STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092140	A. BUILDING: _____ B. WING _____	R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WRENETTES PLACE	7029 SAN JAN HILL COURT RALEIGH, NC 27610

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on December 16, 2016 and December 21, 2016.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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, interviews and record reviews, the facility failed to assure that a blood pressure medication was administered as ordered by the licensed prescribing practitioner for 1 of 3 residents sampled (Resident #1). The findings are: Review of Resident #1's FL-2 dated 11/30/16 revealed: -Diagnoses included Crohns Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident, Hyperlipidemia, Mild Cognitive Impairment -Physician medication orders included Lisinopril (used to treat high blood pressure and heart disease) 10 milligrams (mg) ½ tablet by mouth daily. Review of a prior FL-2 written for Resident #1 dated 11/02/16 revealed an order for Lisinopril 5 mg ½ tablet daily.	C 330		

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C 330	Continued From page 1 Review of Resident #1's November 2016 Medication Administration Record (MAR) revealed: -There was a hand written entry on the MAR for Lisinopril 5 mg take ½ tablet by mouth every day. -The MAR showed documentation that Lisinopril 5 mg ½ tablet was administered every day at 8:00 A.M. from 11/19/16 to 11/30/16. Review of Resident #1's December 2016 MAR revealed: -There was a change in the medication order for Lisinopril on 12/5/16. -The new hand written entry on the MAR read Lisinopril 10 mg take 1 tablet by mouth daily. -From 12/6/16 to 12/21/16 Resident #1 was documented as being administered Lisinopril 10 mg daily at 8:00 A.M. Review of Resident #1's medication on hand revealed: -A bottle of medication labeled Lisinopril 5 mg take ½ tablet every day. -Another bottle of medication labeled Lisinopril 10 mg take ½ tablet every day. Interview with Resident #1 on 12/21/2016 at 5:30 P.M. revealed: -Resident did not know what medications he received in the mornings. -Medications were given to him by the Administrator each morning. -He denied any dizziness or being light headed. Interview with the Administrator on 12/21/16 at 7:00 P.M. revealed: -She was the "only one that deals with the medications". -She read the most recent order listed on the	C 330		

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C 330	Continued From page 2 FL-2 dated 11/30/2016 as Lisinopril 10 mg take 1 tablet by mouth daily instead of Lisinopril 10 mg ½ tablet. -She read the order incorrectly and transcribed to the MAR incorrectly. -She did not compare the directions on the bottle of Lisinopril 10 mg to the order written on the MAR. -She checked Resident #1's blood pressure with a manual blood pressure cuff and it read 125/77. -She called and spoke with the doctor on call concerning Resident #1 receiving the incorrect amount of Lisinopril since December 6, 2016. -She received instructions to start admininstering the correct dosage of Lisinopril 10 mg ½ tablet and checking Resident #1's blood pressure before administering Lisinopril. -She denied any concerns with Resident #1's blood pressure during the months of November and December 2016. -She would start reading both the directions on the MAR and on the medication bottle and call the doctor for clarification if they did not give the same directions. Physician was not available for interview.	C 330		