STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL024015	A. BUILDING: _____ B. WING _____	R 02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABOR COMMONS	703 ELIZABETH STREET TABOR CITY, NC 28463

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on February 8, 2017 through February 10, 2017.	{D 000}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the Primary Care Provider (PCP) was contacted for 1 of 5 sampled residents (#5) with unclear and incomplete orders for sliding scale insulin and that contact with the PCP was documented in the resident's record. The findings are: Review of Resident #5's current FL-2 dated 1/20/17 revealed: -Diagnoses included Hyperglycemia and Type II Diabetes Mellitus. -There was an order to check FSBS twice daily	D 344		

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and fax results to the Primary Care Provider (PCP) every week.

Review of a "Telephone Order Sheet" for Resident #5 dated 12/8/16 revealed:
-There was a "Clarification order for FSBS twice daily per sliding scale: Novolog 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, greater than 451 call MD if refuses insulin.
-The sheet was signed by the Primary Care Provider (PCP) and dated 12/9/16.

Review of Resident #5's December 2016 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for FSBS checks twice daily at 6:30am and 8pm.
-There were 40 results ranging from 77-542 from 12/1/16 through 12/31/16.
-There was an entry for Novolog with FSBS twice a day dose per sliding scale 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, greater than 451 call MD if refuses insulin.
-There were 21 FSBS results documented, where 19 were greater than 150, and of the 19 opportunities, there were 9 entries where staff initials were circled.
-There was a stop date of 12/22/16 at 4:00pm documented on the Novolog entry.
-There was documentation under "Exceptions" that the resident refused the Novolog on the 9 entries where staff initials were circled.

Review of the facility's copy of the "Fax Cover Sheet" for Resident #5 dated 12/22/16 revealed:
-There was a note documenting "Resident returning from the hospital today and here are D/C (discharge) papers and order changes."

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-There was a note documenting "Agree with meds (medication orders) from hospital and start sliding scale" signed by the PCP and dated 12/22/16.

Review of a "Fax Cover Sheet" from the facility received by the pharmacy for Resident #5 dated 12/22/16 revealed:
-There was a note documenting "Resident returning from the hospital today and here are D/C (discharge) papers and order changes."
-There were no other notations.

Review of hospital discharge instructions for Resident #5 dated 12/22/16 revealed there was no order for Novolog sliding scale insulin (SSI) documented under "Continue Taking These Home Medications," "Start Taking These Medications" or "Stop Taking These Medications."

Review of a "Telephone Order Sheet" for Resident #5 dated 1/17/17 revealed there was a note documenting "Order for second time; send sliding scale on file for everyone," signed by the PCP and dated 1/17/17.

Review of Resident #5's January 2017 eMAR revealed:
-There was no entry for SSI.
-There was an entry for FSBS checks twice daily at 6:30am and 8pm.
-There were 35 results greater than 300 from 1/1/17 through 1/31/17.

Review of Resident #5's February 2017 eMAR revealed:
-There was no entry for SSI.
-There was an entry for FSBS checks twice daily at 6:30am and 8pm.
-There were 11 results ranging greater than 300

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D 344	Continued From page 3 from 2/1/17 through 2/8/17. Review of a copy of Resident #5's PCP's standing sliding scale orders documented on a "Telephone Order Sheet" revealed: -There were typed entries for "Standing orders for Novolin R Sliding Scale: Activate order if FSBS is above 300; 301-350 = 6 units, 351-400 = 8 units, 401 and above = 10 units recheck in 30 minutes and notify MD if FSBS has not decreased." (Novolin is a fast acting insulin used to regulate blood sugar levels.) -There was no date or PCP signature. Further review of Resident #5's January and February 2017 eMARs revealed there were 25 FSBS results greater than 300 between 1/18/17 and 2/8/17, for example 516 on 1/21/17 at 6:30am, 591 on 1/21/17 at 8pm, 596 on 1/26/17 at 8pm, 500 on 2/2/17, 437 on 2/6/17 at 6:30am and 563 on 2/7/17 at 8pm. Interview with Resident #5 on 2/9/17 at 4:37pm revealed: -He sometimes told the staff he did not want to take insulin because his sugar would drop too low. -His sugar did not bother him when it was high, but it bothered him when it was low. -The last time he had a shot of insulin was yesterday sometime in the morning and it made his sugar drop "real low" last night. -When his blood sugar was high the staff would give him a shot or tell him to drink a lot of water. Review of "Charting Notes" dated 12/13/16 through 2/8/17 for Resident #5 revealed: -On 1/16/17 at 10:01pm a Medication Aide (MA) documented "Blood sugar Hi, gave two 6 ounce cups of water at 10pm still Hi, gave 12 ounce cup	D 344		

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of water. Will continue to monitor until it comes down."
-On 1/16/17 at 11:31pm a MA documented "Rechecked resident's blood sugar, still registering High. Resident refused to be sent out and asked for a 12 ounce cup of water."
-On 1/17/17 at 1:33am a MA documented "Rechecked resident's blood sugar at 1:30am, it registered 440. He said he felt fine and did not want to be sent out and that his blood sugar would continue to drop."
-On 1/21/17 at 11:12pm a MA documented "Rechecked resident's blood sugar, it was 490. Gave resident water to drink because he refused to be sent out at 11:10pm."
-On 1/23/17 at 2:46am a MA documented "Resident said he felt bad, checked blood sugar, it was 490. He said he was hot, turned fans on and gave a cup of ice water."
-On 1/30/17 at 4:08pm the Resident Care Coordinator (RCC) documented "Printed out a copy of MARs with his blood sugars recorded on them and I faxed a copy to [name of PCP] medical doctor and a copy to [name of endocrinologist]. Also spoke with his Hospice nurse about his blood sugars being high and she agreed to faxing both doctors to let them be aware of his blood sugars. [Name of PCP] sent back changes on his medications and I faxed them to [name of endocrinologist] and made a copy for his Hospice nurse."

Interview with a MA on 2/10/17 at 11:01am and 12:36pm revealed:
-The MAs were only responsible for changes in orders like telephone orders or "FYI's;" an FYI was a note of concern or a question faxed to the PCP.
-Pending responses from the PCP were communicated verbally at change of shift to the

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oncoming MA and also documented in the electronic charting notes.
-All telephone orders and PCP responses were left on the RCC desk for review.
-Orders coming directly from the primary care provider like the order on 1/17/17 to start sliding scale for Resident #5 would go to the RCC, "she is the one that does the orders."
-The facility process was to contact the MD or send the resident out to the emergency room (ER) for blood sugars less than 50 or greater than 350.
-Resident #5 was "very particular about insulin because his blood sugar was either uncontrollably high or really low; he was better with high blood sugars than low because he got really lethargic when his blood sugar was low."
-When Resident #5 had high blood sugars he would usually refuse to be sent out to the ER so staff would recheck the FSBS in 30 minutes to see if it came down.
-He refused his insulin "all the time" and that was the reason for the Hospice referral.

Interview with the RCC on 2/10/17 at 11:23am revealed:
-There was a standing sliding scale on file in the facility for [name of Resident #5's PCP]. I it needed to be updated and had not been faxed to the pharmacy or PCP for Resident #5.
-The facility's process for high blood sugars was for the MA to notify the PCP and get orders.
-The facility notified the PCP for blood sugars less than 50 or greater than 350, unless there were other parameters written by the PCP.
-Resident #5 frequently had high and low blood sugars and frequently refused insulins so a lot of times the MAs would send a telephone order sheet to the PCP to let her know he had a high blood sugar and then came back down.

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-The high and low blood sugars with frequent insulin refusals was one of the reasons Resident #5 was referred to Hospice.
-The MAs, Administrator, Office Manager and RCC would all fax orders to the pharmacy.
-There was a confirmation sheet for all faxes sent.
-All faxes and confirmation sheets were put on the RCC's desk until the RCC verified that pharmacy had entered all orders.
-Faxing and verifying orders was "primarily" the RCC's responsibilities.
-A copy of all orders was also placed in the medication room so that the MAs would know when the medication came in from the pharmacy.
-Once the order was verified in the computer system by the RCC, the original order was filed in the resident record.

Telephone interview with the facility's contracted Pharmacy; Pharmacy Technician on 2/9/27 at 3:17pm revealed:
-The last order for Novolog was dated 11/21/16.
-The Novolog SS was discontinued on 12/22/16, because it was not listed on the hospital discharge orders.
-When a resident returned from the hospital all medications were "cut from the profile and rekeyed based on the hospital discharge orders."

Review of a "Telephone Order Sheet" for Resident #5 dated 2/9/17 revealed:
-There was a "Clarification on order from 12/22/16 when he [Resident #5] returned from the hospital for sliding scale. He had no orders for sliding scale on hospital orders and you agreed with continue hospital order, but on fax cover sheet was wrote start sliding scale, but no order was sent. Did you want to D/C sliding scale?"
-There was a note documenting "No need, on

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Hospice?? No need for sliding scale," signed by the PCP and dated 2/9/17.
-The sheet documented a fax date of 2/9/17 and time of 2:17pm.

Review of a "Telephone Order Sheet" for Resident #5 dated 2/9/17 revealed:
-There was a "Clarification on V/O (verbal order) given 12/22/16 [name of PCP] gave V/O on 12/22/16 to D/C (discontinue) sliding scale order. Can't find original V/O. Sliding scale was D/C'd on 12/22/16 per V/O."
-The sheet was signed by the PCP and dated 2/10/17.
-The sheet documented a fax date of 2/9/17 and time of 3:24pm.

Review of a "Telephone Order Sheet" for Resident #5 dated 2/9/17 revealed:
-There was a "Clarification on sliding scale, MD gave V/O on 12/22/16 to D/C standing order sliding scale unless MD notify and requested to start again due to refusals."
-The sheet was signed by the PCP and dated 2/10/17.
-The sheet documented a fax date of 2/10/17 and time of 10:45am.

Review of a "Telephone Order Sheet" for Resident #5 dated 2/10/17 revealed:
-There was a note documenting "Discussed with [name of PCP] verbally on 1/17/17 on starting sliding scale standing order again and resident said no that he would refuse it. [Name of PCP] verbally agreed to not start standing order sliding scale."
- There was a note documenting "Agree. Patient noncompliant and well documented refusals, knows he could hasten death and agreed to Hospice. Patient very noncompliant and will

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always continue to (word illegible) compliance with staff on all my visits. I know of all refusals before and after hospitalizations and his severe noncompliance and he has signed knowing refusing any insulin etc. could lead to death," signed by the PCP and dated 2/10/17.
-The sheet documented a fax date of 2/10/17 and time of 12:28pm.

Interview with the RCC on 2/10/17 at 1:07pm and 1:50pm revealed:
-She had understood the 12/22/16 order to mean the standard SS the PCP put in place for all diabetic residents.
-She had spoken with the PCP for Resident #5 regarding the order to start SSI dated 12/22/16.
-She had reported to the PCP that she had spoken with Resident #5 and he said he wouldn't take the insulin.
-The PCP then gave a verbal order to not start the SSI which the RCC did write on the telephone order sheet, but could not find so she completed the clarification request dated 2/9/17.
-The order dated 1/17/17 meant to fax the standing order sheet to the pharmacy for Resident #5.
-The SSI was not started after the 1/17/17 order because the resident refused it and the PCP was contacted and gave a verbal order not to start the SSI.
-Resident #5 refused insulin because it would "bottom out" his blood sugar.
-The documentation for the refusals between 12/22/16 and 2/8/17 may have been missed.

Review of an untitled document from the Hospice provider for Resident #5 dated 2/1/17 revealed:
-Resident #5 was admitted for Hospice services on 1/23/17.
-Diagnoses included Severe Protein Malnutrition,

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D 344	Continued From page 9 Disorder of the Pancreas, Bipolar Affective Disorder, Anemia, Atrial Fibrillation, Type II Diabetes Mellitus, Hypothyroidism and Dementia. Interview with the RCC on 2/10/17 at 2:50pm revealed: -She was not sure why she sent the three clarification requests on 2/9/17 for the 12/22/16 SSI order. -"I contradicted myself." -She was trying to make sure things were done correctly and everything was in order. -She did speak with the PCP the day Resident #5 was discharged from the hospital and did receive orders to stop the SSI. Written response faxed from the PCP on 2/10/17 for Resident #5 revealed: -The SS ordered 12/22/16 meant the regular insulin SS standing order on file at the facility. -Not having insulin administered for frequent FSBS results of 300-500 could cause death and Resident #5 knew that and still refused insulin on several occasions. Interview with the Administrator on 2/10/17 at 2:03pm revealed: -The order dated 12/22/16 was clear in that it meant the PCP agreed with the discharge orders and wanted to start SSI. -It appeared as if previously documented verbal orders to clarify the SSI had been misplaced. -It was possible that something may have been overlooked. -The Administrator, support nurse and systems were available and in place to assist with checking and double checking the order and medication processes. -Staff were expected to recheck high blood sugars (ex. over 450). The resident would usually	D 344		

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D 344	Continued From page 10 ask for a large cup of water and his blood sugar would usually come down. -If his blood sugar did not come down, staff were supposed to send him out, but a lot of times he would refuse to be sent out.	D 344		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure medications were administered as ordered by the prescribing practitioner for 2 of 5 residents (Residents #4 and #5) sampled with physician orders for a medication used to treat diabetes (#4), a vitamin supplement (#4) and a medication used to treat high blood pressure (#5). The findings are: 1. Review of Resident #4's current FL-2 dated 07/13/2016 revealed diagnoses included diabetes, hypertension, dementia, gastro-esophageal reflux disease, and mild mental retardation. a. Review of physician's orders for Resident #4 revealed a physician's order dated 01/30/2017 for	{D 358}		

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{D 358}	Continued From page 11 Farxiga (a medication used to treat diabetes) 10mg tablet daily. Review of the January 2017 and February 2017 electronic Medication Administration Records (eMARs) for Resident #4 revealed: -There were no printed instructions to the eMARs for Farxiga. -There was no documentation of administration for the Farxiga medication. Observation of the medications on hand on 02/09/2017 revealed there was no Farxiga on hand for Resident #4. Interview with Resident #4 on 02/09/2017 at 11:00am revealed: -She did not know about medications prescribed for her. -She did not believe she took any medications. -Her finger stick blood sugar was checked "2 or 3" times a day by different staff. Interview with the Resident Care Coordinator (RCC) on 02/09/2017 at 11:30am revealed: -She had contacted the pharmacy provider today (02/09/2017) to inquire about the Farxiga order. -The Farxiga medication needed a prior authorization from the insurance carrier. -She received the prior authorization form from the pharmacy on 02/09/2017 and had faxed the form to the physician to request the prior authorization. -She contacted the pharmacy about the Farxiga after it had been bought to her attention that the Farxiga was not on hand or listed on Resident #4's MARs. -She usually checked new physician orders every day. -She made a copy of all new orders and put them	{D 358}		

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in the medication room so the Medication Aides (MAs) could check off when the medication was delivered.
-The Medication Aides (MAs) also checked the new orders and medications at night and were supposed to leave the RCC a note to follow up when a medication was not received in the facility.
-She did not know why she had not gotten to follow up on the Farxiga until today (02/09/2017).
-She thought she would have found the Farxiga order "probably this week" when chart audits would have been done.

Interview with the Administrator on 02/09/2017 at 11:50am revealed:
-The RCC performed chart audits but not on a regular basis.
-The RCC reviewed physician orders monthly to compare medication orders for the current month with the previous month.

Interview with the Pharmacy Provider Representative on 02/09/2017 at 12:15pm revealed:
-The original order for Farxiga was dated 01/30/2017.
-The pharmacy received a copy of the order by fax on 02/09/2017.
-A prior authorization was needed for payment from the resident's insurance provider.
-The pharmacy had also received an order at 11:40am on 02/09/2017 to discontinue the Farxiga order.

Interview with the Primary Care Provider (PCP) on 02/09/2017 at 12:45pm revealed:
-She added the Farxiga trying to get Resident #4's diabetes under control.
-There was no effect to the resident by the

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medication not being administered.
-She discontinued the Farxiga.

Interview with the MA on 02/10/2017 at 12:30pm revealed:
-She went by the eMAR to determine what medications to administer to residents.
-She could not administer a medication to a resident if the medication was not on the eMAR.
-She would check with the RCC if there was a question about a medication.

Interview with a second MA on 02/10/2017 at 12:45pm revealed:
-She administered medication according to the eMARs.
-Sometimes she would check an order in a resident's record and discuss it with the RCC if she did not understand the order.
-New medication orders were faxed to the pharmacy by the MA's, RCC, and Administrator.
-Most of the time the pharmacy would input new orders to the eMARs.
-She had input new orders to the eMARs when she worked on the weekend if the medication order was new and the medication was something the resident needed to be started on.

b. Review of a laboratory report dated 09/15/2016 for Resident #4 revealed:
-A laboratory result for Vitamin D1 of 21.8 (normal reference range for Vitamin D is 30 -100).
-Documentation of physician review on 09/16/2016 of "ok".
-There was a physician's order for Vitamin D (dietary supplement) 50,000 unit tablet every week written on the 09/15/2016 laboratory report.
-Handwritten instructions to "recheck 4 months".

Review of a laboratory report dated 01/27/2017

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{D 358}	Continued From page 14 for Resident #4 revealed: -A Vitamin D1 result of 17.0. -Documentation of physician review on 01/30/2017 of "ok". -Handwritten instructions to "recheck 4 months". Review of the December 2016, January 2017, and February 2017 electronic Medication Administration Records (eMARs) for Resident #4 revealed: -There were no printed instructions to the eMARs for Vitamin D. -There was no documentation of administration for the Vitamin D medication. Observation of the medications on hand on 02/09/2017 revealed there was no Vitamin D on hand for Resident #4. Interview with Resident #4 on 02/09/2017 at 11:00am revealed: -She did not know about medications prescribed for her. -She did not believe she took medication. -She had fallen in the dining room "a couple weeks ago, slipped on some food on the floor." The resident denied injuries from the fall. Interview with the Resident Care Coordinator (RCC) on 02/09/2017 at 10:25am revealed: -The Vitamin D order dated 09/16/2016 "was not caught on our end or pharmacy." -She had completed a medication error report for the Vitamin D today (02/09/2017) and called the physician. -The physician gave an order to start the Vitamin D now on Friday's. Interview with the Administrator on 02/09/2017 at 11:25am revealed:	{D 358}		

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{D 358}	Continued From page 15 -The physician visited the facility every week. -The physician reviewed the resident's medications. -The physician had reviewed the Vitamin D1 laboratory results for 01/30/2017 and did not order anything. Interview with the Resident Care Coordinator (RCC) on 02/09/2017 at 11:30am revealed: -She usually checked new physician orders every day. -She made a copy of all new orders and put them in the medication room so the Medication Aides (MAs) could check off when the medication was delivered. -The Medication Aides (MAs) also checked the new orders and medications at night and were supposed to leave the RCC a note to follow up when a medication was not received in the facility. Interview with the Administrator on 02/09/2017 at 11:50am revealed: -The RCC performed chart audits but not on a regular basis. -The RCC reviewed physician orders monthly to compare medication orders for the current month with the previous month. Interview with the Pharmacy Provider Representative on 02/09/2017 at 12:10pm revealed: -The pharmacy received a faxed copy of a clarification order dated 02/09/2017 for the Vitamin D 50,000 unit tablet weekly order originally dated 09/16/2016. -There was an "oversight" of the 09/16/2016 order for Vitamin D 50,000 units weekly, and Vitamin D was not started. -The pharmacy received a faxed copy of the	{D 358}		

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{D 358}	Continued From page 16 09/16/2016 Vitamin D order on 02/08/2017 at 5:01pm after they had left the pharmacy. -The pharmacy did not get the September 2016 original order for Vitamin D. Interview with the Pharmacist on 02/09/2017 at 12:20pm revealed: -It did not appear there had been any negative outcome to Resident #4 not having the Vitamin D administered. -Resident #4 probably should have been getting the Vitamin D because of the fact that the Vitamin D level for Resident #4 went down. -A delay in treatment of a low Vitamin D level has the potential for bones to break. -A lot of people walked around with low Vitamin D. Interview with the Primary Care Provider (PCP) on 02/09/2017 at 12:45pm revealed: -The PCP was made aware that the Vitamin D had not been administered "after the fact". -The PCP received a copy of a medication error regarding the Vitamin D on 02/08/2017 and had responded to the facility. -Resident #4 needed the Vitamin D because of a Vitamin D deficiency. -There had not been any effect to the resident by the medication not being administered. Interview with a Medication Aide (MA) on 02/09/2017 at 10:40am revealed: -She would administer the Vitamin D on days it popped up on the eMAR for administration. -She did not remember administering Vitamin D to Resident #4. -Instructions for administration of the Vitamin D had been added to the eMAR with an original date of 02/09/2017.	{D 358}		

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{D 358}	Continued From page 17 Interview with the MA on 02/10/2017 at 12:30pm revealed: -She went by the eMAR to determine what medications to administer to residents. -She could not administer a medication to a resident if the medication was not on the eMAR. -She would check with the RCC if there was a question about a medication. Interview with a second MA on 02/10/2017 at 12:45pm revealed: -She administered medication according to the eMARs. -Sometimes she would check an order in a resident's record and discuss it with the RCC if she did not understand the order. -New medication orders were faxed to the pharmacy by the MA's, RCC, and Administrator. -Most of the time the pharmacy would input new orders to the eMARs. -She had input new orders to the eMARs when she worked on the weekend if the medication order was new and the medication was something the resident needed to be started on. 2. Review of Resident #5's current FL-2 dated 1/20/17 revealed diagnoses included Chest Pain, Hypertension, Myocardial Infarction and Atrial Fibrillation. Review of a "Physician's Orders" form for Resident #5 signed by the Primary Care Provider (PCP) and dated 12/1/16 revealed there was an order for Carvedilol 3.125mg twice daily; hold if systolic blood pressure (SBP) less than 120 or heart rate (HR) less than 60. (Carvedilol is a beta blocker used to treat heart failure and high blood pressure.) Review of hospital discharge instructions for	{D 358}		

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{D 358}	Continued From page 18 Resident #5 dated 12/22/16 revealed there was an order to stop taking Carvedilol 3.125mg twice daily documented under "Stop Taking These Home Medications." Review of Resident #5's December 2016 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Carvedilol 3.125mg twice daily at 8am and 6pm. -There were four entries from 12/14/16 through 12/16/16, where the SBP was documented as less than 120. -On 12/14/16 at 8am the SBP was documented as 114, on 12/15/16 at 8am the SBP was documented as 102, on 12/16/16 at 8am the SBP was 108, and on 12/16/16 at 6pm the SBP was documented as 104. -There were staff initials entered for 12/14/16 through 12/16/16. -There was a note documenting "Held, BP low" under "Pass Notes" for 12/16/16 at 6:36pm. -There were no "Pass Notes" or "Exceptions" documented for the 8am doses 12/14/16 through 12/16/16. -There was a stop date of 12/22/16 at 4:00pm documented on the Carvedilol entry. Interview with a Medication Aide (MA) on 2/9/17 at 1:20pm revealed: -The 8am dose of Carvedilol was not given on 12/14/16 when the resident's SBP was 114. -She normally documented in electronic charting notes. -She was not able to pull up the note where she documented not giving the dose. -She did not have a response for if there were staff initials documented that were not circled, how would it be documented that the dose was not given.	{D 358}		

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{D 358}	Continued From page 19 -She could not say if all MA's documented medications that were not given the same way. Interview with the Resident Care Coordinator (RCC) on 2/9/17 at 1:25pm revealed she would have to look at the charting notes in the system because the MA entered "Late entry" and she did not know if that meant the MA gave it or not. Interview with a second MA on 2/10/17 at 11:01am revealed: -The initials documented on 12/16/16 for 8am dose of Carvedilol were the MA's initials. -It looked like the dose should have been held because his [Resident #5] blood pressure was down. -It looked like she made "a computer error" and did not mark it as withheld. -Usually she would click on the "exceptions" box and click on "withheld per MD order" if a medication was withheld. The MA who entered initials for the 12/15/16 8am dose was not available for interview. Interview with the RCC on 2/10/17 at 11:23am revealed: -The MAs were responsible for checking blood pressures right before giving the medications with those parameters. -When a medication was not administered, the MA electronically clicked on the medication which opened a screen with a drop down box labeled "exceptions." -The MA could electronically click on the exceptions box and choose options to document why a medication was not given like refused, withheld per MD order and unable to take. -There was also a "plus sign" next to the "exceptions" box that staff could electronically	{D 358}		

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click on and enter a specific narrative note of why a medication was not given like "BP was low, medication not given"
-She had talked to all the MAs about documenting medications properly and entering notes.
-She thought that completing the exceptions documentation for medications would create the circled initials on the eMAR indicating a medication was not given.
-If there was a blank box on the eMAR, then there should have been a note on the last pages of the eMAR.

Telephone interview with the PCP on 2/9/17 at 12:55pm revealed:
-She would have been aware of Resident #5 receiving Carvedilol on three occasions with a SBP of 102-114 if there was a medication error form signed and dated by her.
-All of the cardiac patients had parameters on blood pressure lowering medications.
-SBPs from 100-120 were "not so bad" and there would be a concern for hypotension if the resident's SBP was less than 100.
-"You don't want hypotension with a diabetic."

Interview with the Administrator on 2/9/17 at 1:25pm revealed the Carvedilol should not have been given if the SBP was less than 120.

Review of a "Telephone Order Sheet" for Resident #5 dated 2/9/17 revealed:
-There was a note documenting "Resident had a order for Coreg (Carvedilol) 3.125mg take one tablet by mouth twice a day, hold if systolic blood pressure less than 120 or HR less than 60. This order was discontinued on 12/22/16. Please see where medication was given on 12/16/16 at 10:07am, 12/15/16 at 9:38am and 12/14/16 at

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{D 358}	Continued From page 21 9:27am. We just want to make sure you are aware." -There was a note documenting "Likely made aware at visit to facility and this is fine," signed by the PCP and dated 2/9/17.	{D 358}		