STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

(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
D 000	Initial Comments The Adult Care Licensure Section and the Duplin County Department of Social Services conducted an annual survey and a follow-up survey on August 9 - 11, 2016.	D 000		
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 observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a prescribing practitioner for 1 of 5 residents observed during the medication passes (#1), including errors with Neurontin, Restasis eye drops, and a Dulera inhaler, and 1 of 5 residents (#1) sampled. The findings are: 1. The medication error rate was 9% as evidenced by the observation of 3 errors out of 28 opportunities during the 9:00am and 4:00pm medication passes on 08/09/2016, and the 9:00am medication pass on 08/10/2016. Review of Resident #1's FL-2 dated 08/21/2015 revealed the resident's diagnoses included diabetes mellitus type II, bipolar disorder,	D 358		

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depressive disorder, gout, hyperlipidemia, anxiety, muscle weakness, arthritis, abnormal gait, and open angle glaucoma.

a. Review of the FL-2 dated 08/21/2015 for Resident #1 revealed there was a physician order for Restasis 0.05% eye emulsion one drop in both eyes twice daily (a prescription eye lubricant used to treat chronic dry eyes).

Observation of the 9:00am medication pass on 08/09/2016 at 10:05am revealed:
-The Medication Aide (MA) prepared to administer 16 medications to Resident #1.
-There were no Restasis eye drops administered to Resident #1.

Review of the August 2016 electronic Medication Administration Records (eMARs) for Resident #1 revealed:
-Restasis 0.05% eye emulsion instill 1 drop in both eyes twice daily was printed to the eMAR.
-The Restasis eye emulsion was scheduled for administration to Resident #1 at 9:00am and 9:00pm daily.
-The MA entered the "symbol key" for "not administered see notes" on the eMAR for the 9:00am dose of Restasis.
-The MA documented the reason for the Restasis not administered as "med not on cart will order today".

Interview with the MA on 08/09/2016 on 08/09/2016 at 10:15am revealed:
-The MA did not see the Restasis on the medication cart.
-The MA was off on 08/08/2016 and the MA may have used the last vial of Restasis on 08/09/2016.
-The MA would check in the "back up meds" to see if there was Restasis eye emulsion for

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D 358	Continued From page 2 Resident #1. Interview with the MA on 08/09/2016 at 11:50am revealed; -The MA had called the back up pharmacy for the Restasis. -The Restasis would be picked up from the back up pharmacy provider at 12:30pm. Observations of the Restasis 0.05% eye emulsion for Resident #1 on 08/09/2016 at 2:15pm revealed: -The Restasis was labeled with a pharmacy label from the facility provider back up pharmacy. -The pharmacy fill date printed was 08/09/2016. Interview with the Administrator on 08/10/2016 at 11:00am revealed: -The Resident Care Coordinator was responsible for checking the medication carts every month to ensure medications listed on the eMAR were on hand in the facility. -The protocol was to match the medications with the eMAR. Interview with Resident #1 on 08/10/2016 at 11:20am revealed: -The resident was administered the Restasis eye drops for dry eyes. -The eye drops were administered twice a day "morning and night". -The resident did not get the eye drops administered on 08/10/2016. -The resident's eyes felt "alright right now, run water a lot, eyes feel dry everyday, Restasis helps with dryness". The Resident Care Coordinator was not available for interview.	D 358		

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D 358	Continued From page 3 Interview with another MA on 08/10/2016 at 3:45pm revealed: -Whichever MA the recognized the need for a medication to be reordered was responsible to reorder the medication. -Medications were reordered by fax, telephone, or by pushing a button on the eMAR. -Reordered medications were delivered to the facility the evening the medications were reordered. -The MA thought when medications were reordered through the eMAR, the reordered was not always recognized at the pharmacy and medications might not be delivered. b. Review of physician's orders for Resident #1 dated 06/22/2016 revealed an order for Gabapentin (generic name for Neurontin) 300mg capsule take 1 capsule at bedtime. (Gabapentin is used to treat pain). Observation of the 9:00am medication pass on 08/09/2016 at 10:05am revealed: -The Medication Aide (MA) prepared to administer 16 medications to Resident #1. -The MA administered to Resident #1 Gabapentin 300mg one capsule at 10:05am on 08/09/2016 Review of the August 2016 electronic Medication Administration Records (eMARs) for Resident #1 revealed: -Gabapentin 300mg take one capsule at bedtime was printed to the eMAR. -The Gabapentin 300mg capsule was scheduled for administration to Resident #1 at 9:00pm daily. -There was no documentation of administration for the Gabapentin 300mg at 9:00am on the eMAR. Interview with the Medication Aide (MA) on	D 358		

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D 358	Continued From page 4 08/09/2016 at 2:40pm revealed: -There was no order for Resident #1 to be administered Gabapentin in the morning. -The Gabapentin was supposed to be administered at bedtime. -The MA did not remember and could not tell if she had administered the Gabapentin the morning of 08/09/2016. Further review of the August 2016 eMAR for Resident #1 on 08/10/2016 revealed: -There was documentation on the eMAR of the "symbol key" for "not administered see notes" for the 9:00pm dose of Gabapentin for 08/09/2016. -There were Medication Notes documented for 08/09/2016 at 9:00pm documenting the Gabapentin not administered per doctor's order. Interview with Resident #1 on 08/10/2016 at 11:20am revealed: -The resident did not know the names of all the medications she was administered. -The resident did not know whether she had been administered the Gabapentin. -The resident stated she had had leg pain before but was not having any leg pain at present. A second interview with the MA on 08/10/2016 at 11:50am revealed: -When the MA administered medications to residents, the MA compared the medicine with the eMAR before administering. -The MA looked at the medication "three times" to ensure the medication being prepared for administration matched the eMAR. -Sometimes the MA used the scanner on the medication cart to scan the medication labels prior to administering the medication. -The MA had not used the scanner on the medication cart to scan the medication labels	D 358		

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prior to administering morning medications on 08/09/2016.
-The MA felt using the medication label scanner made the medication pass longer.
-The MA realized the use of the medication label "scanner would have caught the error yesterday".

c. Observation of the 9:00am medication pass on 08/09/2016 at 10:05am revealed:
-The Medication Aide (MA) prepared to administer 16 medications to Resident #1.
-The MA administered to Resident #1 Dulera 100mcg/5mg inhaler 2 puffs at 10:26am on 08/09/2016

Review of the August 2016 electronic Medication Administration Records (eMARs) for Resident #1 revealed there were no instructions printed on the eMAR for the Dulera inhaler.

Review of physician orders for Resident #1 revealed no order was found in the resident's record with instructions for administration of the Dulera inhaler.

Interview with the Medication Aide (MA) on 08/09/2016 at 2:45pm revealed:
-The MA remembered administering the Dulera inhaler and stated "yeah, I gave her this" as the MA removed the Dulera inhaler from the top drawer of the medication cart.
-The MA stated she had administered to 2 puffs of the Dulera inhaler to Resident #1 on the morning of 08/09/2016.
-The order for the Dulera inhaler should be in Resident #1 ' s record.
-The Dulera inhaler labeled for Resident #1 had been received from the pharmacy on 07/28/2016.
-The MA stated Resident #1 had "been on it [Dulera inhaler] for a while".

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-The MA did not see instructions for administration for the Dulera printed on the August eMAR.
-The MA had looked at the eMAR when administering the medications to Resident #1 the morning of 08/09/2016 and "could have sworn" she had seen the Dulera printed to the eMAR.

Interview with the Administrator on 08/09/2016 at 2:50pm revealed:
-She did not know about the Dulera inhaler.
-She would contact the pharmacy to inquire about the Dulera inhaler order.

Interview with the facility Public Relations Representative (PRR) on 08/09/2016 at 2:55pm revealed:
-The Dulera was originally ordered on 03/25/2016.
-The last refill for the Dulera inhaler was 07/28/2016.

A second interview with the MA on 08/10/2016 at 11:50am revealed:
-When the MA administered medications to residents, the MA compared the medicine with the eMAR before administering.
-The MA looked at the medication "three times" to ensure the medication being prepared for administration matched the eMAR.
-Sometimes the MA used the scanner on the medication cart to scan the medication labels prior to administering the medication.
-The MA had not used the scanner on the medication cart to scan the medication labels prior to administering morning medications on 08/09/2016.
-The MA felt using the medication label scanner made the medication pass longer.
-The MA realized the use of the medication label

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D 358	Continued From page 7 "scanner would have caught the error yesterday". Interview with the Administrator on 08/10/2016 at 11:00am revealed: -The Resident Care Coordinator was responsible for checking the medication carts every month to ensure medications listed on the eMAR were on hand in the facility. -The protocol was to match the medications with the eMAR. The Resident Care Coordinator was not available for interview. Interview with the Administrator on 08/11/2016 at 11:05am revealed she did not understand why staff had not seen instructions for the Dulera medication was not printed on the eMAR. Interview with the Administrator on 08/11/2016 at 11:25am revealed: -The original order date for the Dulera inhaler was 03/25/2016. -She had received information from the provider pharmacy that the Dulera order was not showing on the eMAR. The resident had been on another inhaler that was switched to the Dulera due to insurance issues. The prescription for the Dulera was "hidden" to the eMAR "to test insurance". When the order came from the physician the prescription was never "unhidden" which resulted in it not showing to the eMAR. The medication was sent to the facility in March 2016 and again on 07/28/2016. -She did not fully understand the eMAR system. Interview with the MA on 08/11/2016 at 11:10am revealed: -The Dulera inhaler had been added to the eMAR.	D 358		

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D 358	Continued From page 8 -She was not able to say why it had not been noticed that the Dulera inhaler had not previously been added to the eMAR. -She had been administering the Dulera inhaler to Resident #1 for "a couple of weeks". Interview with Resident #1 on 08/11/2016 at 11:15am revealed: -The resident had been getting the inhaler administered in the mornings 2 puffs "twice" but did not get the inhaler in the evenings. -The resident did not know for sure how long she had been getting the inhaler. -The inhaler "must be helping". -The resident denied having any breathing problems. -The resident stated she would get shaky if she got up to do anything. Interview with a second MA on 08/11/2016 at 11:20am revealed: -The first time the MA had administered the Dulera inhaler was 08/10/2016. -The MA only administered those medications that "pop up" on the eMAR.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment;	D 367		

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D 367	Continued From page 9 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure accurate documentation on the medication administration records (MARs) for 2 of 5 residents (#1, #2) sampled for record review. The findings are: 1. Review of Resident #2's current FL-2 dated 03/25/2016 revealed: -Diagnoses included hypertension, diabetes mellitus, vitamin D deficiency, multiple sclerosis, depression disorder, general anxiety, gastro-esophageal reflux disease, and hyperlipidemia. -An admission date of 07/11/2013. Review of the June 2016 Medication Administration records for Resident #2 revealed: -There was documentation of administration for Spironolactone (used to treat fluid retention) 25mg tablet every day. -The Spironolactone was documented as administered daily at 9:00am from 06/01/2016 through 06/30/2016.	D 367		

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D 367	Continued From page 10 Review of the July 2016 Medication Administration records for Resident #2 revealed: -There was documentation of administration for Spironolactone (used to treat fluid retention) 25mg tablet every day. -The Spironolactone was documented as administered daily at 9:00am from 07/01/2016 through 07/31/2016. Review of the August 2016 Medication Administration records for Resident #2 revealed: -There was documentation of administration for Spironolactone (used to treat fluid retention) 25mg tablet every day. -The Spironolactone was documented as administered daily at 9:00am from 08/01/2016 through 08/09/2016. Review of physician orders for Resident #2 revealed no order found in the record for Spironolactone 25mg tablet daily. Review of medications on hand for Resident #2 on 08/11/2016 at 12:50pm with the Medication Aide (MA) revealed no Spironolactone on hand. Interview with the MA on 08/11/2016 at 1:10pm revealed: -The MA had documented administering the Spironolactone 25mg tablet to Resident #2 as recent as the morning of 08/11/2016. -The MA did not know where the empty bottle for the Spironolactone or the Spironolactone medication could be located. -The MA stated "evidently I didn't give it to her, I can't remember if I saw it on the eMAR, don't remember seeing it pop up on the EMAR, remember her being on it several months ago, she would refuse it".	D 367		

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D 367	Continued From page 11 Telephone interview with the Provider Pharmacy Representative (PPR) on 08/11/2016 at 1:50pm revealed: -The pharmacy inputs orders to the facility eMAR system. -The facility had the capability to add temporary orders to the eMAR system. -Majority of orders were faxed to the pharmacy for input to the eMAR by the pharmacy. -The pharmacy did not dispense the Spironolactone to the facility for Resident #2 but did input orders to the eMAR for Resident #2. -The pharmacy used the drug information sheet dated April 28, 2016 to input the instructions to the eMAR for administration of the Spironolactone. -The drug information sheet indicated the Spironolactone had been filled. -The pharmacy received the drug information sheet from the facility on April 28, 2016 and input the drug information to the eMAR on April 28, 2016. -The facility should be reconciling medication orders with the eMARs. Interview with the Administrator on 08/11/2016 at 3:13pm revealed: -The Administrator had just talked with the Resident Care Coordinator (RCC) and the Spironolactone was not supposed to be in the facility. -The Administrator had found a drug fact sheet for the Spironolactone 25mg tablet for Resident #2 in a box of documents that had been thinned from resident records. -The Spironolactone had only been ordered for 5 days in April 2016. -The Administrator did not know why staff were still documenting administration for the Spironolactone.	D 367		

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D 367	Continued From page 12 Review of the Spironolactone drug fact sheet dated April 28, 2016 for Resident #2 revealed: -The Spironolactone 25mg tablet was prescribed by Resident #2 ' s Primary Care Provider (PCP). -The instructions for administration were Spironolactone 25mg tablet once daily. -A quantity of five tablets were dispensed by another pharmacy provider. -"No refill" was printed on the drug information sheet. -Handwritten instructions were provided to the pharmacy from the facility were to only add the prescription to the eMAR. Interview with Resident #2 on 08/11/2016 at 3:50pm revealed: -The resident stated she did not take Spironolactone. -The resident stated she would recognize the Spironolactone as one of her prescribed medications. -The resident remembered being prescribed "fluid pills" in the past. The RCC was not available for interview. 2. Review of Resident #1's current FL-2 dated 08/21/2015 revealed the resident's diagnoses included diabetes mellitus type II, bipolar disorder, depressive disorder, gout, hyperlipidemia, anxiety, muscle weakness, arthritis, abnormal gait, and open angle glaucoma. Observation of the 9:00am medication pass on 08/09/2016 at 10:05am revealed the Medication Aide (MA) administered to Resident #1 Dulera 100mcg/5mg inhaler 2 puffs at 10:26am on	D 367		

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D 367	Continued From page 13 08/09/2016 Review of the June 2016 electronic Medication Administration Records (eMARs) for Resident #1 revealed: -There were no instructions printed on the eMAR for the Dulera inhaler. -There was no documentation on the eMAR or on a paper Medication Administration Record (MAR) that the Dulera inhaler had been administered in June 2016. Review of the July 2016 eMARs for Resident #1 revealed: -There were no instructions printed on the eMAR for the Dulera inhaler. -There was no documentation on the eMAR or on a paper MAR that the Dulera inhaler had been administered in July 2016. Review of the August 2016 eMARs for Resident #1 revealed: -There were no instructions printed on the eMAR for the Dulera inhaler. -There was no documentation on the eMAR or on a paper MAR that the Dulera inhaler had been administered in August 2016. Review of physician orders for Resident #1 revealed no order was found in the resident's record with instructions for administration of the Dulera inhaler. Interview with the Medication Aide (MA) on 08/09/2016 at 2:45pm revealed: -The MA stated she had administered to 2 puffs of the Dulera inhaler to Resident #1 on the morning of 08/09/2016. -The order for the Dulera inhaler should be in Resident #1's record.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 14 -The MA stated Resident #1 had "been on it [Dulera inhaler] for a while". -The MA did not see instructions for administration for the Dulera printed on the August eMAR. -The MA had looked at the eMAR when administering the medications to Resident #1 the morning of 08/09/2016 and "could have sworn" she had seen the Dulera printed to the eMAR. Interview with the Administrator on 08/09/2016 at 2:50pm revealed: -She did not know about the Dulera inhaler. -She would contact the pharmacy to inquire about the Dulera inhaler order. Interview with the facility Public Relations Representative (PRR) on 08/09/2016 at 2:55pm revealed: -The Dulera was originally ordered on 03/25/2016. -The last refill for the Dulera inhaler was 07/28/2016. Interview with the Administrator on 08/10/2016 at 11:00am revealed: -The Resident Care Coordinator (RCC) was responsible for checking the medication carts every month to ensure medications listed on the eMAR were on hand in the facility. -The protocol was to match the medications with the eMAR. The RCC was not available for interview. Interview with the Administrator on 08/11/2016 at 11:05am revealed she did not understand why staff had not seen instructions for the Dulera medication printed on the eMAR.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 15 Interview with the Administrator on 08/11/2016 at 11:25am revealed: -The original order date for the Dulera inhaler was 03/25/2016. -She had received information from the provider pharmacy that the Dulera order was not showing on the eMAR. The resident had been on another inhaler that was switched to the Dulera due to insurance issues. The prescription for the Dulera was "hidden" to the eMAR "to test insurance". When the order came from the physician the prescription was never "unhidden" which resulted in it not showing to the eMAR. The medication was sent to the facility in March 2016 and again on 07/28/2016. -She did not fully understand the eMAR system. Interview with the MA on 08/11/2016 at 11:10am revealed: -The Dulera inhaler had been added to the eMAR. -She was not able to say why it had not been noticed that the Dulera inhaler had not previously been added to the eMAR. -She had been administering the Dulera inhaler to Resident #1 for "a couple of weeks". Interview with Resident #1 on 08/11/2016 at 11:15am revealed: -The resident had been getting the inhaler administered in the mornings 2 puffs "twice" but did not get the inhaler in the evenings. -The resident did not know for sure how long she had been getting the inhaler. -The inhaler "must be helping". -The resident denied having any breathing problems. -The resident stated she would get shaky if she got up to do anything.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 16 Telephone interview with the Pharmacist on 08/11/2016 at 1:45pm revealed: -The pharmacy had received a verbal order for Dulera from Resident #1's Primary Care Provider (PCP) on 03/25/16. -The pharmacy placed the Dulera order as "hidden" from the facility on the eMAR, as it was prescribed by the PCP as an alternate to another inhaler previously prescribed (due to insurance issues). -The facility had no access to the hidden information. -The pharmacy erred by keeping the Dulera order as "hidden" on the eMAR since March 2016, so it was never visible to the facility. -The facility should have documented Dulera administration by an alternate method, as the eMAR system was not available for this drug. -The pharmacy delivered the Dulera to the facility on 3/25/16, along with documentation of the PCP's order, via drug tote. -The pharmacy had no knowledge of the lack of documentation of the physician's order for the Dulera inhaler in Resident #1's record. -The pharmacy refilled the Dulera prescription on 07/28/16. -The facility should be reconciling medication orders with the eMARs or alternate medication administration documentation systems, such as paper MARs. Interview with the Administrator on 08/11/2016 at 3:00pm revealed she did not know why staff were not documenting administration of the Dulera inhaler to Resident #1. The RCC was not available for interview.	D 367		