Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019020	A. BUILDING: _____ B. WING _____	10/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA MEADOWS FAIRWAYS	700 A CAROLINA MEADOWS CHAPEL HILL, NC 37517

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/13/15 - 10/16/15.	D 000		
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 record review and interview, the facility failed to assure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#5) as related to failing to notify the physician of a resident's non-compliance with self-catheterization, failing to follow-up with the nurse practitioner or cardiologist about decreasing the dosage of a diuretic, and failing to follow-up with the ear, nose, and throat appointment in which the resident was given an order to treat an ear infection. The findings are: Review of Resident #5's current FL-2 dated 04/14/15 revealed diagnoses included memory loss, urinary retention, recurrent urinary tract infections, chronic kidney disease, hypertension, congestive heart failure, bilateral foot drop, and history of myocardial infarction in 12/2012. A. Review of Resident #5's current FL-2 dated 04/14/15 revealed an order for the resident to self-catheterize 4 times a day and as needed. Review of Resident #5's Resident Register revealed:	D 273	A. A staff in-service on non-compliance along with changes in condition will be held with staff by an RN. Non-compliance of care and changes of condition are shared daily by shift to shift reporting by the nursing team. Confirmed non-compliance of care or change in condition is then to be noted in a resident's chart to be shared with one's provider by a nurse as appropriate. The nurse will convey the information to the provider and will note the communication in the resident's chart. Nursing staff will also be made aware of communication with providers via shift to shift reporting	~~12/31/15~~ per telephone addendum on 12/7/15 c Administrator -atw Date of Correction 11/20/15 /ken

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adele Dowell TITLE: Administrator (X6) DATE: 11/19/15

STATE FORM 6899 FWOZ11 If continuation sheet 1 of 46

12/7/15 · Plan of Correction Approved c telephone Addendum kmelic

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D 273	Continued From page 1 - The resident used a walker and required assistance with bathing. - The resident self-catheterized 4 times a day and as needed. - The section for memory was blank. Review of the resident's assessment and care plan dated 05/20/15 revealed: - The resident self-catheterized and self-medicated. - The resident required limited assistance with bathing and toileting. - The resident was independent with dressing and hygiene although a family member and staff may assist on occasion. - The resident was ambulatory with a walker. - The resident had occasional incontinence of bowel. - The resident was noted to be oriented. Review of the August 2015, September 2015, and October 2015 treatment records revealed: - An entry for "resident to self cath four times daily and as needed". - The treatment was scheduled for 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. - The blocks for documenting the self-catheterization were marked with "x" due to the resident self-catheterizing. Review of a facility nursing note dated 08/12/15 revealed: - Nursing staff was called to Resident #5's room. - The resident complained of urgency. - The resident was unable to make it to the bathroom tonight and saturated his bed linens. - The resident felt the need to go back to the bathroom where he urinated a little and had a small bowel movement. - The resident used to self-catheterize which he	D 273		

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D 273	Continued From page 2 stated he no longer has to. - Resident #5's family member (Resident #6) stated this had been going on for several days. - A urinal was provided to the resident and a clinical appointment was made. - A urine specimen was obtained. - New order for antibiotic for urinary tract infection was received. Review of a progress note from a Nurse Practitioner (NP) visit on 08/12/15 revealed: - Resident #5 was seen for urinary / fecal incontinence and urgency. - The resident has a history of benign prostatic hypertrophy and urinary retention. - The resident woke up in the middle of night last night and the bed was saturated with urine. - The resident has chronic urinary and bowel incontinence. - The resident responds to questions appropriately but at times his memory is not as accurate as his family member's memory. - The resident has a history of urinary retention and used to self-catheterize several times per day but he discontinued doing this it appears sometime in the fall. - The resident currently has no difficulty urinating and has no abdominal pain. - The resident cannot recall why he quit catheterizing himself. - The assessment and plan noted urinary incontinence and the resident will continue to use incontinence briefs. Review of a facility nursing note dated 10/05/15 revealed: - Resident #5 pushed panic button at 5:45 a.m. - Resident #5's family member (Resident #6) stated Resident #5 kept getting up frequently during the night for rest room and voiding in	D 273		

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D 273	Continued From page 3 incontinence brief and discarding on the floor. - Four incontinence briefs were observed on the bathroom floor and one was heavily saturated with urine. - The other three were slightly damp. - Resident #5's family member (Resident #6) expressed it was unusual for resident getting up so frequently during the night. Review of a facility nursing note dated 10/08/15 revealed: - Resident #5 requested to see nursing this morning. - Resident #5 reported that his family member (Resident #6) instructed him to catheterize this morning because the family member reported Resident #5 was up multiple times throughout the night to urinate. - Resident #5 voiced that he did not feel the need to catheterize as he was voiding and not retaining fluid. - The facility nurse reviewed with the resident that he does have an order from his physician to catheterize 4 times daily as needed. - The resident was told to notify staff with further concerns. - Facility noted they would continue to monitor. Review of a progress note from a Nurse Practitioner (NP) visit on 10/14/15 revealed: - Resident #5 was seen for acute weakness. - Resident #5 had difficulty getting out of bed this morning. - The resident was in wheelchair and appears at baseline. - The resident has a low grade fever but states he does not feel ill. - The resident is more and more incontinent of bowel and bladder. - The resident is unable to provide his own	D 273		

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D 273	Continued From page 4 incontinence care. - The resident has been self-catheterize 4 times a day for many months. - The resident has not catheterized today but did yesterday. - The resident has possible burning with urination. - The resident is frail looking with no apparent distress. - The resident will be admitted to the nursing home for work up and ongoing care. Review of NP progress note visits dated 05/12/15, 06/29/15, 08/12/15, and 10/14/15 for Resident #5 revealed the past medical history list included urinary retention ("patient self caths"). Interviews with Resident #6 on 10/13/15 at 3:02 p.m. and 10/14/15 at 3:50 p.m. and 4:15 p.m. revealed: - She had noticed her family member (Resident #5) was starting to have some memory issues over the last few weeks. - Resident #5 was also having incontinence episodes of bowel and bladder. - When they first moved to the facility, Resident #5 was very good about self-catheterizing. - Resident #5 self-catheterizes sometimes but not every day. - The last time Resident #5 self-catheterized was yesterday on 10/13/15. - He was trained by a nurse at the nursing home before they came to the facility on how to self-catheterize and use good handwashing technique. - He used to be good about washing his hands but now she has to remind him. - About 2 months ago, she found a bunch of catheter supplies and realized he had not been self-catheterizing.	D 273		

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D 273	Continued From page 5 - Resident #5 told her that he did not need to do it anymore. - She thought the physician knew he was not self-catheterizing but she was not sure. - Resident #5 was admitted to the nursing home on 10/14/15 and was unavailable for interview. Interview with a medication aide on 10/15/15 at 10:16 a.m. revealed: - Resident #5 has a lot of incontinence episodes in the last couple of weeks. - Resident #5's family member (Resident #6) said he was getting up a lot during the night to go to the bathroom. - The resident self-catheterizes. - She asked the resident yesterday if he needed to self-catheterize and the resident told her he did not self-catheterize. - She thought the resident was supposed to self-catheterize in the morning and at bedtime. - She was unsure how often the resident was actually self-catheterizing. - She had never observed the resident self-catheterize. Interview with a personal care aide (PCA) on 10/15/15 at 10:40 a.m. revealed: - Resident #5 was supposed to self-catheterize in the morning and at bedtime to her knowledge. - The resident told the PCA that he did not need to do it. - The resident was only self-catheterizing about 3 times a week in the morning. - She had not observed the resident self-catheterizing. - She did not know if facility nursing staff was aware he was not self-catheterizing every day. - Resident #5 told the PCA he had been getting up more at night for the last 2 weeks to go to the bathroom.	D 273		

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D 273	Continued From page 6 Interview with a facility nurse/shift supervisor on 10/15/15 at 12:52 p.m. revealed: - Resident #5's family member (Resident #6) will report the resident has urinary frequency but Resident #5 will not voice that. - Resident #5 has not needed to self-catheterize but his family member would sometimes demand he self-catheterize. - She thought Resident #5 was observed self-catheterizing when he was first admitted but she was not sure. - It should be documented. - She was not aware of the resident having any fluid retention and had not noticed the resident having any distention. - Resident #5 was alert and oriented x4 and was able to verbalize his needs. - She was aware of the order for the resident to self-catheterize but she had not contacted the physician about the resident not self-catheterizing as ordered. Telephone interview with a Nurse Practitioner (NP) on 10/16/15 at 12:17 p.m. revealed: - Resident #5 has a chronic problem with urinary issues including a history of urinary retention. - She saw the resident for a visit on 08/12/15. - The resident was having urinary frequency. - The resident had stopped self-catheterizing ("in the fall of 2014"). - She discussed it with the resident but the resident did not know why he stopped. - NP did not write the order for the resident to self-catheterize so she did not make any changes to the order during the visit in 08/2015. - Resident #5 did not respond appropriately to her at times and he was not always accurate in the information he provided. - Resident #5's family member (Resident #6)	D 273		

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D 273	Continued From page 7 does a lot of talking for him. - She was not aware Resident #5 was not currently self-catheterizing. - The primary physician was unavailable for interview. Review of an email to the Administrator from a second NP dated 10/15/15 revealed: - When the NP saw the resident on 10/14/15, Resident #5 assured the NP that he had been self-catheterizing. - Resident #5 told the NP he had not self-catheterized on the morning of 10/14/15 because he knew he was going to the clinic. - He was not aware of any concerns regarding problems with the resident's catheterizations. Telephone interview with the second NP on 10/16/15 at 11:44 a.m. revealed: - NP saw Resident #5 on 10/14/15 and he asked the resident if he had self-catheterized. - The resident said he did not self-catheterize that morning because he was told to stay in bed since he did not feel well. - The resident did not say how often he self-catheterized. - The facility had not notified the NP that Resident #5 was not self-catheterizing. - He was not aware of the resident's current issue with frequent urination. - If there are concerns about a resident, the facility will usually let them know. - Resident #5 was admitted to the nursing home on 10/14/15 and found to have a urinary tract infection. - If facility have notified the NP's clinic of any concerns, it would be noted in the electronic correspondence notes but he did not see any on file. - Resident #5 has some short term memory	D 273		

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D 273	Continued From page 8 deficits. Interview with the Administrator on 10/15/15 at 4:05 p.m. revealed if facility staff was aware Resident #5 was not self-catheterizing as ordered, it should have been documented and the physician should have been contacted. B. Review of Resident #5's current FL-2 dated 04/14/15 revealed: - Order for Lasix 20mg twice daily. (Lasix is a diuretic.) - Order to self-administer medications. Review of the resident's assessment and care plan dated 05/20/15 revealed: - The resident self-medicates. - The resident was noted to be oriented. Interviews with Resident #6 on 10/13/15 at 3:02 p.m. and 10/14/15 at 4:15 p.m. revealed: - She had noticed her family member (Resident #5) was starting to have some memory issues over the last few weeks. - Resident #5 was also having incontinence episodes of bowel and bladder. - He was getting up several times at night to use the bathroom. - She had always administered Resident #5's medications to him. - She administered his Lasix in the morning and at bedtime. Review of a facility nursing note dated 08/12/15 revealed: - Nursing staff was called to Resident #5's room. - The resident complained of urgency. - The resident was unable to make it to the bathroom tonight and saturated his bed linens. - The resident felt the need to go back to the	D 273	B. Provider notes indicating further follow up will generate applicable action by the nursing team until resolved. The follow up will be monitored via shift reporting, appointment checklist and oversight by the nurse manager and/or administrator.	11/20/15

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D 273	Continued From page 9 bathroom where he urinated a little and had a small bowel movement. - The resident used to self-catheterize which he stated he no longer has to. - Resident #5's family member (Resident #6) stated this had been going on for several days. - A urinal was provided to the resident and a clinical appointment was made. - A urine specimen was obtained. - New order for antibiotic for urinary tract infection was received. Review of a progress note from a Nurse Practitioner (NP) visit on 08/12/15 revealed: - Resident #5 was seen for urinary / fecal incontinence and urgency. - The resident has a history of benign prostatic hypertrophy and urinary retention. - The resident woke up in the middle of night last night and the bed was saturated with urine. - The resident has chronic urinary and bowel incontinence. - The assessment and plan noted urinary incontinence and the resident will continue to use incontinence briefs. - NP wrote she would ask the cardiologist if he can decrease Lasix from 20mg twice daily to once daily in the morning. Review of Resident #5's record revealed no documentation the cardiologist had been contacted about decreasing the Lasix dose. Review of a facility nursing note dated 10/05/15 revealed: - Resident #5 pushed panic button at 5:45 a.m. - Resident #5's family member (Resident #6) stated Resident #5 kept getting up frequently during the night for rest room and voiding in incontinence brief and discarding on the floor.	D 273		

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D 273	Continued From page 10 - Four incontinence briefs were observed on the bathroom floor and one was heavily saturated with urine. - The other three were slightly damp. Review of a facility nursing note dated 10/08/15 revealed: - Resident #5 requested to see nursing this morning. - Resident #5 reported that his family member (Resident #6) instructed him to catheterize this morning because the family member reported Resident #5 was up multiple times throughout the night to urinate. - Resident #5 voiced that he did not feel the need to catheterize as he was voiding and not retaining fluid. - The facility nurse reviewed with the resident that he does have an order from his physician to catheterize 4 times daily as needed. - The resident was told to notify staff with further concerns. - Facility noted they would continue to monitor. Interview with a medication aide on 10/15/15 at 10:16 a.m. revealed: - Resident #5 has a lot of incontinence episodes in the last couple of weeks. - Resident #5's family member (Resident #6) said he was getting up a lot during the night to go to the bathroom. Interview with a personal care aide (PCA) on 10/15/15 at 10:40 a.m. revealed Resident #5 told the PCA he had been getting up more at night for the last 2 weeks to go to the bathroom. Interview with the Administrator on 10/15/15 at 5:12 p.m. revealed: - She was unable find any documentation of	D 273		

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D 273	Continued From page 11 follow-up by the facility with the NP or the cardiologist's office regarding the decrease in Lasix. - She had been unable to determine when Resident #6 was last seen by a cardiologist. - She called the Nurse Practitioner (NP) regarding the note to contact Resident #5's cardiologist about decreasing the Lasix. - The NP did not recall what happened or if the cardiologist was contacted. Telephone interview with a Nurse Practitioner (NP) on 10/16/15 at 12:17 p.m. revealed: - Resident #5 has a chronic problem with urinary issues including a history of urinary retention. - She saw the resident for a visit on 08/12/15. - The resident was having urinary frequency. - She made a note during the visit on 08/12/15 about asking the cardiologist about decreasing the Lasix from twice a day to once daily in the morning. - She thought it might help with the urinary frequency at night. - She could not recall if she contacted the cardiologist's office about the Lasix. - She did not see any documentation related to it. - The most current order she could see in the record was from the primary physician in September 2015. - The resident was supposed to receive Lasix 20mg twice a day (morning and noon). - She saw a note in the resident's record from July 2015 where the primary physician had spoken with the cardiologist about Resident #5's Aspirin. - The note indicated the resident would be assigned to a new cardiologist because the current one had completed his fellowship. - She did not know if the resident had a new cardiologist.	D 273		

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D 273	Continued From page 12 - The primary physician was unavailable for interview. Telephone interview with a representative from the cardiologist's office on 10/16/15 at 12:35 p.m. revealed: - She did not see any recent or upcoming appointments scheduled for Resident #5. - The computer system dated back to March 2014 and she did not see any entries to indicate Resident #5 had been seen at the cardiologist's office from then up to the present time. - The cardiologist was unavailable for interview. C. Review of a progress note from a Nurse Practitioner (NP) visit on 09/29/15 revealed: - Resident #5 was seen for ear cleaning. - Resident #5's family member (Resident #6) has been assisting with the application of Debrox ear drops for Resident #5. (Debrox is used to soften ear wax.) - The wax was partially removed. - Return in 2 days for removal. Review of a progress note from a Nurse Practitioner (NP) visit on 10/01/15 revealed: - Resident #5 was seen for repeat ear cleaning. - Resident #6 has been using ear drops in Resident #5's left ear again for the last 2 nights. - The wax was partially removed. - Refer to local ear, nose, and throat (ENT) physician for ear cleaning. Review of a facility nursing note dated 10/01/15 revealed: - Resident #5 was seen in the clinic today for left ear cleaning. - New order received to refer to local ENT office for left ear cleaning. - Life services aware to schedule appointment.	D 273	12/9/15 Tc. Addendum c Admin Staff Date of Correction 11/20/15 Not 12/31/15 Monitoring of systems = Visit Notes, orders - Each shift 1st and 2nd will review + process daily. Oversight: will track c a form for each resident c orders. • Nurse manager to monitor daily. d/a Administrator. Kuder C. The daily appointment log has a designated column for receipt of paperwork from appointments. The receptionist will notify nursing both of acquired paperwork by checks throughout the day and turning in receipt report at the end of the receptionist shift. The ultimate receipt of paperwork is then the responsibility of the shift supervisors to obtain by follow up with the resident, the provider's office or access to chart systems through the computer. Oversight of this process is monitored by nurse manager and/or administrator.	11/20/15

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D 273	Continued From page 13 Review of a facility nursing note dated 10/02/15 revealed nursing noted Resident #5 has an appointment on 10/07/15 at 10:30 a.m. at a local ENT office. Review of Resident #5's record revealed no documentation the resident was seen by the ENT physician. Interview with Resident #6 on 10/13/15 at 3:02 p.m. and 10/14/15 at 3:50 p.m. revealed: - She self-administers her medications and gives her family member (Resident #5) his medications. - She orders their medications herself and picks them up at a local pharmacy. - Resident #5 went to the ENT physician last Wednesday for his ears. - They gave him some antibiotic ear drops. - She was putting 5 drops in his left ear once a day. - She did not have the ear drops on hand because his medications were sent with him to the nursing home earlier that day. Interview with the Administrator on 10/15/15 at 4:10 p.m. revealed: - She was unaware Resident #5 was receiving antibiotic ear drops from the ENT visit. - She did not see where any paperwork had been received by the facility regarding the ENT visit on 10/07/15. - The facility usually follows up to get paperwork from residents' appointments. - They would check on the ENT appointment. Interview with the facility's nurse manager on 10/16/15 at 12:45 p.m. revealed: - When they tried to call the ENT office today, the office was already closed for the day.	D 273		

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D 273	Continued From page 14 - They would have to call the ENT office back on Monday to get further information about Resident #5's recent appointment. - They got a copy of a prescription today from a local pharmacy used by Resident #5. Review of a prescription faxed by the pharmacy on 10/16/15 revealed an order for Cortisporin otic drops, 5 drops in left ear twice daily for 7 days. (Cortisporin is an antibiotic ear drop for infection.) Interview with the Administrator on 10/16/15 at 3:06 p.m. revealed: - They were unable to reach anyone at the ENT office because it was already closed today when they called. - They will follow-up on Monday morning, 10/19/15.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care	D 280	An RN is to review current resident for LHPS tasks and complete LHPS assessments as tasks are identifed as indicated per 10ANCAC13F .0903(c). A note will be written in the resident's chart if no LHPS task was identified. 12/7/15 Telephone Addendum - Administrator Date of Correction: 11/30/15. • All records reviewed for LHPS tasks • Nurse Manager will review all new resident records + new orders → resident assessed needs for new LHPS tasks • a spread sheet will be created to ensure LHPS reviews completed in timely manner. • Administrator will monitor this system.	12/31/15

KM/bes

Division of Health Service Regulation

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D 280	Continued From page 15 being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure a registered nurse completed an on-site Licensed Health Professional Support (LHPS) review and evaluation within 30 days of admission and quarterly thereafter for 1 of 3 sampled residents (#5) with a required task of urinary catheter. The findings are: Review of Resident #5's current FL-2 dated 04/14/15 revealed: - Diagnoses included memory loss, urinary retention, recurrent urinary tract infections, chronic kidney disease, hypertension, congestive heart failure, bilateral foot drop, and history of myocardial infarction in 12/2012. - An order for the resident to self-catheterize 4 times a day and as needed. Review of Resident #5's Resident Register revealed: - The resident used a walker and required assistance with bathing. - The resident self-catheterized 4 times a day and as needed. Review of the resident's assessment and care plan dated 05/20/15 revealed: - The resident self-catheterized and self-medicates. - The resident required limited assistance with bathing and toileting.	D 280	Training of LHPS tasks will be conducted for nursing supervisors, medication technicians and certified nursing assistants by RN. Training to occur for existing staff, upon hire and with any concerns of knowledge deficit to support communication about LHPS tasks. RN will communicate concerns to the resident's PCP as appropriate and/or delegate communication to PCP as appropriate per 10A NCAC 13F .0902(c). Communication to provider will be documented in the resident's chart.	12/31/15 10/14/15

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D 280	Continued From page 16 - The resident was independent with dressing and hygiene although family member and staff may assist on occasion. - The resident was ambulatory with a walker. - The resident had occasional incontinence of bowel. - The resident was noted to be oriented. Review of the August 2015, September 2015, and October 2015 treatment records revealed: - An entry for "resident to self cath four times daily and as needed". - The treatment was scheduled for 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. - The blocks for documenting the self-catheterization were marked with "x" due to the resident self-catheterizing. Review of Resident #5's record revealed no documentation of any Licensed Health Professional Support (LHPS) reviews. Review of a facility nursing note dated 08/12/15 revealed: - The resident complained of urgency. - The resident was unable to make it to the bathroom tonight and saturated his bed linens. - The resident felt the need to go back to the bathroom where he urinated a little and had a small bowel movement. - The resident used to self-catheterize which he stated he no longer has to. Review of a progress note from a Nurse Practitioner (NP) visit on 08/12/15 revealed: - Resident #5 was seen for urinary / fecal incontinence and urgency. - The resident has a history of benign prostatic hypertrophy and urinary retention. - The resident woke up in the middle of night last	D 280		

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D 280	Continued From page 17 night and the bed was saturated with urine. - The resident has chronic urinary and bowel incontinence. - The resident responds to questions appropriately but at times his memory is not as accurate as his family member's memory. - The resident has a history of urinary retention and used to self-catheterize several times per day but he discontinued doing this it appears sometime in the fall. - The resident currently has no difficulty urinating and has no abdominal pain. - The resident cannot recall why he quit catheterizing himself. - The assessment and plan noted urinary incontinence and the resident will continue to use incontinence briefs. Review of a facility nursing note dated 10/08/15 revealed: - Resident #5 reported that his family member (Resident #6) instructed him to catheterize this morning because the family member reported Resident #5 was up multiple times throughout the night to urinate. - Resident #5 voiced that he did not feel the need to catheterize as he was voiding and not retaining fluid. - The facility nurse reviewed with the resident that he does have an order from his physician to catheterize 4 times daily as needed. - The resident was told to notify staff with further concerns. - Facility noted they would continue to monitor. Review of NP progress note visits dated 05/12/15, 06/29/15, 08/12/15, and 10/14/15 for Resident #5 revealed the past medical history list included urinary retention ("patient self caths").	D 280		

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D 280	Continued From page 18 Interviews with Resident #6 on 10/13/15 at 3:02 p.m. and 10/14/15 at 3:50 p.m. and 4:15 p.m. revealed: - She had noticed her family member (Resident #5) was starting to have some memory issues over the last few weeks. - Resident #5 was also having incontinence episodes of bowel and bladder. - When they first moved to the facility, Resident #5 was very good about self-catheterizing. - Resident #5 self-catheterized sometimes but not every day. - The last time Resident #5 self-catheterized was yesterday on 10/13/15. - He was trained by a nurse at the nursing home before they came to the facility on how to self-catheterize and use good handwashing technique. - He used to be good about washing his hands but now she has to remind him. - About 2 months ago, she found a bunch of catheter supplies and realized he had not been self-catheterizing. - Resident #5 told her that he did not need to do it anymore. - She thought the physician knew he was not self-catheterizing but she was not sure. - Resident #5 was admitted to the nursing home on 10/14/15 and was unavailable for interview. Interview with a medication aide on 10/15/15 at 10:16 a.m. revealed: - The resident self-catheterizes. - She asked the resident yesterday if he needed to self-catheterize and the resident told her he did not self-catheterize. - She thought the resident was supposed to self-catheterize in the morning and at bedtime. - She was unsure how often the resident was actually self-catheterizing.	D 280		

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D 280	Continued From page 19 - She had never observed the resident self-catheterize. Interview with a personal care aide (PCA) on 10/15/15 at 10:40 a.m. revealed: - Resident #5 was supposed to self-catheterize in the morning and at bedtime to her knowledge. - The resident told the PCA that he did not need to do it. - The resident was only self-catheterizing about 3 times a week in the morning. - She had not observed the resident self-catheterizing. - She did not know if facility nursing staff was aware he was not self-catheterizing every day. Interview with a facility nurse/shift supervisor on 10/15/15 at 12:52 p.m. revealed: - Resident #5 has not needed to self-catheterize but his family member would sometimes demand he self-catheterize. - She thought Resident #5 was observed self-catheterizing when he was first admitted but she was not sure. - It should be documented. Telephone interview with a Nurse Practitioner (NP) on 10/16/15 at 12:17 p.m. revealed: - Resident #5 has a chronic problem with urinary issues including a history of urinary retention. - She saw the resident for a visit on 08/12/15. - The resident was having urinary frequency. - The resident had stopped self-catheterizing ("in the fall of 2014"). - She discussed it with the resident but the resident did not know why he stopped. - NP did not write the order for the resident to self-catheterize so she did not make any changes to the order during the visit in 08/2015. - The primary physician was unavailable for	D 280		

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D 280	Continued From page 20 interview. Interview with the Administrator on 10/15/15 at 3:50 p.m. revealed: - She has been unable to locate any LHPS reviews for Resident #5. - When a resident is admitted, the nurse manager check them in and any LHPS tasks will trigger the nurse to put that resident on her radar to do a LHPS review. - The nurse manager who admitted Resident #5 was no longer employed by the facility. - She did not know why the previous nurse manager did not do a LHPS review for Resident #5. - The nurse may have thought since the resident self-catheterized that she did not have to do a review. - The Administrator and the nurse manager use a spreadsheet to track and audit the LHPS. - She had not noticed the LHPS had not been done for Resident #5.	D 280		
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.	D 376	1. Policy updated by administrator to include: a) The self-administration assessment may be conducted in conjunction with a speech therapist. b) Each resident must administer and possess their own medications, without the assistance of other persons (spouse, friend, family, caregiver, et al.).	10/20/15 11/10/15

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D 376	Continued From page 21 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 3 of 3 sampled residents (#1, #5, #6) with orders to self-administer medications. The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: - A self-administration test will be performed by the nurse to determine the resident's ability to self-administer medication. - The initial testing for self-administration will be conducted with speech therapy to obtain a baseline of ability and cognition and provide therapy if needed. - The self-administration test will be administered quarterly thereafter by a shift supervisor. - It must be completed with all satisfactory scores in order to continue to self-administer. - It will be at the discretion of the shift supervisor, nurse manager, or administrator to suspend the self-administration privileges until consulting with the primary physician if the resident is not administering their medications correctly or has failed to communicate new orders or medications being taken or discontinued. - In order to self-administer, the resident must be able and willing to administer the entire medication regimen including obtaining medication refills. - All residents will be informed of this policy at the time of the self-administration test. 1. Review of Resident #5's current FL-2 dated 04/14/15 revealed diagnoses included memory loss, urinary retention, recurrent urinary tract infections, chronic kidney disease, hypertension,	D 376	2. Educational session to be conducted by the nurse manager and a pharmacist from our institutional pharmacy with the residents that seld-administer their medications to include: a) Review of the self-administration policy, b) Review of the current concerns as related to self-administration c) Review of the Fairways' expectations of each resident that administers their own medications and d) Facts about dosage amounts, frequency changes and administration times. 3. Self-administration policy based reminder sheet will be provided for the residents to store with his or her medications. 4. A thorough reconcilliation of medications on hand verses physician's orders to be conducted along with self-administration test with each self-administering resident by RN to confirm compliance, competency and ability based upon updated policy.	12/31/15 12/31/15 12/31/15

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D 376	Continued From page 22 congestive heart failure, bilateral foot drop, and history of myocardial infarction in 12/2012. Review of Resident #5's current FL-2 dated 04/14/15 revealed: - Order for Lasix 20mg twice daily. (Lasix is a diuretic.) - Order for Lipitor 20mg once daily. (Lipitor lowers cholesterol.) - Order for Aspirin 81mg once daily. (Aspirin may be used decrease risk of heart disease.) - Order for Flomax 0.4mg at bedtime. (Flomax is for urinary symptoms in men with benign prostatic hypertrophy.) - Order for Metoprolol Succinate ER 200mg once daily. (Metoprolol is for blood pressure/heart.) - Order for Multivitamin 1 once daily. (Multivitamin is a supplement.) - Lotemax 0.5% eye drops 1 drop in each eye once daily. (Lotemax is for inflammation of the eye.) - Order that resident may self-administer medications. - Order for the resident to self-catheterize 4 times a day and as needed. Review of subsequent physician's orders in Resident #5's record revealed: - Order dated 04/20/15 to discontinue Flomax. - Order dated 07/16/15 for Preparation H ointment to apply externally on hemorrhoids and/or in lower portion of anal canal 4 times daily as needed for hemorrhoid flare. - Order dated 07/29/15 to hold Aspirin. - Order dated 09/15/15 to restart Aspirin. - Order dated 09/15/15 for Omeprazole 20mg daily. (Omeprazole reduces stomach acid.) - Order dated 09/24/15 for Preparation H suppository insert 1 per rectum once a day as needed for hemorrhoid flare.	D 376	5. In-service to be conducted by RN with medication technicians, LPN and RN staff on updated policy for self-administration of medications. 6. Medication audits to be conducted by a trained designee (RN, LPN or med tech) to compare medications on hand versus medication orders and verification that all medications are available, are not expired, and are labeled with the resident's name. Discrepancies discovered during audits will be brought to the attention of the provider. Compliance will be reviewed in quality assurance meetings. D376. Telephone Addendum = Administrator * Date of Correct was 11/30/15 extension to 12/4/15. • All records of residents reviewed for self administration • The nurse manager will monitor residents = self administration quarterly. for concerns/problems. • Any concerns/problems will be check = M.D. • Administrator will look behind nurse manager weekly to ensure = meetings weekly w/concerns are addressed. /KMiles	12/31/15 12/31/15

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D 376	Continued From page 23 - Order dated 09/26/15 for Debrox ear drops 5 - 10 drops in the left ear at bedtime for 3 days prior to irrigation. (Debrox is used to soften ear wax.) - Order dated 09/29/15 for Debrox ear drops 5 - 10 drops in the left ear at bedtime for 2 days prior to irrigation. Review of signed Nurse Practitioner (NP) progress note visits dated 05/12/15, 06/29/15, and 10/14/15 for Resident #5 revealed: - The list of medications included Metoprolol Succinate 200mg at bedtime (previously taken in the morning). - The list of medications included Lasix 20mg twice daily (morning and noon). Review signed physician's order sheet for Resident #5 revealed an order dated 05/06/15 for the medication aide to perform self-medication audit the 10th of each month. Review of the October 2015 medication administration record (MAR) revealed: - Multivitamin, Metoprolol, Lotemax, Aspirin, and Omeprazole were scheduled to be administered once daily at 9:00 a.m. - Lasix 20mg was scheduled twice daily at 9:00 a.m. and 9:00 p.m. - Lipitor and Debrox ear drops were scheduled at 9:00 p.m. Interview with Resident #5 on 10/13/15 at 3:02 p.m. revealed: - He did not know what medications he was taking. - His family member (Resident #6) gave his medications to him each day. Interview with Resident #6 on 10/13/15 at 3:02 p.m. revealed:	D 376		

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(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 376	Continued From page 24 - She self-administers her medications and gives her family member (Resident #5) his medications. - Their medications are kept in a drawer in the kitchenette area. - She orders their medications herself and picks them up at a local pharmacy. - She has always given Resident #5 his medications even when they lived in the independent apartments on campus. - The facility staff knows that she does Resident #5's medications. - She had noticed Resident #5 was starting to have some memory issues over the last few weeks. Interview with Resident #6 on 10/14/15 at 4:15 p.m. revealed: - She had always administered Resident #5's medications to him. - The facility staff knew that she administered Resident #5's medications to him. - She did not currently have Resident #5's medications in their room. - Resident #5's medications were taken with him today when he was admitted to the nursing home. - She could verbally explain how she administered his medications. - Resident #5 was taken off his Aspirin for a while but he was currently taking a baby Aspirin every morning. - She administered his Multivitamin, Metoprolol and Omeprazole once in the morning. - She administered his Lasix in the morning and at bedtime. - She administered his Lipitor at bedtime. - Resident #5 administers his Lotemax eye drops himself every morning with 1 drop in each eye. - She had administered the Debrox ear drops a few weeks ago for the wax removal. - She was currently administering an antibiotic	D 376		

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	HAL019020	A. BUILDING: _____ B. WING _____	10/16/2015

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D 376	Continued From page 25 ear drop from the ear, nose, and throat (ENT) physician. - She was putting 5 drops in the left ear once daily. Interview with Resident #6 on 10/14/15 at 3:50 p.m. revealed: - Resident #5 went to the ENT physician last Wednesday for his ears. - They gave him some antibiotic ear drops. - She was putting 5 drops in his left ear once a day. Review of a prescription faxed by the pharmacy on 10/16/15 revealed an order for Cortisporin otic drops, 5 drops in left ear twice daily for 7 days. (Cortisporin is an antibiotic ear drop for infection.) Review of the Medication Self-Administration Assessment Form for Resident #5 revealed: - The resident's initial assessment was done on 04/20/15. - A second assessment was done on 07/18/15. - There was a score of satisfactory beside each of the questions on the form for both assessment dates. - There was no assessment documented after 07/18/15. - There was no issues or concerns were documented on the assessment form. Review of the log for monthly medication checks for self-medicating residents on 10/16/15 revealed: - Instructions were to check expiration dates and verify orders for all medications. - Resident #5 had monthly checks initialed for June 2015 (no specific date specified), July 2015 (no specific date specified), 08/10/15, and 09/11/15.	D 376		

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D 376	Continued From page 26 - The column for October 2015 was blank with no documentation of a monthly check being done for Resident #5. Telephone interview on 10/16/15 at 12:39 p.m. with the facility's nurse who did the self-administration assessment on 07/18/15 for Resident #5 revealed: - When she does the self-administration assessments, she take a list of the resident's current medication orders and the assessment for to the resident's room. - She asks the resident the questions on the assessment form such as what the medications are and when does the resident take them. - She would ask the resident to show her where they store their medications and if there was anything else they take. - She would check their medications on hand for expiration and how many were on hand. - If a resident had eye drops, she would ask them to show her how they administered them. - When she did the self-administration assessment for Resident #5, his family member (Resident #6) tried to answer the questions instead of letting him answer. - She then questioned Resident #5 separately from his family member and he was able to answer general questions like he took a certain medication for his heart. - Resident #5 was able to say when he took his medications and how often. - Resident #5 was able to demonstrate how to take the lid off of the eye drop bottle. - She did not observe Resident #5 take any of his medications. - She did not recall if there were any issues with Resident #5's medications when she did the July 2015 assessment. - She did not recall having any concerns about	D 376		

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D 376	Continued From page 27 Resident #5 being able to self-administer at that time. - She was not aware Resident #5's family member (Resident #6) was administering his medications. Interview with the Administrator on 10/16/15 at 3:00 p.m. revealed: - The monthly checks should be done on the 10th of the month. - She did not know why the October 2015 monthly checks had not been done for Resident #5. Interview with the Administrator on 10/16/15 at 3:05 p.m. revealed: - The initial testing for self-administration for Resident #5 was not conducted in conjunction with a speech therapist to obtain a baseline of ability and cognition as indicated in the facility's policies and procedures. - The policy should read, "may" instead of "will" be conducted in conjunction with speech therapy. - Resident #5 chose not to include speech therapy for the self-administration assessment. - The facility's policy needed to be updated to reflect the correct wording. 2. Review of Resident #6's current FL-2 dated 04/14/15 revealed: - Diagnoses included coronary artery disease status post percutaneous intervention left circumflex, congestive heart failure, aortic stenosis, zenker's diverticulum, hyperlipidemia, degenerative joint disease left knee, peripheral neuropathy, and osteoporosis. - Order for Losartan 50mg once daily. (Losartan is for blood pressure/heart.) - Order for Pravachol 80mg once daily. (Pravachol lowers cholesterol.)	D 376		

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D 376	Continued From page 28 - Order for Aspirin 81mg once daily. (Aspirin may be used decrease risk of heart disease.) - Order for Metoprolol Succinate ER 25mg once daily. (Metoprolol is for blood pressure/heart.) - Order for Vitamin D3 1000 units 2 tablets daily. (Vitamin D3 is a supplement.) - Order for Proflavanol C Multivitamin 1 twice daily. (Multivitamin is a supplement.) - Order for Colace 100mg once daily. (Colace is a stool softener.) - Order for Preservision AREDS 1 twice daily. (Preservision is a vitamin supplement for eye problems.) - Order for Vitamin B Complex 1 once daily. (Vitamin B Complex is a vitamin that contains multiple B vitamins.) - Order for Calcium Carbonate plus Vitamin D 200mg/100iu take 2 tablets twice daily. - Order for Tums OTC take 1 daily as needed. (Tums is used to treat heartburn.) - Order that resident may self-administer medications. Review of subsequent physician's orders in Resident #6's record revealed: - Order dated 04/27/15 for Tylenol 1000mg 3 times a day as needed for pain. (Tylenol is for pain and fever.) - Order dated 04/27/15 for Loratadine 10mg once daily. (Loratadine is an antihistamine for allergies.) - Order dated 07/17/15 to discontinue Aspirin and Colace. - Order dated 09/11/15 for Nitroglycerin 0.4mg sublingually every 5 minutes x 3 as needed for chest pain. (Nitroglycerin is used to treat chest pain.) - Order dated 09/11/ for Melatonin 2mg at bedtime as needed for insomnia. (Melatonin is a hormone used to help with sleep.)	D 376		

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D 376	Continued From page 29 Review of the October 2015 medication administration record (MAR) revealed: - Losartan, Pravastatin, Metoprolol, Vitamin D3, Vitamin B Complex, Loratadine, and Tums were scheduled to be administered once daily at 9:00 a.m. - Proflavanol, Preservision, and Calcium Carbonate with Vitamin D were scheduled twice daily at 9:00 a.m. and 9:00 p.m. - Tylenol, Melatonin, and Nitroglycerin were listed as "prn" (as needed) medications. - Aspirin and Colace were not listed on the MAR. Interview with Resident #6 on 10/13/15 at 3:02 p.m. revealed: - She self-administers her medications and gives her family member (Resident #5) his medications. - Their medications are kept in a drawer in the kitchenette area. - She orders their medications herself and picks them up at a local pharmacy. Review of Resident #6's medications in her room on 10/14/15 at 4:15 p.m. and the resident's medication orders revealed: - Losartan, Pravachol, Metoprolol, Vitamin D3, Proflavanol, Preservision, Calcium Carbonate with Vitamin D, Tylenol, and Loratadine were on hand and matched the most current orders. - There was Aspirin 81mg, Aspirin 325mg, and Vitamin B12 1000mcg on hand but no current orders for these medications. - There was no Melatonin or Tums on hand but there was current orders for these medications to be administered. Interview with Resident #6 on 10/14/15 at 4:15 p.m. revealed: - She took one Aspirin 81mg every morning.	D 376		

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D 376	Continued From page 30 - She only took the Aspirin 325mg tablets if she had pain like a headache. - She did not have any Vitamin B Complex tablets and she thought she was supposed to take the Vitamin B12 tablets and she took one of those every morning. - She did not have any Tums and she did not need them. - She did not take the Loratadine anymore because she was not having any allergy problems. - She did not have any Melatonin and she did not need any because it did not help her. - Facility staff checks her medications at times. - She thought a question had come up one time before about the Vitamin B12 during one of the checks. - She thought the Vitamin B12 issue had been straightened out. - She did not recall Aspirin being discontinued but the Colace was stopped and she no longer takes the Colace. - She did not recall the last time facility staff checked her medications. Review of the Medication Self-Administration Assessment Form for Resident #6 revealed: - The resident's initial assessment was done on 04/20/15. - A second assessment was done on 07/18/15. - There was a score of satisfactory beside each of the questions on the form for both assessment dates. - There was no assessment documented after 07/18/15. - There was no issues or concerns were documented on the assessment form. Review of the log for monthly medication checks for self-medicating residents on 10/16/15	D 376		

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D 376	Continued From page 31 revealed: - Instructions were to check expiration dates and verify orders for all medications. - Resident #6 had monthly checks initialed for June 2015 (no specific date specified), July 2015 (no specific date specified), 08/10/15, and 09/11/15. - The column for October 2015 was blank with no documentation of a monthly check being done for Resident #6. Interview with a medication aide on 10/15/15 at 10:16 a.m. revealed: - The medication aides do self-administration medication audits on the 5th and 10th of each month. - They print off a medication list and compare to physician's orders and MARs. - They compare the medications to the list. - She usually asks the residents if they have taken their medications the day she does the audit. - She recalled Resident #6 had fiber tablets at one time but she did not have them now. - She felt like Resident #6 was capable of self-administering her medications. Interview with a facility nurse/shift supervisor on 10/15/15 at 12:52 p.m. revealed: - The shift supervisors are responsible for doing the initial and quarterly self-administration assessments. - The medication aides were responsible for doing monthly self-administration audits to make sure the medications were on hand and not expired. - She did not recall doing a self-administration assessment for Resident #6. Telephone interview on 10/16/15 at 12:39 p.m.	D 376		

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D 376	Continued From page 32 with the facility's nurse who did the self-administration assessment on 07/18/15 for Resident #6 revealed: - When she does the self-administration assessments, she takes a list of the resident's current medication orders and the assessment for to the resident's room. - She asks the resident the questions on the assessment form such as what the medications are and when does the resident take them. - She would ask the resident to show her where they store their medications and if there was anything else they take. - She would check their medications on hand for expiration and how many were on hand. - She did the July 2015 self-administration assessment for Resident #6. - She did not recall if there were any issues with Resident #6's medications when she did the July 2015 assessment. - She did not recall having any concerns about Resident #6's self-administration of medications at that time. Interview with the Administrator on 10/16/15 at 3:00 p.m. revealed: - The monthly checks should be done on the 10th of the month. - She did not know why the October 2015 monthly checks had not been done for Resident #6. Interview with the Administrator on 10/16/15 at 3:05 p.m. revealed: - She was unaware of the discrepancies with Resident #6's self-administration of medications and medication orders. - The initial testing for self-administration for Resident #6 was not conducted in conjunction with a speech therapist to obtain a baseline of	D 376		

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D 376	Continued From page 33 ability and cognition as indicated in the facility's policies and procedures. - The policy should read, "may" instead of "will" be conducted in conjunction with speech therapy. - Resident #6 chose not to include speech therapy for the self-administration assessment. - The facility's policy needed to be updated to reflect the correct wording. 3. Review of Resident #1's fl-2 dated 6/10/2015 revealed: - Diagnoses of Pacemaker for Sick Sinus Syndrome, history of Gastrointestinal Bleed, Left Upper Extremity Deep Vein Thrombosis secondary to Pacemaker, Abnormal Liver Function Tests, Anemia, history of Cerebrovascular Accident with residual left-sided deficits, Hypertension, Normocytic Anemia, Abdominal Pain/ Constipation. - Physician's orders for Melatonin 1 milligrams (used as a sleep aide) by mouth nightly. - Physician's orders for Ondansetron 4 milligrams (Zofran- used to treat nausea and vomiting) by mouth daily as needed for nausea. - Physician's orders for Tramadol 50 milligrams (Ultram- used for moderate to severe pain relief) by mouth every six hours as needed for pain. - Physician's orders for Rivaroxaban 15 milligrams (Xarelto- a blood thinner used to prevent the formation of blood clots) by mouth twice daily through evening dose on 6/30/15 then stop taking this dosage and start Xarelto 20 milligrams daily. Review of Resident #1's interdisciplinary physician's notes dated 10/8/2015 revealed: - Listed among Resident #1's self-administered medications was Melatonin 1 milligrams (used as a sleep aide) by mouth at bedtime - Lexapro was discontinued from medication list	D 376		

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D 376	Continued From page 34 on 10/8/15 because Resident #1 told her physician that she had not taken it since January 2015. Observation of Resident #1's medications on hand to be self-administered revealed: - These medications were among Resident #1's self-administered medications but they were no longer listed on the October 2015 MAR: Vitamin B12 (B12 deficiency), Tramadol (Ultram- used for pain relief), Simethicone (used to reduce bloating, discomfort or pain caused by excessive gas), Lasix (Furosemide- used to relieve fluid retention), Xarelto (Rivaroxaban- blood thinner that treats and prevent blood clots), Vitamin B6 (B6 deficiency). - Resident #1 had on hand Melatonin 3 milligram and Melatonin 5 milligram. - There was also on hand the medication Lexapro (Escitalopram- used to treat depression and anxiety) which had an order to discontinued on 10/8/15. Review of Resident 1's August 2015 Medication Administration Record (MAR) revealed: - These medications were not listed on the MAR: Vitamin B6, Vitamin B12 and Simethicone. - Melatonin 1 milligram was listed on MAR to be given nightly. - There was no listing for Melatonin 3 milligram or Melatonin 5 milligram. Review of Resident #1's September 2015 MAR revealed: - These medications were not listed on the MAR: Vitamin B6, Vitamin B12 and Simethicone. - Melatonin 1 milligram was listed on MAR to be given nightly. - There was no listing for Melatonin 3 milligram or Melatonin 5 milligram.	D 376		

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D 376	Continued From page 35 Review of Resident #1's October 2015 MAR revealed: - These medications were not listed on the MAR: Vitamin B6, Vitamin B12, Tramadol, Simethicone, Lasix and Xarelto. - Melatonin 1 milligram was listed on MAR to be given nightly. - There was no listing for Melatonin 3 milligram or Melatonin 5 milligram Interview with Resident #1 on 10/15/15 at 3:40 P.M. revealed: - She takes Vitamin B6, Vitamin B12, and Temazepam for sleep, Losartan for blood pressure but not sure about dosage. - She takes Melatonin but was not sure how many milligrams. - She takes Tylenol 650 milligram in the evening and maybe in the day. - She also takes Lomotil for diarrhea if needed and Miralax for constipation if needed. - States that staff comes in and checks her medications sometimes but not sure how often. Interview with Resident #1 on 10/16/15 at 3:50 P.M. revealed: - Resident #1 has been taking vitamin B6 and vitamin B12 "for one year at least" even though they are not listed on her MAR. - Staff lets her know when she has a new medication or when medication is discontinued. - Resident #1 denies taking Tramadol, Simethicone, Xarelto, and Lasix. Interview with a Medication Aide (MA) on 10/16/15 at 12:30 P.M. revealed: - For residents who self-administered their medications we check their medications once per month on the 5th of every month.	D 376		

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D 376	Continued From page 36 - A Medication Aide goes to the resident's room and make sure that there are no expired medications, that they have the right medications and the right dosage. - Usually when a medication is discontinued we remove it and send it back to the pharmacy to be destroyed. - Resident #1 was not self-administering her medications a few months ago. - Two to Three months ago staff was administering Resident #1's medications. - When Resident #1 first moved in she was self-administering her medications. - She went out to the hospital and when she came back staff started to administer her medications. - Then she went back to self-administering her medications. Interview with Supervisor on 10/16/15 at 11:35 A.M. revealed: - Before a resident can self-administer medications there is a form that facility has to complete with five or six questions that are reviewed with resident quarterly. - The Nurse also takes a list of resident's current medications with her to resident's room. - She uses this current medication list to check that medications resident has on hand reconcile with current orders. - The Nurse also checks to make sure medications are not expired. Interview with same Supervisor on 10/16/15 at 3:07 P.M. revealed that the Supervisor generates a list of residents who self-administer their medications to be checked on monthly by the Medication Aide. Another interview with same Supervisor on	D 376		

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D 376	Continued From page 37 10/16/15 at 3:45 P.M. revealed that the list of medications that is review with resident when they start self-administering medications is generated from the current orders. Interview with same MA on 10/16/15 at 2:50 P.M. revealed: - Resident #1 was not listed on the monthly medication check list because at the time list was prepared she was not self-administering her medications. - Staff was administering medications to Resident #1 from May 13, 2015 until June 1, 2015 when she restarted self-administering her medications. - It is possible that a monthly medication check was done and not noted. - The nurses make list of residents who self -administer medications to be checked monthly. Review of current monthly medication check list for self-administering residents revealed: - Resident #1 was not listed to have her medications checked for the months of June 2015, July 2015, August 2015, September 2015 and October 2015. - This list was used to check for expired dates on medications and to verify orders for all self-administered medications. Review of the Medication Self-administration Assessment Form revealed: - An assessment of resident's ability to self-administer medication was performed 6/22/15 and 9/27/15. - A notation was made that "resident demonstrated ability to open medication packages correctly with some work because of right hand limited use." - Resident #1 scored satisfactory in all six assessment areas.	D 376		

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D 376	Continued From page 38 Interview with another Supervisor on 10/16/15 at 11:50 A.M. revealed: - Resident #1 was able to open medication bottles satisfactory as noted on Medication Self-administration Assessment form. - Resident #1 return medication bottle caps loosely on bottles so that she is able to open them easier. - Resident #1 was able to open medication bottles without assistance at the time of assessment. - Not aware that Resident #1 had a bottle of Xarelto which was discontinued 8/10/15 in with her self-administered medications. - Any medications that are not listed on current MAR are taken to nurse's office. - If it is a medication that resident is taking that has not been discontinued by the physician, the physician is notified and made aware that resident is requesting to take this particular medication. - Medication is returned to resident when an order is received from physician for that medication. - If physician does not give an order for that medication then it is explained to resident that physician does not want resident to take that medication. - Supervisor was not sure why the medication Lexapro was still in with Resident #1's self-administered medications even though it was discontinued 10/8/15. - The normal procedure is that when a medication is discontinued that medication is removed from resident's self-administering medications. - MAs failed to pull the Lexapro and Xarelto when they received the discontinued order for these medications. Interview with Administrator on 10/15/15 at 4:25	D 376		

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D 376	Continued From page 39 P.M. revealed: - The Registered Nurse (RN) goes into resident's rooms quarterly to administer Medication Self-administration Assessment. - The RN reconciles medications on hand to current MAR. - MA goes in about monthly if resident will allow and reconcile all medications on hand to current MAR. - Residents who self-administer their medications gets a list of medications that they should be taking. Interview with Administrator on 10/16/15 at 3:30 P.M. revealed: - Resident #1 should have been on the monthly medication check list. - Staff administered her medications sometime during the month of May 1015 or June 2015. - Resident #1 then requested to be reconsidered for self-administering of medications in June 2015. - Resident #1 passed the assessment to be placed back on self-administering of medication list on 6/22/15. - It is the function of the shift supervisor to generate monthly medication check list for self-administering residents. - Will start a monthly Quality Improvement program to double check self-administering list before it goes out on the unit. - The Supervisors will check to make sure that monthly medication checks are been done by MAs.	D 376		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services	D 400	1. Audit of the residents who are currently on diuretics once and then monthly thereafter to ensure proper medication administration times. Follow-up with PCP as indicated. Per addendum on page 41. KM.	11/27/15 Date of Correction TW

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D 400	Continued From page 40 of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure the licensed pharmacist addressed medication-related problems for 1 of 5 sampled residents (#5) for the quarterly medication review who was exhibiting symptoms of urinary frequency during the night and taking a	D 400	2. Verification with pharmacist by either the administrator or nurse manager that they have audited the medication administration records during the quarterly audits, including those residents that self-administer their medications, prior to the pharmacist's exit . 3. Review any use of diuretics during quality assurance meeting to assess findings. 4. Pharmacist will conduct an in-service with nursing staff regarding hours of administration for certain drug classes. D400 Telephone Addendum = Administrator Date of correction 11/23/15 • All resident records will included for all medications administered. • An internal audit was completed • Review of quarterly drug Reviews completed by pharmacy will include assurance all areas of this rule were assesed. Review by nurse manager. • Concerns will be addressed = pharmacist at quarterly faculty Meting. • A template for pharmacy reviews will be created to assure rule is completed Khleles	1st Quarter 2016 4thQtr meeting 01/16 12/31/15

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D 400	Continued From page 41 diuretic at bedtime. The findings are: Review of Resident #5's current FL-2 dated 04/14/15 revealed: - Diagnoses included memory loss, urinary retention, recurrent urinary tract infections, chronic kidney disease, hypertension, congestive heart failure, bilateral foot drop, and history of myocardial infarction in 12/2012. - Order for Lasix 20mg twice daily. (Lasix is a diuretic.) - Order to self-administer medications. Review of NP progress note visits dated 05/12/15, 06/29/15, and 10/14/15 for Resident #5 revealed the list of medications included Lasix 20mg twice daily (morning and noon). Review of the October 2015 medication administration record (MAR) revealed Lasix 20mg was scheduled twice daily at 9:00 a.m. and 9:00 p.m. Interviews with Resident #6 on 10/13/15 at 3:02 p.m. and 10/14/15 at 4:15 p.m. revealed: - She had noticed her family member (Resident #5) was starting to have some memory issues over the last few weeks. - Resident #5 was also having incontinence episodes of bowel and bladder. - He was getting up several times at night to use the bathroom. - She had always administered Resident #5's medications to him. - She administered his Lasix in the morning and at bedtime. Review of a progress note from a Nurse Practitioner (NP) visit on 08/12/15 revealed: - Resident #5 was seen for urinary / fecal	D 400		

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D 400	Continued From page 42	D 400		

incontinence and urgency.
- The resident woke up in the middle of night last night and the bed was saturated with urine.
- The resident has chronic urinary and bowel incontinence.
- The assessment and plan noted urinary incontinence and the resident will continue to use incontincence briefs.
- NP wrote she would ask the cardiologist if he can decrease Lasix from 20mg twice daily to once daily in the morning.

Review of Resident #5's record revealed no documentation the cardiologist had been contacted about decreasing the Lasix dose.

Review of a facility nursing note dated 10/05/15 revealed:
- Resident #5's family member (Resident #6) stated Resident #5 kept getting up frequently during the night for rest room and voiding in incontinence brief and discarding on the floor.
- Four incontinence briefs were observed on the bathroom floor and one was heavily saturated with urine.
- The other three were slightly damp.

Review of a facility nursing note dated 10/08/15 revealed:
- Resident #5 stated his family member (Resident #6) reported Resident #5 was up multiple times throughout the night to urinate.
- Facility noted they would continue to monitor.

Telephone interview with a Nurse Practitioner (NP) on 10/16/15 at 12:17 p.m. revealed:
- Resident #5 has a chronic problem with urinary issues including a history of urinary retention.
- She saw the resident for a visit on 08/12/15.
- The resident was having urinary frequency.

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D 400	Continued From page 43 - She made a note during the visit on 08/12/15 about asking the cardiologist about decreasing the Lasix from twice a day to once daily in the morning. - She thought it might help with the urinary frequency at night. - She could not recall if she contacted the cardiologist's office about the Lasix. - She did not see any documentation related to it. - The most current order she could see in the record was from the primary physician in September 2015. - The resident was supposed to receive Lasix 20mg twice a day (morning and noon). - The primary physician was unavailable for interview. Review of Resident #5's most recent medication review dated 10/14/15 revealed: - The pharmacist listed the resident's past medical history. - The pharmacist noted the resident was admitted to the nursing home today. - There was no documentation regarding any medication related problems. - There was no documentation regarding the resident's documented symptoms of urinary frequency during the night. - There was no documentation regarding the Lasix, a diuretic, being scheduled to be administered at bedtime. - The pharmacist noted there was no recommendations. Telephone interview with the Consultant Pharmacist (CP) on 10/16/15 at 12:01 p.m. revealed: - CP did the most recent medication review for October 2015 at the facility. - CP was filling in for the assigned CP for this	D 400		

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D 400	Continued From page 44 facility. - CP logged into and had access to the electronic records when he did the medication reviews. - CP had access to the residents' records including medication orders, FL-2 forms, labs, facility progress notes, prescribing practitioner progress notes, and medication administration records (MARs). - CP reviewed all residents' record including those who self-administered their medications. - CP usually looked for any clinical issues such as drug interactions or side effects. - CP did not look at the MARs for residents who self-administered because he thought the orders in the electronic record were linked and would automatically reflect changes on the MARs. - CP did not check the MARs for self-administration residents since staff did not actually document the administration of those residents' medications and there would be no "holes" (omissions) to see. - CP checks to see if residents who self-administer have had assessments every 6 months. - CP did not recall seeing any documentation in the progress notes about Resident #5's urinary frequency especially at night. - CP did not review Resident #5's MARs since he self-administered. - CP did not realize Resident #5's Lasix was scheduled on the MAR at 9:00 a.m. and 9:00 p.m. - If he had been aware of Resident #5's urinary frequency at night and the bedtime dose of Lasix, it would have alerted him to address it as a clinical issue in the medication review. Interview with the Administrator on 10/16/15 at 3:05 p.m. revealed: - The CP who did the most recent medication reviews this week was not the usual pharmacist	D 400		

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D 400	Continued From page 45 who did the reviews. - She did not realize the fill-in CP did not review the MARs for the residents who self-administered medications. - If there were any recommendations, it was usually documented by the pharmacist.	D 400		