STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013041	A. BUILDING: _____ B. WING _____	06/08/2016

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MT PLEASANT HOUSE	935 PAGE DRIVE MOUNT PLEASANT, NC 28124

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on June 7, 2016 and June 8, 2016.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician notification for 2 of 5 sampled residents (Residents #3 and #5) regarding physician ordered laboratory tests that were not completed. A. Review of Resident #3's current FL2 dated 03/08/16 revealed diagnoses included chronic obstructive pulmonary disease, atherosclerotic heart disease, and peripheral vascular disease. Review of Resident #3's record revealed: -A Nurse Practitioner (NP) dictated a history and physical for Resident #3 on 04/08/16 and electronically signed on 04/08/16. -Resident #3 was being seen for assessment because she had been "seeing a lot of blood in her urine". -Resident #3 reported blood had been in her urine for "a few weeks and was getting worse." -A diagnosis on 04/08/16 of dysuria (the feeling of pain, burning, or discomfort when urinating). -A signed order dated 04/08/16 on a prescription order form for a urinalysis culture and sensitivity to rule out a urinary tract infection (UTI). -There were no results of a urinalysis culture and	D 273	It is the policy of Mount Pleasant House to assure referral and follow up to meet the routine and acute health care needs of residents. 1. Facility has developed lab tracking log book and lab tracking sheets. 2. All MD orders for labs will be faxed to the Lab and maintained in the lab tracking log book for the specific LAB DAY, and a copy will be also charted in the resident file 3. The Lab tracking sheet will be reviewed /signed by the Phlebotomist and signed upon completion on the lab draw day. The RCM will sign off and review/verify the lab tracking sheet for that day against MD orders. 4. All staff have been trained on the process for lab draws. 5. The ED will monitor this process weekly for 30 days monthly for one month and ongoing Completed 06/14/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Drye 7/1/16 TITLE: Executive Director (X6) DATE

RECEIVED JUL - 7 2016 ADULT CARE LICENSURE SECTION RALEIGH

Received and Accepted. 7/28/16
Stacey Pipkin, MA, BSW
FSC

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D 273	Continued From page 1 sensitivity in Resident #3's record. Interview with a Medication Aide (MA) on 6/08/16 at 1:45 pm revealed: -Some residents had outside of the facility doctors. The transportation aide or the MAs would prepare the paperwork and the resident was transported by the facility or by a family member to have their labwork drawn at their physician's office or the laboratory located within the hospital. -Once the laboratory results were received the results were filed in the resident's record and available for the physician to review at the next visit or the results were faxed to the physician offices. -There was no process in place to verify all ordered laboratory tests had been obtained and reviewed by the ordering physican. Interview with the facility NP on 06/08/16 at 2:40 pm revealed: -She saw Resident #3 on 04/08/16 and ordered the urine culture because Resident #3 had symptoms of a possible UTI. -She did a urine test utilizing a "dipstick sometime around 04/01/16" and the results were negative for a UTI. -She did not currently have access to Resident #3's record to give more specific information. -She was not sure why the urinalysis ordered on 04/10/16 was not arranged by the facility. Interview with the Executive Director on 6/08/16 at 2:32 pm revealed: -Facility staff obtained urine specimens and transported all of the specimens to the laboratory to be processed. --There was no process in place to ensure all laboratory work that was ordered by the	D 273		

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D 273	Continued From page 2 physicians had been obtained and processed by the lab. A second interview with the Executive Director on 06/08/16 at 2:40 pm revealed: -She was unaware the urinalysis ordered on 04/10/16 for Resident #3 had not been completed. -She would have been responsible for reviewing orders included in the medical provider's dictated summary on 04/10/16 for Resident #3, including the order for the urinalysis. B. Review of Resident #5's current FL2 dated 6/26/15 revealed diagnoses included diabetes mellitus, hypertension, congestive heart failure, psychosis, hypercholesterolemia, anxiety and history of cellulitis. Review of Resident #5's record revealed: -An electronically signed physician order dated 4/08/16 to obtain blood tests including a glycolated hemoglobin (HgbA1c, a blood test taken to identify the three month average plasma glucose concentration), a lipid panel (a blood test which measures total cholesterol, triglyceride levels, HDL and LDL cholesterol), a comprehensive metabolic panel (CMP) (a blood test which measures glucose level, electrolyte and fluid balance, kidney function, and liver function) and a valproic acid level (VPA) (a blood test which measures the amount of valproic acid in the blood related to administration of seizure medication to manage seizure activity and behavioral issues) . -A hand-written, signed physician order dated 4/08/16 to obtain blood tests including a complete blood count (CBC) (a blood test which measures the concentration of white blood cells, red blood cells, and platelets in the blood and aids in the diagnosis of conditions), a CMP, a thyroid	D 273		

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D 273	Continued From page 3 stimulating hormone level (TSH) (a test that measures the level of thyroid stimulating hormone which is a reflection of thyroid activity) a HgbA1c and a lipid panel on the next lab day. Further review of Resident #5's record revealed: -Blood test laboratory results that included a HgbA1c, CMP, a lipid panel and a VPA level, these results were all within normal limits. -There were no results of the CBC or the TSH level. Interview with the Executive Director on 6/09/16 at 2:40 pm revealed: -The dictated physician orders were printed and given to the phlebotomist and these orders included the HgbA1c, CMP, VPA and lipid panel. These labs were drawn and the results were in Resident #5's record. -She was unaware there was a hand written order for a CBC and TSH. If she had known there was a second set of hand-written physician orders she would have made a copy of those orders and had the phlebotomist draw those additional tests at the same time when the other blood work was drawn. Based on record review, observation and interview, it was determined Resident #5 was not interviewable. Attempted interview Resident #5's Physician was unsuccessful. Interview with a Medication Aide (MA) on 6/08/16 at 1:45 pm revealed: -There was one main physician who visited the facility and this practice had their own phlebotomists. -With this physican's group the Resident Care	D 273		

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D 273	Continued From page 4 Manager (RCM) printed all of the dictated physician orders and one copy was filed in the record and the other copy was given to the phlebotomist and the phlebotomist drew the labwork according to these physician orders. -Some residents have outside of the facility doctors. The transportation aide or the MAs would prepare the paperwork and the resident was transported by the facility or by a family member to have their labwork drawn at their physician's office or the laboratory located within the hospital. -Once the laboratory results were received they were filed in the resident's records and available for the physician to review at the next visit or the results were faxed to the physicians' offices. -The was no process in place to verify all ordered laboratory tests were obtained and reviewed by the ordering physican. Interview with the Executive Director on 6/08/16 at 2:32 pm revealed: -She was recently promoted to the role of Executive Director, but was also acting as the Resident Care Manager (RCM) until one could be thoroughly trained. -Their house physician had his own set of phlebotomists that drew all of his ordered blood tests. -The facility staff obtained the urine specimens and the phlebotomists obtained the blood specimens and they transport all of the specimens to the laboratory to be processed. -The RCM was responsible for preparing the paperwork for the phlebotomists. -Preparing the paperwork entailed printing the dictated physician orders and making a copy for the record and a copy was given to the phlebotomists. -The phlebotomist would obtain the specimens	D 273		

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D 273	Continued From page 5 according to the physician orders on the printed dictation. -It was possible a phlebotomist could overlook a test that physician ordered. -There was no process in place to ensure all laboratory work that was ordered by the physicians were obtained and processed by the lab.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure blood pressure medications (Diltiazem and Hydrochlorothiazide) were administered as ordered for 2 of 5 sampled residents (Residents #1and #3). A. Review of Resident #1's current FL-2 dated 7/30/15 revealed the resident's diagnoses included diabetes mellitus type II, chronic obstructive pulmonary disease, insomnia, abdominal pain, chronic pain, acute bronchitis, diastolic congestive heart failure, acute cystitis, atrial fibrillation, acute kidney failure, acute pyelonephritis, necrosis, bipolar anxiety, anemia and depression.	D 358	It is the policy of Mount Pleasant House to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practicioner which are maintained in the resident's record. 1. Immediate review of medication approval and reviewing procedures with RCM including comparing MD orders to entry in QuickMAR prior to approval. 2. ED reviewed with RCM process to contact MD with any orders which are not clear. 3. Medication aide review training on 7/7/16 on medication administration to include hold orders, and orders with parameters to assure meds are held or given per MD orders. 3. ED will monitor this process for 30 days, then monthly for one month and ongoing. Date of Completion	7/7/16

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D 358	Continued From page 6 Review of Resident #1's electronically signed discharge summary dated 3/31/16 revealed an order for diltiazem 120mg/24 hours extended release one capsule daily. Review of Resident #1's physican order with hand written signature dated 3/31/16 revealed an order for diltiazem 120 mg/24 hours extended release one capsule daily. Review of Resident #1's March 2016 electronic Medication Administration Record (eMAR) revealed a computerized entry for diltiazem 240 mg/24h-one capsule daily with no documented administrations. Review of Resident #1's April 2016 eMAR revealed: -A computerized entry for diltiazem 240 mg/24h-one capsule daily with documented administrations at 8:00 am from 4/01/16 to 4/13/16. -Resident #5 was in the hospital from 4/13/16 through 4/18/18. -A second computerized entry for diltiazem 240 mg/24h-one capsule daily with documented administration at 8:00 am from 4/19/16 to 4/30/16. Observation of medications on hand on 6/08/16 for Resident #1 revealed a 2 day supply of diltiazem dispensed on 05/20/16 was on hand. Interview with a representative from the contracted pharmacy on 6/08/16 at 3:39 pm revealed: -On 3/31/16 8 diltiazem 240 mg/24hr capsules were dispensed. -On 4/08/16 13 diltiazem 240 mg/24hr capsules were dispensed.	D 358		

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D 358	Continued From page 7 -On 5/01/16 17 diltiazem 240 mg/24hr capsules were dispensed. -On 5/20/16 12 diltiazem 240 mg/24hr capsules were dispensed. -The original order the pharmacy had on file for Resident #1's diltiazem was for 120mg/24hr and the pharmacy had input and dispensed the incorrect dose. -The keyers at the pharmacy were responsible for entering the new orders into the eMAR. -The pharmacy expected the Resident Care Manager (RCM) to review all orders and approve them prior to the medication being administered. -The entry for diltiazem 240 mg/24hr capsule-once capsule daily was approved by the RCM. Interview with a Medication Aide (MA) on 6/08/16 at 2:15 pm revealed: -The MAs are expected to fill out an "order sheet" which is a check list with each step of processing a new order. -When a physician order was received it should be faxed to the pharmacy and then documented in the residents record. -These steps would be checked off on the order sheet checklist. -The order is entered into the eMAR by the pharmacy, the pharmacy dispenses the medication and it is sent to the facility that evening. -The MAs check the order in the eMAR compared with the label on the medication and once it is verified as received and correct then this was checked off on the checklist. -Once the medication is received it is verified that the order is in the eMAR. -Once the checklist is complete the MAs turn this, the order and a fax confirmation sheet into the RCM.	D 358		

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D 358	Continued From page 8 -The order is approved in the eMAR by the RCM and the MAs would be able to administer the medication. -The eMAR or the medication labels were not checked against the order that was filed in the resident record. Interview with a Executive Director on 6/08/16 at 2:44 pm revealed: -The MAs are expected to fax the new order to the pharmacy and then document in the resident record. -The pharmacy enters all new orders in to the eMAR and they send the medication to the pharmacy the same evening. -The MAs are expected to check the medications ordered were received. -They had a check list that they utilized to ensure each step of the process was completed. -She approved the orders were entered by the pharmacy correctly and this enabled the MAs to administer the new medication ordered. -The pharmacy entered the diltiazem incorrectly and she did approve it as she did not catch that it was not the correct dosage. Resident #12 was unavailable for interview on 6/08/16 at 3:30 pm. Interview with Resident #1's Physician on 6/08/16 at 3:56 pm revealed: -He did not know that she was originally ordered diltiazem 120 mg/hr and was taking the 240 mg/hr capsule daily. -He had seen her in the office and had reviewed her blood pressure and pulses and they were all within normal range. -She also had a follow-up documented in Resident #1's record at his office and there were no significant findings or medication changes.	D 358		

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D 358	Continued From page 9 -She was hospitalized 4/18/16 and Resident was seen by cardiology and made changes to the dose and continued Resident #1 on diltiazem 240 mg/hr daily. -"There was no evidence the higher dose contributed to her second hospitalization". B. Review of Resident #3's current FL2 dated 03/08/16 revealed diagnoses included chronic obstructive pulmonary disease, atherosclerotic heart disease, and peripheral vascular disease. Review of Resident #3's current FL2 dated 03/08/16 revealed an order for Microzide 12.5mg (used to control blood pressure) take one daily and hold if systolic blood pressure (SBP) is less than 120. Review of Resident #3's April 2016 Medication Administration Record (MAR) revealed: -A computer generated entry for Hydrochlorothiazide (equivalent to Microzide) 12.5mg take one capsule daily (hold if systolic blood pressure is less than 120). -The Hydrochlorothiazide was scheduled to be administered at 6:00am. -Resident #3's blood pressure on 04/03/16 was 110/64, 04/04/16 was 118/72, 04/07/16 was 114/70, 04/10/16 was 116/72, 04/15/16 was 110/72, and 04/20/16 was 110/80. -Resident #3 was administered Hydrochlorothiazide 12.5mg at 6:00 am daily from 04/01/16 to 04/30/16. -There was no documentation regarding Resident #3's systolic BP being less than 120 on 04/03/16, 04/04/16, 04/07/16, 04/10/16, 04/15/16, and 04/20/16. Review of a Nurse Practitioner's (NP) dated	D 358		

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D 358	Continued From page 10 assessment dated 04/08/16 of Resident #3 revealed no documentation of complications related to blood pressures. Review of Resident #3's May 2016 MAR and June 2016 MAR revealed there were no blood pressures with a systolic value less than 120. Interview with Resident #3 on 06/08/16 at 4:45 pm revealed: -She had been on blood pressure medication for years. -Her blood pressure was usually high. -She received blood pressure medication daily. -She was not aware staff was to hold her blood pressure medication if the systolic "top number" was less than 120. Interview with a first shift Medication Aide (MA) on 06/08/16 at 7:44 am revealed: -The MA or Personal Care Aide (PCA) obtained blood pressures and recorded them on "the vitals sheet." -The MA was responsible for holding medications according to the given parameters ordered by the physician. -The MA was responsible for selecting "Hold per MD orders" on the electronic MAR to show the resident did not receive a medication. -The MA entered the BP on the electronic MAR. -The MA should contact the physician if medication was not administered. -Third shift staff was responsible for obtaining blood pressures and administering the blood pressure medication. Interview with a second shift MA on 06/08/16 at 7:51 am revealed: -The PCA's record blood pressures on the vital signs sheet.	D 358		

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D 358	Continued From page 11 -If the BP didn't look correct or was below the parameter, she "checked the BP myself". -The MA could enter on the electronic MAR that the medication was not administered and was withheld per doctor's orders. Interview with the Executive Director on 06/08/16 at 2:30 pm revealed: -She was unaware the Hydrochlorothiazide had not been help according to the parameters specified in the physician order and on the MAR. -The MAs should have held the Hydrochlorothiazide when Resident #3's systolic blood pressure was less than 120. -The MAs should have notified the physician if the systolic blood pressure was below 120. -She would re-train the MAs regarding parameters related to medication orders.	D 358	Med Techs to receive additional training on 7/4/16 on Medication administration in order to ensure that all medications are being help per MD orders and BP/pulse are within parameter specificied per MD notification. Also a training refresher on resident charting to ensure proper documentation is being properly recorded.	7/4/16