

Division of Health Service Regulation

PRINTED: 12/06/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL034015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/28/2016
NAME OF PROVIDER OR SUPPLIER PARKVIEW FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2778 REYNOLDS PARK ROAD WINSTON-SALEM, NC 27107			
(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 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			

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

62UK11

If continuation sheet 1 of 10

Renewed and accepted 1/30/17 PM

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STREET ADDRESS, CITY, STATE, ZIP CODE

PARKVIEW FAMILY CARE HOME

2778 REYNOLDS PARK ROAD
WINSTON-SALEM, NC 27107

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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 "transferrin deficiency" 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	Because residents are always accompanied to doctor's appts. by staff. Staff is aware of all medication changes + DC orders. To ensure that all medication changes + DC orders are related to the pharmacist. Staff will fax a copy of the medication change / DC order to the pharmacy. At that time staff will make a follow-up call to the pharmacy to further ensure the change was received by pharmacy staff. A log will be kept in each resident's chart listing any medication changes + date as a tracking tool. The goal is that at the time our Facility (FCH) receive a medication change from the physician that those changes will be related to the pharmacy (ASAP)	

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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	The med tech F/U by 1/1/17 The manager & med tech (Tangela Jones) will check mar's @ the beginning of every month to ensure all orders are properly transcribe for accuracy. After checking mar's if any orders are incorrect staff will contact the pharmacy to clarify the order and to get updated & correct Mar's if need be. Note: mar's are now being checked by both med techs to ensure accuracy.		

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C 342	Continued From page 3 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.	C 342	To eliminate the pharmacy sending electronic prescription Refill on DC'd meds. when the (FCH) staff receive a DC order The pharmacy will also receive a faxed copy of that order file by a phone call to ensure the order was was indeed received by the pharmacy.	11/1/17	

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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	#2 The med tech f/u by management will check All mar's at the beginning of each month for accuracy. The mar's, Doctor's orders & pill packs will all be compared to ensure all meds are listed on the mar's. At that time if any inconsistencies the pharmacy will be contacted to clarify any medication prescribed that is <u>not</u> listed on the mar's. Note: Both med techs will check the mar's for accuracy each month. And keep a monthly log of the dates we check mar's for accuracy and any inconsistencies found that we need to clarify. f/u on will also be documented on the monthly log to assure accountability	11/1/17	

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C 342	Continued From page 6 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	C 342		

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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	#3 After each scheduled Doctor's appts, Both med techs will check the Doctor's notes + orders to ensure to ensure that no medication changes is overlooked. After each scheduled appt. if there are medication changes they will be highlighted + Flagged in the chart. To ensure accuracy on the mar's Both med techs will check mar's @ the beginning of every month and if inconsistencies is found we will then contact the Pharmacy for clarification and get a correct mar's if need be. A log will be kept monthly stating the dates Both med techs ✓ the mar's. and if any inconsistencies →	1/1/17

Division of Health Service Regulation

STATE FORM

8529

62UK11

If continuation sheet 8 of 10

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C 342	Continued From page 8 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	C 342	found on the mark. The med techs will also document the inconsistencies to ensure we follow pharmacy. This will make med techs accountable while checking marks on a monthly basis. Also Both med techs will check Doctor's orders after each Doctor's appt to ensure no orders have been overlooked, and to ensure the marks reflect any changes the doctor have made if any. In addition a form will be created and put in each residents chart, to track any medication changes + dates ordered. Staff will have the Doctor document + sign + date the medication change	1/1/17

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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	The Mar's will be compared to the Doctor's orders + Bubble pill pack to ensure no medication is eliminated off the mar's. Again both Medtechs will check Mar's for accuracy. Previously only one checked Mar's. We check behind each other for Quality Control.	1/1/17