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	FCL034015	A. BUILDING: _____ B. WING _____	11/28/2016

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PARKVIEW FAMILY CARE HOME	2778 REYNOLDS PARK ROAD WINSTON-SALEM, NC 27107

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C 000	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services conducted an annual survey on 11/28/16.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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; (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 interviews and record reviews, the facility failed to assure medication administration records were accurate and complete for 2 of 3 sampled residents with physician's orders for loratadine, potassium (Resident #2), metoprolol, stool softener and stomach acid reducer (Resident #3).	C 342		

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C 342	Continued From page 1 The findings are: A. Review of Resident #2's current FL-2 dated 10/14/16 revealed diagnoses included hypertension, schizophrenia, irritable bowel syndrome and "trandeficiency" anemia. 1. Review of Resident #2's current FL-2 dated 10/14/16 revealed a physician's order for potassium (a mineral supplement) with "DC'd" written next to it for discontinued. No dose or frequency were specified. Review of Resident #2's printed "Physician's Orders" printed by pharmacy and signed by the physician on 10/14/16 revealed an entry for potassium chloride 20 mEq daily with a handwritten discontinued notation over the entry. Review of Resident #2's quarterly pharmacy review revealed: -A recent pharmacy review performed on 11/14/16 with a notation to "take prn medicine only as needed". -No reference to potassium was documented. Review of Resident #2's October 2016 MAR revealed: -An entry for potassium chloride 20 mEq daily with a handwritten discontinued notation next to the entry in the documentation section. -No doses of potassium chloride were documented as administered. Review of Resident #2's November 2016 MAR revealed an entry for potassium chloride 20 mEq daily and documented as administered daily at 8:00 am from 11/01 to 11/27/16. Observation of medications on hand for Resident	C 342		

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C 342	Continued From page 2 #2 on 11/28/16 at 10:00 am revealed: -A full bingo card (30 tablets) of potassium chloride 20 mEq dispensed on 10/24/16. No doses were missing. -The potassium chloride 20 mEq card was kept separately from Resident #2's medication drawer. Interviews on 11/28/16 at 9:50 am and 2:10 pm with Resident #2 revealed: -The facility staff administered her medications. -"I do not want to take those big potassium pills, so my doctor stopped them." Interview on 11/28/16 at 10:20 am with the facility Manager revealed: -She had been the facility Manager for 15 years. -Resident #2 did not want to take potassium any longer and discussed it with the physician at the 10/14/16 appointment. -"I attend the physician appointments with the residents, so I know what was said." -"The potassium chloride order was discontinued on the FL2 by the physician, and I discontinued it on the October MARs." -The Manager or the Medication Aide (MA) verified MARs for accuracy when they were received from the pharmacy before starting the next month's MARs. -The potassium chloride "order was not caught on the November MAR that it was discontinued. We have not administered potassium chloride to (Resident #2). It was a documentation mistake." -"I administered medications to Resident #2 this week, and did not administer potassium chloride. I don't know why I initialed that I did." "I would have thought the pharmacist would have caught the potassium chloride mistake with the 11/14/16 quarterly review." Interview on 11/28/16 at 10:30 with a MA	C 342		

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revealed:
-The Manager or a MA review the MARs for accuracy when they were received from the pharmacy before starting the next month's MARs.
-The potassium chloride should not have been on Resident #2's November MAR since it was discontinued in October.
-She was not sure why a full medication card of potassium chloride for Resident #2 was sent since the medication was discontinued. She had not called the pharmacy to ask.

Telephone interview on 11/28/16 at 11:00 am with the facility's contract pharmacy revealed:
-There was an active order for potassium chloride 20 mEq dated 11/16/16 electronically send by Resident #2's physician.
-The pharmacy did not routinely send a copy of electronic physician orders to the facility, but they would send this potassium chloride order to the facility.

Second interview on 11/28/16 at 1:00 pm with the facility Manager revealed:
-The pharmacy had not sent the 11/16/16 electronic prescription for Resident #2's potassium chloride. "If they had sent it, I would have immediately contacted her physician to get it discontinued since (Resident #2) did not want to take it. We discussed this at her physician's appointment."
-She was not aware a medication card of potassium chloride for Resident #2 was sent from the pharmacy on 10/24/16.

Review of an electronic prescription for Resident #2 sent from the pharmacy on 11/28/16 revealed a physician's order dated 11/16/16 for potassium chloride 20 mEq daily.

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C 342	Continued From page 4 Telephone interview on 11/28/16 at 1:45 pm with Resident #2's primary physician's office nurse revealed: -There was documentation in the office files that the potassium chloride had been discontinued at Resident #2's 10/14/16 office visit. -There was documentation the pharmacy called to request an auto refill order for potassium chloride on 11/16/16, so "we just gave it". -She "could not say if the physician would think it was ok that the resident did not get the potassium chloride or not". 2. Review of Resident #2's current FL-2 dated 10/14/16 revealed a physician's order for loratadine 10 mg daily prn (as needed) (used for seasonal allergies). Review of Resident #2's printed "Physician's Orders" printed by pharmacy and signed by the physician on 10/14/16 revealed no entry for loratadine. Review of Resident #2's quarterly pharmacy review revealed: -A recent pharmacy review performed on 11/14/16 with a notation to "take prn medicine only as needed". -No reference to loratadine. Review of Resident #2's October 2016 Medication Administration Record (MAR) revealed no entry for loratadine 10 mg daily prn. Review of Resident #2's November 2016 MAR revealed: -A handwritten entry for loratadine but no dosage or frequency was documented. -Loratadine was not documented as administered from 11/01 to 11/27/16.	C 342		

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C 342	Continued From page 5 Observation of medications on hand for Resident #2 on 11/28/16 at 10:00 am revealed loratadine 10 mg bingo card with 31 tablets was dispensed on 4/04/16 with 19 doses remaining. Interviews on 11/28/16 at 2:10 pm with Resident #2 revealed: -The facility staff administered her medications. -She was ordered an allergy medication but had not "needed it recently". Interview on 11/28/16 at 10:20 am with the facility Manager revealed: -She had been the facility Manager for 15 years. -The Manager or the Medication Aide (MA) verified MARs for accuracy when they were received from the pharmacy before starting the next month's MARs. -"Loratadine is a prn medication that (Resident #2) takes only during the season changes. She has not requested it recently. I do not know why it fell off the MAR, because we do have the medication on hand." Interview on 11/28/16 at 10:30 with a MA revealed: -The Manager or a MA review the MARs for accuracy when they were received from the pharmacy before starting the next month's MARs. -Resident #2 had not requested loratadine recently. -She did not know why the loratadine was not on the October or November MARs. Telephone interview on 11/28/16 at 11:00 am with the facility's contract pharmacy revealed: -There was an active order for Loratadine 10 mg daily as needed for Resident #2. -They did not know why it was not printed on the	C 342		

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current MARs.
-There was a "do not fill until asked" note in their system dated 4/15/16.

Telephone interview on 11/28/16 at 1:45 pm with Resident #2's primary physician's office nurse revealed there was an active order in their files for Resident #2 to be given loratadine 10 mg daily as needed for allergies.
B. Review of Resident #3's current FL-2 dated 10/20/16 revealed the resident's diagnosis was unspecified schizophrenia.

1. Review of Resident #3's 10/20/16 FL-2 revealed a physician's order for metoprolol 50 mg tablets, give 2 tablets twice daily. (Metoprolol is used to lower blood pressure.)

Review of Resident #3's record revealed a physician's order dated 11/17/16 for metoprolol 50 mg twice daily.

Review of the handwritten October 2016 Medication Administration Record (MAR) revealed:
-An entry for Metoprolol 50 mg, two tablets was scheduled twice daily administration at 8:00 am and 8:00 pm.
-Metoprolol 50 mg, two tablets was documented as administered twice daily as scheduled on the MAR from 10/20/16 through 10/31/16.

Review of the handwritten November 2016 MAR revealed:
-An entry for Metoprolol 50 mg (not two tablets) was scheduled for administration at 8:00 am and 8:00 pm.
-There was not a new entry on the MAR to reflect the new order received on 11/17/16.
-Metoprolol 50 mg was documented as

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C 342	Continued From page 7 administered twice daily as scheduled on the MAR from 11/01/16 through 11/28/16. -There was no documentation Metoprolol 50 mg, two tablets was administered twice daily from 11/01/16 to 11/17/16 when the new order was received. Interview on 11/28/16 at 2:20 pm with the Medication Aide (MA) revealed: -She filled out the handwritten MAR for November 2016. -She routinely used the previous MAR and medication pharmacy labels as a guide to fill out new monthly MARs. -She was unsure why she did not include the metoprolol instructions to give two tablets twice daily when she completed the November MAR and "must have overlooked it". -The resident was previously on two tablets of metoprolol twice daily, but the dosage changed and he had recently been receiving one tablet twice daily. -The MA was not sure when the dosage changed from two tablets to one tablet. Interview on 11/28/16 at 2:12 pm with the facility Manager revealed: -She accompanied Resident #3 to the doctor's office on 11/17/16 and transcribed the new orders to the November 2016 MAR. -She did not transcribe a new entry for metoprolol to begin on 11/17/16 because the new order was the same as what was already on the MAR to be given. -She did not realize the new metoprolol order changed the resident's dosage from the previous order. -The physician did not discuss a change in the resident's metoprolol dosage and thought the physician mistakenly left off the instructions to	C 342		

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administer two tablets.
-She had not clarified the order with the physician but would do so today.
-There was a system in place whereby the MAs were supposed to compare MARs monthly to ensure accuracy, but the metoprolol dosage change must have been missed during the month-to-month comparison.

Interview on 11/28/16 at 1:15 pm with Resident #3 revealed:
-He relied on the staff to administer his medications as ordered by the physician.
-He was aware he took medication for his blood pressure, but was not aware the dosage had been changed.
-He had not experienced any problems with his medications and thought the facility administered his medications correctly.

2. Review of Resident #3's record revealed a physician's order dated 11/17/16 to start omeprazole 40 mg daily and docusate sodium 100 mg daily.

Review of the handwritten November 2016 Medication Administration Record (MAR) revealed:
-Entries for Omeprazole 40 mg and docusate sodium 100 mg scheduled for administration daily at 8:00 am.
-"New Order" was written across the section of the MAR designated for documenting administration of the medications.
-There was no documentation the omeprazole or docusate sodium was administered.

Review of Resident #3's medications on hand on 11/28/16 at 1:15 pm revealed:
-A bubble package of omeprazole 20 mg

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C 342	Continued From page 9 capsules, (two capsules per bubble) containing 22 capsules (11 doses) of 36 capsules (18 doses) dispensed on 11/18/16. -A bubble package of docusate sodium 100 mg gelcaps containing 17 gelcaps of 30 dispensed on 11/18/16. Interview on 11/28/16 at 2:20 pm with the Medication Aide (MA) revealed: -She had been administering the omeprazole and the docusate sodium as scheduled on the MAR. -She did not know why she had not been documenting the administration of the medications and must have "overlooked those two (medications)". Interview on 11/28/16 at 1:15 pm with Resident #3 revealed: -He relied on the staff to administer his medications as ordered by the physician. -He had not experienced any problems with his medications and thought the facility administered his medications correctly. -He was previously experiencing problems with nausea and constipation, but since he started taking the new medication (omeprazole and docusate sodium), he was feeling better and stated, "I'm getting well!"	C 342		