administered or discontinued as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Residents #1 and #4) with orders for Anastrozole and Vitamin B12. [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation).] | D912 | | |