STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060082	A. BUILDING: _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF LITTLE AVENUE	7745 LITTLE AVENUE CHARLOTTE, NC 28226

(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 and the Mecklenburg County Department of Social Services conducted an annual survey on February 15, 2017 and February 16, 2017.	D 000		
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 reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents with physician's orders for vitamin D3 (Resident #1), and aspirin, hydralazine, senna, Tylenol, and saline nasal spray (Resident #3). The findings are: A. Review of Resident #1's current FL 2 dated 12/28/16 revealed: -Diagnoses included stage 3 chronic kidney disease, carotid artery stenosis, cardiac ischemia, hypertension, and history of gastro-esophageal ulcer bleed. -A physician's order for vitamin D3 (a supplement used for Vitamin D deficiency) 50,000 units every 3 weeks.	D 358		

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D 358	Continued From page 1 Review of Resident #1's Resident Register revealed an admission date of 8/08/16. Review of a physician's order dated 1/9/17 for Resident #1 revealed: -A physician's order to "discontinue the current vitamin D order". -A physician's order for "vitamin D2 50,000 units every month after dinner for 12 months, then stop". Review of Resident #1's record revealed no Vitamin D lab results. Review of Resident' #1's December 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for Vitamin D2 50,000 units every week for 3 months and scheduled at 8:00 am weekly with a discontinued date of 12/27/16. -Vitamin D2 50,000 units was documented as administered weekly at 8:00 am on 12/01, 12/08, and 12/15/16, with a notation on 12/22/16 the medication was not administered as "Resident (#1) was sent out to Emergency Room (ER)". Review of Resident #1's January 2017 eMAR revealed: -An entry for Vitamin D2 50,000 units every month after dinner for 12 months and scheduled at 5:30 pm., but there was no date specified for the medication to be administered. -There was no documentation Vitamin D2 50,000 units was administered from 1/01/17 to 1/31/17. Review of Resident #1's February 2017 eMAR on 2/15/17 revealed: -An entry for Vitamin D2 50,000 units every month after dinner for 12 months and scheduled	D 358		

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D 358	Continued From page 2 at 5:30 pm, but there was no date specified for the medication to be administered. -There was no documentation that Vitamin D 50,000 units was administered from 2/1/17 to 2/15/17. Interviews on 2/15/17 at 3:15 pm and 2/16/17 at 12:00 pm with the Resident Services Director (RSD) revealed: -"We see only the transcribed order, not the dates to be administered" when pending orders were reviewed in the eMAR. -She was not aware she could see the input data, and was not aware a date of administration was not selected. -The Vitamin D2 50,000 units was in the eMAR system, and it appeared the text entry was correct for monthly, but the order was "inputted for every 2 months", and no date was specified for the medication to be administered. -She was not aware Resident #1's Vitamin D2 was not administered monthly as ordered. Review of Resident #1's eMAR order in the eMAR system for Vitamin D2 with the RSD and a Medication Aide (MA) on 2/15/17 at 3:15 pm revealed an entry dated 1/10/17 for Vitamin D2 50,000 units was to be administered monthly per the text entry area, but the input area specified it was to be administered every 2 months per the drop down box selections. There was no start date specified. There was no prompt for the facility to enter a date or contact the pharmacy to enter a date for the medication to be administered on. The medication was not administered as the data was inputted for every 2 months. Review of medications on hand on 2/15/17 at 4:30 pm for Resident #1 revealed a Vitamin D2	D 358		

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bingo card with one tablet and labeled to be administered every month after dinner with a dispensed date of 2/06/17.

Interviews on 2/15/17 at 3:25 pm and 4:30 pm with a MA revealed:
-When a medication was due for administration, the medication order appeared in a box, but did not appear in a monthly eMAR format, so she would not be aware that a medication was X'd out for the entire month as it was on the printed eMAR copy.
-She was not aware Resident #1's Vitamin D was not administered monthly as ordered.
-She was aware the Vitamin D was on the medication cart, but thought it was administered on a day when she did not work.

Telephone interview on 2/15/17 at 3:50 pm with the facility's contracted pharmacy revealed:
-The active order for Resident #1's Vitamin D2 50,000 units was every month after dinner for 12 months and was dated 1/09/17. The administration time was scheduled for 5:30 pm. No start date was specified as the pharmacy did not know when the facility wanted to administer the medication.
-The representative did not understand that the input data in the facility's eMAR system showed it was entered as every 2 months although the text data was correct. She did not understand what was being asked, and there was no one else available to come to the telephone.
-The facility should have contacted the pharmacy and selected a date for the Vitamin D2 to be administered.
-One tablet of Vitamin D 50,000 units was last dispensed on 2/06/17 for Resident #1.

Interview on 2/16/17 at 8:30 am with Resident #1

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D 358	Continued From page 4 revealed he was not aware how often he was ordered Vitamin D, when he last received it, or if he had missed any doses. Interview on 2/16/17 at 10:35 am with the Wellness Nurse (WN) revealed: -Resident #1's Vitamin D2 order would first show as a pending order with the text only and a start and end date. "We did not see boxes, or a date to start a medication". -She had not noticed Vitamin D2 was not administered to Resident #1 since the order changed at the end of December 2016. Review of Resident #1's eMAR order on 2/16/17 at 11:30 am with two first shift MAs revealed Resident #1's Vitamin D2 was still in the eMAR system as monthly for the text information, but "every 2 months" for the input data frequency. Attempted telephone interview on 2/16/17 at 11:50 am with Resident #1's physician was not successful. Interview on 2/16/17 at 12:00 pm with the Administrator revealed: -She was not aware Resident #1 had not received Vitamin D2 monthly as ordered. Refer to interviews on 2/15/17 at 3:15 pm and 2/16/17 at 12:00 pm with the RSD. Refer to interviews on 2/15/17 at 3:25 pm and 4:30 pm with a MA. Refer to interview on 2/16/17 at 10:35 am with the WN. Refer to interview on 2/16/17 at 11:30 am with two first shift MAs.	D 358		

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D 358	Continued From page 5 Refer to interview on 2/16/17 at 12:00 pm with the Administrator. B. Review of Resident #3's current FL 2 dated 1/25/17 revealed: -Diagnoses included congestive heart failure (CHF) and diabetes type 2. -Documentation the resident had intermittent confusion. -A physician's order for Aspirin (a blood thinner and nonsteroidal anti-inflammatory drug that can be used to reduce the risk of heart disease) 81 mg daily. -A physician's order for hydralazine (used to treat high blood pressure) 25 mg every 8 hours and hold for systolic blood pressure (BP) less than 95. -A physician's order for saline nasal spray (used to soothe dry nasal passages) 1 spray in both nostrils daily. -A physician's order for "senna (a laxative used to treat constipation) 8.6 mg x2 tablets twice a day". -A physician's order for "Tylenol (used to treat minor aches and pain) 500 mg x2 tablets daily". Review of Resident #3's Resident Register revealed an admission date of 2/10/17. Review of Resident #3's record revealed: -A physician's order dated 2/08/17 for aspirin 81 mg twice a day. -A physician's order dated 2/08/17 for hydralazine 25 mg daily. No BP parameters to hold the medication were specified. -A physician's order dated 2/08/17 for nasal spray 0.65 %, 1 spray in both nostrils at bedtime. -A physician's order dated 2/08/17 for senna-s 8.6-50 mg 1 tablet, twice a day. -A physician's order dated 2/08/17 for Tylenol 500 mg twice a day.	D 358		

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D 358	Continued From page 6 Review of Resident #3's February 2017 electronic Medication Administration Record (eMAR) revealed: -An entry dated for aspirin 81 mg daily and documented as administered daily at 9:00 am from 2/12/17 to 2/15/17. The current order dated 2/08/17 was for aspirin 81 mg twice a day.) -An entry dated for hydralazine 25 mg every 8 hours, hold if systolic BP was less than 95 and scheduled to be administered at 9:00 am, 3:00 pm and 9:00 pm. Hydralazine was documented as administered every 8 hours from 2/11/17 to 2/15/17. BP results were posted and ranged from 113/61 to 131/88. The current order dated 2/08/17 was for hydrazine 25 mg daily. -An entry dated for nasal spray 1 spray in both nostrils daily, scheduled for 9:00 am, and documented as administered daily at 9:00 am from 2/12/17 to 2/15/17. The order was for nasal spray to be administered at bedtime. -An entry dated for senna 2 tablets twice a day and documented as administered at 9:00 am and 9:00 pm from 2/11/17 to 2/15/17. The current order dated 2/08/17 was for senna 8.6-50 mg 1 tablet twice a day. -An entry dated for Tylenol 500 mg 2 tablets daily and documented as administered daily at 9:00 am from 2/12/17 to 2/15/17. The current order dated 2/08/17 was for Tylenol 500 mg 1 tablet twice a day. Review of medications on hand on 2/15/17 at 4:30 pm and available to be administered to Resident #1 revealed: -Aspirin 81 mg labeled correctly to be administered twice a day with 30 tablets dispensed on 1/12/17. -Hydralazine 25 mg was labeled to be administered every 8 hours with 30 tablets	D 358		

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dispensed on 1/12/17.
-Nasal Spray labeled with Resident #3's name, and with a current expiration date that was approximately 75% full.
-Senna 8.6 mg was labeled to be administered 2 tablets twice a day. There were 4 bingo cards on the cart, with the most recent dispense date of 2/05/17.
-Tylenol 500 mg was labeled correctly to be administered 1 tablet twice a day with 30 tablets dispensed on 2/07/17.

Interview on 2/15/17 at 2:15 pm with the Resident Services Director (RSD) revealed:
-The facility had recently experienced server connection issues with their eMAR system. When the system was down the staff was still able to document medications as administered in the eMAR. That documentation was to cross over when the system was re-connected to the server.
-The server issues covered the date Resident #3 moved in on 2/10/17.
-She was not aware that there were issues with Resident #3's orders and eMAR not matching.

Telephone interview on 2/15/17 at 3:50 pm with the facility's contracted pharmacy revealed:
-Resident #3 had active orders dated 2/09/17 but were received on 2/10/17 (when the pharmacy opened) for Aspirin, Dulcolax, hydralazine, nasal spray, senna and Tylenol.
-The active order dated 2/09/17 for aspirin 81 mg was 1 tablet twice a day, with 60 tablets dispensed on 10/18/16, and 30 tablets dispensed on 1/12/17.
-The active order dated 2/09/17 for hydralazine 25 mg was for daily, with 30 tablets dispensed on 1/12/17. No BP parameters were specified, but "if the parameters were listed previously, I usually leave them unless they were ordered to be

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D 358	Continued From page 8 stopped or changed". -The active order dated 2/09/17 for saline nasal spray was 1 spray at bedtime. -The active order dated 2/09/17 for senna was 1 tablet twice a day. On 9/30/16, 60 tablets were dispensed when it was an as needed order. -The active order dated 2/09/17 for Tylenol 500 mg was one tablet twice a day, with 30 tablets dispensed on 2/07/17. -The facility entered temporary orders into the system if the order was received after hours. The pharmacy entered the official orders during business hours. The facility was to verify that the entry was correct before administering medications. -He was not aware why the current orders did not match in the facility's eMAR system and said a different department managed the eMAR server system issues. Interview on 2/16/17 at 9:20 am with Resident #3 revealed: -She was not aware what medications she was ordered, or when they were to be administered. -She was aware the staff monitored her BP since she was on a BP medication, but could not name the medication. -"I'm 101 years old, I don't remember everything anymore." Interview on 2/16/17 at 9:30 am with Resident #3's family member revealed: -He was also a resident at the facility, but was not a part of the physician decisions regarding Resident #3. The resident "does all that for herself." -He was not aware what medications Resident #3 was on, but "she says her BP was stable". Interview on 2/16/17 at 10:00 am with the facility's	D 358		

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D 358	Continued From page 9 contracted eMAR company's representative revealed: -The facility had "lots of communications problems with the server, so the system was way backed up". It had been happening on and off 6 days ago and lasted 4 days. They are still transferring data." -"The records get cued up to the server, and if there was a large number of data records to load, then it takes awhile to sync up." It could be the facilities internet connection slowing things down, but he was not sure. -The staff could still document on the eMAR when the system was down, and it would still show the exact times a medication was given. -The pharmacy entered the orders into whatever system the pharmacy had, and "it interfaces with our system and floats to the facility". -"The facility had entered 'temporary orders' for Resident #3 because of server issues the past few days. The temporary orders last for 3 days but can be re-issued." -He showed temporary orders and pharmacy entered orders all dated 2/11/17 for aspirin, hydralazine, saline nasal spray, senna and Tylenol, but they were not correct to the current orders on Resident #3's record. -Aspirin 81 mg daily was entered on 2/11/17 by the facility and by the pharmacy. -Hydralazine 25 mg every 8 hours was entered on 2/11/17 by the facility and by the pharmacy. -Saline nasal spray 1 spray each nostril daily and scheduled in the morning was entered on 2/11/17 by the facility and by the pharmacy. -Senna 8.6 mg x2 tablets daily was entered on 2/11/17 by the facility and by the pharmacy. -Tylenol 500 mg x2 tablets daily was entered on 2/11/17 by the facility and by the pharmacy. Interview on 2/16/17 at 10:35 am with the	D 358		

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D 358	Continued From page 10 Wellness Nurse (WN) revealed: -Resident #3 was admitted on a Friday, and we were having server issues with the eMAR system. -The MA put Resident #3's orders in as temporary orders since it was after hours. The temporary orders were until pharmacy entered the orders in the system, then the temporary ones would be discontinued. -"We do not get pending orders to approve until the server syncs (with the main system)." -She discovered 2/16/17 that "the problem with Resident #3's orders were that she had made copies of the Hospice physician's orders dated 2/08/17 with the aspirin, hydralazine, saline nasal spray, senna and Tylenol changes. She placed one copy in Resident #3's record, and placed one copy in the folder to check off when the medications arrived. She also used a copy to check off the medications that were sent with Resident #3. A copy of the FL 2 dated 1/25/17 was also in the notebook, and that was what was used by the MA when she entered the temporary orders into the system." -The orders in the eMAR system were from the FL2 dated 1/25/17, not from the Hospice orders dated 2/08/17. -She was not aware Resident #3 had not received the aspirin, hydralazine, saline nasal spray, senna and Tylenol as ordered by her physician. Interview on 2/16/17 at 12:00 with the RSD revealed: -She had filled out a new FL2 upon Resident #3's arrival on 2/10/17, but it was still waiting the physician's signature. It had the correct medication orders. -She was not aware Resident #3's orders in the eMAR system were from the FL2 dated 1/25/17, not from the orders dated 2/08/17. -She was not aware Resident #3 had not received	D 358		

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D 358	Continued From page 11 the aspirin, hydralazine, saline nasal spray, senna and Tylenol as ordered by her physician. Interview on 2/16/17 at 12:00 pm with the Administrator revealed: -She was not aware Resident #3's orders in the eMAR system were from the FL2 dated 1/25/17, not from the orders dated 2/08/17. -She was not aware Resident #3 had not received the aspirin, hydralazine, saline nasal spray, senna and Tylenol as ordered by her physician. Telephone interview on 2/16/17 at 12:20 pm with Resident #3's Hospice nurse revealed: -She was aware the facility had been having server issues with the eMAR, and that the system was down frequently, but she was told that usually medication order entry and documentation was not a problem. -She was not aware Resident #3 had not received the new doses for aspirin, hydralazine, saline nasal spray, senna and Tylenol as ordered by her physician since her admission on 2/11/17. -She would check with the Hospice physician to let him know, and to check if there were any implications in not getting the medications as ordered, especially the aspirin and the hydralazine. -The facility should administer medications as written and call if orders differed. Refer to interviews on 2/15/17 at 3:15 pm and 2/16/17 at 12:00 pm with the RSD. Refer to interviews on 2/15/17 at 3:25 pm and 4:30 pm with a MA. Refer to interview on 2/16/17 at 10:35 am with the WN.	D 358		

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D 358	Continued From page 12 Refer to interview on 2/16/17 at 11:30 am with two first shift MAs. Refer to interview on 2/16/17 at 12:00 pm with the Administrator. _____ Interviews on 2/15/17 at 3:15 pm and 2/16/17 at 12:00 pm with the Resident Services Director (RSD) revealed: -She was a Licensed Practical Nurse (LPN) and had worked at the facility since May 2016. -The pharmacy entered medication orders into the eMAR system, then a prompt appeared on the facility's computer screen for a verification approval to be performed before the medication could be administered. -The Medication Aides (MA), the Wellness Nurse (WN) or the RSD were to review the order entry compared to the original order. -"We see only the transcribed order, not the dates to be administered" when pending orders were reviewed in the eMAR. -The WN or the RSD were to check the eMARs monthly, but could not look at the eMARs until the 1st of the month. -The WN or the RSD were to check behind the MA entries and verify documentation was correct. Interviews on 2/15/17 at 3:25 pm and 4:30 pm with a MA revealed: -She had worked at the facility since June 2016. -If a medication was not due for administration on that date or time, it did not "pop up" on the screen to be administered. -New orders were faxed to the pharmacy who entered the order into the eMAR system. We received an eMAR prompt to approve or decline the pending order. We checked the eMAR prompt against the actual order to "see if it was correct". -We have a notebook system for tracking the	D 358		

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D 358	Continued From page 13	D 358		

physician orders with folders numbered 1-5. We moved the orders from folder to folder as appropriate. The 3rd shift was responsible for filing the orders from folder #5 into the residents' records.

Interview on 2/16/17 at 10:35 am with the WN revealed:
-She was a LPN and had worked at the facility for 1 year.
-She "try to check the eMARs and MA documentation every month. We've had server issues lately that makes it harder to check. It was easier with paper MARs."
-Orders were faxed to the pharmacy and placed in an order tracking notebook. The order moved from folder to folder until the medication arrived, then the order was filed.
-Pending orders in the eMAR could be approved by the MA, the RSD, or the WN.

Interview on 2/16/17 at 11:30 am with two first shift MAs revealed:
-When a prompt appeared on the eMAR for a pending order approval, the screen had the text written out with how often to give. It the order was wrong, they would close the order and get the nurse to follow-up.
-The pharmacy entered orders in the eMAR system.
-"The MA or the nurses could enter temporary orders into the eMAR system that were for 3 days. Usually by then the pharmacy had entered the order."
-"The approval screen is the same as what we put temporary orders in", and that included text and frequency or a medication or treatment.

Interview on 2/16/17 at 12:00 pm with the Administrator revealed the WN or the RSD were

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D 358	Continued From page 14 to verify eMAR entries by the pharmacy and staff.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or one hour after the scheduled times as ordered by a licensed prescribing practitioner for 2 of 2 (Resident #6 and #7) sampled residents. The findings are: A. Review of the facility census 02/15/17 revealed here was 61 residents in the facility, 35 in the Assisted Living Unit (ALU) and 26 in the Memory Care Unit (MCU). Observation on 02/15/17 between 9:00 am and 10:20 am revealed: -There was one Medication Aide (MA) administering medications in the ALU, and one MA in the MCU. -There was one medication cart on the MCU and two medications carts on the ALU. -The ALU consisted of 2 floors which housed residents on both floors. -In the ALU there were residents standing, and in wheel chairs, waiting for their medications. Review of Resident #6's current FL2 date 3/31/16	D 364		

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revealed diagnoses included chronic obstructive pulmonary disease, dementia, and congestive heart failure.

Review of Resident #6's record revealed subsequent signed physician orders date 12/23/16 for the following medications included: Mapap (used to treat mild pain) 500 mg 2 times daily, Carvedilol (used to treat high blood pressure) 3.125 mg take 1 tablet 2 times daily, artificial tears (used to treat dry eyes) 2 drops each eye four times daily.

Review of Resident #6's February 2017 electronic Medication Administration Record (eMAR) revelaed:
-The following medications were included on the eMAR:
-An entry for artificial tears instill 2 drops into each eye 4 times daily at 8:00 am, at 12:00 pm, at 4:00 pm, and at 8:00 pm.
-An entry for Carvedilol 3.125 mg take 1 tablet two times daily at 8:00 am and at 5:00 pm.
-An entry for Mapap 500 mg take 1 tablet two times daily at 8:00 am and at 4:00 pm.

Observation on 02/15/17 between 9:20 am and 9:30 am of a Medication pass in the ALU revealed:
-Resident #6 was in a wheel chair waiting for her medications to be administered.
-The MA started the administration of medications to Resident #6 at 9:20 am.
-The MA administered the following medications to Resident #6 which included artificial tears, Carvedilol 3.125 mg and Mapap 500 mg.
-The MA documented on the eMAR as administered at 9:30 am.

Review of the facility order administration report

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D 364	Continued From page 16 revealed: -Resident #6's scheduled morning medications included artificial tears, Carvedilol and Mapap were documented as administered on 02/15/17 at 9:30 am. -Resident #6's scheduled afternoon medications included artificial tears were documented as administered on 02/15/17 at 12:51 pm. -Resident #6's scheduled late afternoon medications artificial tears, Carvedilol, and Mapap were documented as administered on 02/15/17 at 4:15 pm. -Resident #6's scheduled medication artificial tears were documented as administered again on 02/15/17 at 7:32 pm. The administration of the medications artificial tears, Carvedilol, and Mapap to close between scheduled times could result in possible complications of the effects of the medications administered to Resident #6. Refer to interview on 02/15/17 at 9:15 am and at 11:40 am with the MA in the ALU. Refer to interview on 02/15/17 at 11:40 am with the Resident Service Director (RSD). Refer to observation on 02/16/17 between 8:00 am and 10:00 pm. Refer to interview on 02/16/17 at 10:55 am with the Wellness Nurse. Refer to attempted telephone interview on 02/16/17 at 12:00 pm with the facility physician. Refer to review of the faciliy medication administration policy.	D 364		

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D 364	Continued From page 17 Refer to interview on 02/16/17 at 1:30 pm with the Administrator. B. Review of Resident #7's current FL2 date 3/22/16 revealed diagnoses included Parkinson disease, hypertension, and glaucoma. Review of Resident #7's record revealed subsequent signed physician orders date 12/23/16 for the following medications: Alphagan (used to treat glaucoma) 0.1 eye drops place 1 drop in both eyes 2 times daily, Docusate (used to reduce constipation) 100 mg 2 times daily, Magnesium oxide (a supplement) 400 mg 2 times daily, carbidopa/levodopa (used treat Parkinson disease) 25/100 mg two times daily, cosopt (used to treat glaucoma) eye drops place 12 drop each eye 2 times daily. Review of Resident #7's February 2017 electronic Medication Administration Record (eMAR) revelaed: -The following medications were included on the eMAR: -An entry for Alphagan 0.1 eye drops place 1 drop in both eyes 2 times daily at 7:30 am and at 7:00 pm. -An entry for caribidopa/levodopa 25/100 mg two times daily at 7:30 am and at 7:00 pm. -An entry for docusate 100 mg 2 times daily at 8:00 am and at 8:00 pm. -An entry for magnesium oxide 400 mg 2 times daily at 8:00 am and at 8:00 pm. -An entry for cosopt eye drops op in both eyes 2 times daily at 7:30 am and at 7:00 pm. Observation on 02/15/17 between 9:30 am and 9:45 am of a Medication pass in the ALU revealed:	D 364		

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D 364	Continued From page 18 -Resident #7 was in line waiting for her medications to be administered. -The MA started the administration of medications to Resident #7 at 9:32 am. -The MA administered the following medications to Resident #6 which included Alphagan eye drops, caribidopa/levodopa 25/100 mg, docusate 100 mg, magnesium oxide, and cosopt eye drops. -The MA documented on the eMAR as administered 9:38 am. Review of the facility order administration report revealed: -Resident #7's morning medications included Alphagan eye drops, caribidopa/levodopa, docusate, magnesium oxide, and cosopt eye drops were documented as administered at 9:38 am on 02/15/17. -Resident #7's scheduled medications included Alphagan eye drops, caribidopa/levodopa, and cosopt eye drops were documented as administered on 02/15/17 at 6:25 pm. -Resident #7's scheduled medications included docusate and magnesium oxide were documented as administered at 8:16 pm on 02/15/17. The administration of the medications Alphagan eye drops, caribidopa/levodopa, docusate, magnesium oxide, and cosopt eye drops to close between scheduled times could result in possible complications of the effects of the medications administered to Resident #7. Refer to interview on 02/15/17 at 9:15 am and at 11:40 am with the MA in the ALU. Refer to interview on 02/15/17 at 11:40 am with the Resident Service Director (RSD).	D 364		

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D 364	Continued From page 19 Refer to observation on 02/16/17 between 8:00 am and 10:00 pm. Refer to interview on 02/16/17 at 10:55 am with the Wellness Nurse. Refer to attempted telephone interview on 02/16/17 at 12:00 pm with the facility physician. Refer to review of the faciliy medication administration policy. Refer to interview on 02/16/17 at 1:30 pm with the Administrator. _____ Interview on 02/15/17 at 9:15 am and at 11:40 am with the MA in the ALU revealed: -She was the only MA administering medications for 35 residents on the ALU. -She started the medication pass on 02/15/17 at 7:00 am, and residents would wait for their morning medications to be administered. -She was aware of the facility policy for administration of medication one hour before and one hour after the scheduled time. -Some of the residents liked to sleep in, and she had given the medications when they requested. -Some of the residents prefer to take their medications after breakfast. -"The morning medication pass is very heavy". -"I usually finish my morning medication pass by 11:00 am". -The management team talked about hiring another MA to help with the morning medication pass, but has not gotten approval as of yet. -"I do the best I can to accommodate the residents and finish my medication pass in the mornings."	D 364		

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D 364	Continued From page 20 Interview on 02/15/17 at 11:40 am with the Resident Service Director (RSD) revealed: -She was aware the facility had a policy for administration of medications to residents one hour before and one hour after the scheduled times. -She had tried to hire another MA to assist with the morning medication pass on the ALU. -She assisted the MAs sometimes with the morning medication pass on the ALU. Observation on 02/16/17 between 8:00 am and 10:00 pm revealed 2 MA were administering medications to the residents in the ALU. Interview on 02/16/17 at 10:55 am with the Wellness Nurse revealed: -She was aware the ALU had a heavy medication pass in the mornings. -Sometimes she was able to assist the MAs on the ALU. -"We always use 1 MA on the AL side and 1 in the MCU". -"I talked with management about a second MA for the AL side, but we had not gotten approval to hire as of yet". -There was a policy for administration of medications one hour before and one hour after the scheduled times. Attempted telephone interview on 02/16/17 at 12:00 pm with the facility physician was unsuccessful. Review of the faciliy Medication Administration policy revealed administration of medications were to be administered one hour before and one hour after the scheduled times. Interview on 02/16/17 at 1:30 pm with the	D 364		

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D 364	Continued From page 21 Administrator revealed she relied on the RSD and the Wellness nurse to oversee the clinical nursing in the facility.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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 observations, record reviews, and interviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate for 1 of 5 sampled residents (Resident # 4) regarding Novolin R (a fasting acting insulin to reduce blood sugar) sliding scale insulin administration.	D 367		

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D 367	Continued From page 22 The findings are: Review of Resident #4's current FL2 dated 9/21/16 revealed: -Diagnoses included diabetes. -An order for Finger Stick Blood Sugar (FSBS) 3 times daily before meals. -Medications ordered included Novolin R give 6 units with the lunch meal and use sliding scale. -Medications ordered included Novolin R sliding scale with parameters as follows: -If FSBS 0-200 give 0 units of Novolin R -If FSBS 201-300 give 2 units of Novolin R -If FSBS 301-400 give 4 units of Novolin R -If FSBS 401-500 give 6 units of Novolin R -If FSBS below 60 or greater than 500 call physican. Review of Resident #4's electronic Medications Administration Record (eMAR) for January 2017 revealed: -An entry for FSBS three times daily before meals. -An entry for Novolin R 6 units with the lunch meal. -An entry for Novolin R sliding scale as follows: -If FSBS 0-200 give 0 units -If FSBS 201-300 give 2 units -If FSBS 301-400 give 4 units -If FSBS 401-500 give 6 units -If FSBS below 60 or greater than 500 call physican. -Documented entry on 01/06, 01/13, 01/20, 01/23, and on 01/31 the quantity administered of Novolin R insulin as 1. Review of Resident #4's FSBS on the eMAR for January 2017 revealed -On 01/06/17 FSBS 129 documented 1 quantity of Novolin R was administered	D 367		

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D 367	Continued From page 23 -On 01/13/17 FSBS 179 documented 1 quantity of Novolin R was administered -On 01/20/17 FSBS 171 documented 1 quantity of Novolin R was administered -On 01/23/17 FSBS 232 documented 1 quantity of Novolin R was administered -On 01/31/17 FSBS 192 documented 1 quantity of Novolin R was administered Review of Resident #4's eMAR for February 2017 revealed: -An entry for FSBS three times daily before meals. -An entry for Novolin R 6 units with the lunch meal. -An entry for Novolin R 6 sliding scale as follows: -If FSBS 0-200 give 0 units -If FSBS 201-300 give 2 units -If FSBS 301-400 give 4 units -If FSBS 401-500 give 6 units -If FSBS below 60 or greater than 500 call physican. -Documented entry on 02/04, 02/05, and on 02/06 the quantity administered of Novolin R insulin as 1. Review of Resident #4's FSBS on the eMAR for February 2017 revealed: -On 02/04/17 FSBS was not documented, but 1 quantity of Novolin R was administered -On 02/05/17 FSBS was 321 documented 1 quantity of Novolin R was administered -On 02/06/17 FSBS was 322 documented 1 quantity of Novolin R was administered Interview on 02/15/17 at 11:15 with Resident #4 revealed she was aware she was administered insulin shots, but unsure of the amount. Inteview on 02/15/17 at 1:45 pm with a	D 367		

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D 367	Continued From page 24 Medication Aide (MA) revealed: -She was familiar with Resident #4's sliding scale insulin orders. -When she documented the insulin administered to Resident #4 she documented the total units administered. -She was unaware why another MA would document 1 as the quantity administered on the eMAR. Interview on 02/15/17 at 3:45 pm with a second MA revealed: -She was aware Resident #4 was on Novolin R sliding scale insulin, and had known the amount of insulin to administer using Resident #4's sliding scale. -When she documented on Resident #4's eMAR she would document 1, that meant she had administered "one shot". -She was unaware who had taught her to document on the eMAR using 1 as the quantity of insulin administered to Resident #4. -She had trained other MAs using 1 to document as the quantity (one shot) of insulin administered. Interview on 02/15/17 at 11:40 am with the Resident Service Director (RSD) revealed: -She was aware Resident #4 had orders for FSBS and Novolin R sliding scale insulin. -She was unaware the MAs had documented 1 on the eMAR when administered insulin to Resident #4. -The MAs were to document the quantity of insulin given as the actual units of insulin administered to Resident #4. -She was unsure why some MAs had documented 1 as the quantity of insulin administered to Resident #4. -The RSD and the Wellness Nurse (WN) were responsible for clinical nursing and overseeing	D 367		

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ELMCROFT OF LITTLE AVENUE	7745 LITTLE AVENUE CHARLOTTE, NC 28226

(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 367	Continued From page 25 the MAs. -The RSD and the WN were responsible for reviewing the eMAR monthly. Interview on 02/16/17 at 10:55 am with the Wellness Nurse revealed: -She was aware Resident #4 had orders for FSBS and Novolin R sliding scale insulin. -She was unaware the MAs had documented 1 as the quantity on the eMAR when they administered insulin to Resident #4. -The MAs were to document the quantity of insulin administered as the actual units of insulin administered to Resident #4. -The WN and the RSD were responsible for reviewing the eMAR monthly. -The WN had looked over the eMAR last month but did not recall reviewing the documentation for Resident #4's insulin,"I looked for holes on the eMAR." -"I prefer the MA used paper MAR in the facility." Attempted telephone interview on 02/16/17 at 12:00 pm with Resident #4's Physician was not successful. Interview on 02/16/17 at 1:30 pm with the Administrator revealed: -She relied on the RSD and the WN to oversee clinical nursing in the facility. -She would immediately conduct a mandatory inservice for all MAs on documentation and administration of insulin.	D 367		