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AVENDELLE ASSISTED LIVING AT ROLESVILLE	129 NORTWICK ROAD ROLESVILLE, NC 27571

(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 survey on March 21-23, 2017.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure blood pressure checks were implemented weekly for 1 of 3 sampled residents (#1) as ordered by the primary care physician . The findings are: Review of Resident #1's current FL-2 dated 1/27/17 revealed: -The resident's diagnoses included dementia, history of abdominal pain, delirium, hypertension, confusion, vertigo, depression, CAD (coronary artery disease), hyperlipidemia, thyroid disease, and hypercholesterolemia. -The resident had an order for blood pressure checks weekly (Thursdays). Review of Resident #1's Resident Register revealed the resident was admitted to facility on 1/16/17. Review of Resident #1's facility chart revealed a	C 249		

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blank vital signs worksheet.

Review of Resident #1's January 2017, February 2017 and March 2017 electronic Medication Administration Records (eMARs) revealed the order for weekly blood pressure checks was not transcribed on the eMAR.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 3/22/17 at 4:21 p.m. revealed:
-She was unaware of the order for weekly blood pressure checks.
-Resident #1's blood pressure readings "have been fine when I've checked" so she had not been concerned. "But, if the doctor ordered it, it should be taken."
-The NP recommended checking directly with the primary care physician.
-She had seen Resident #1 two or three times since admission and there had been no issues.

Interview with Supervisor in Charge (SIC)/Medication Aide (MA) on 3/22/17 at 11:30 a.m. revealed that she was unaware of the order for weekly blood pressure checks and asked to see where it was listed on Resident #1's FL-2 form.

On 3/22/17 at 4:05 p.m., the SIC/MA was observed checking Resident #1's blood pressure upon request. The results were 146/85 with pulse rate of 86.

Interview with Resident #1 on 3/22/17 at 4:10 p.m. revealed:
-Staff gave her medications at night and in the morning.
-She got along with staff; they treated her well.
-This was "the first time my blood pressure's

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C 249	Continued From page 2 been taken since I've been here". Interview with Administrator/Owner on 3/23/17 at 2:55 p.m. revealed: -She was unaware that Resident #1's order for weekly blood pressure checks on the FL-2 form had been "missed". -"I don't know what to tell you; I don't know what to say. But, I can assure you we'll get it done." -The pharmacy created the eMARs including treatments like blood pressure checks. -Her expectations for staff were to administer medications as ordered by the physician and to check for accuracy. -The SIC should be checking MAR documentation daily. -The Clinical Director (RN) should be checking MAR documentation every 2 to 3 weeks. Resident #1's primary care physician could not be reached by the end of the survey.	C 249		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents' rights of respect and dignity were maintained related to a resident (#2) being spoken to in a disrespectful manner by a staff member while trying to assist the resident with personal care.	C 311		

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C 311	Continued From page 3 The findings are: Observation on 3/21/17 at 1:51 p.m. revealed: -The Supervisor-in Charge (SIC) and Resident #2 had gotten into an argument about the resident's catheter bag. -The argument was loud enough to be heard in the facility's kitchen and living room. -The surveyor's were sitting in the small dining room near the kitchen, which was between 20 to 30 feet from the resident's room. -The resident was sitting in the recliner in his room and the SIC was standing by resident with the catheter bag. -In a loud and unkind voice, she kept telling the resident "I am not going to argue with you." -She told the resident "you don't listen to me." -The resident kept trying to tell the SIC where he wanted the catheter bag. -The SIC said, "I can't do this anymore, I am taking a 10 minute break." Interview with a Personal Care Aide (PCA) on 1/21/17 at 1:53 p.m. revealed: -The PCA was asked where was the Clinical Director? -The PCA responded she was upstairs. -The PCA was asked to get the Clinical Director. Observation on 3/21/17 at 1:55 p.m. revealed the Clinical Director came down stairs and she was informed of what happened between the SIC and Resident #2. Interview with the Clinical Director on 3/21/17 at 1:55 p.m. revealed she was not aware of the argument between the SIC and Resident #2 on today (1/21/17).	C 311		

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C 311	Continued From page 4 Observation on 3/21/17 at 1:57 p.m. revealed: -Resident #2 had told a PCA, the catheter bag was not in the hook correctly going down his leg. -The resident was trying to fix the position of the catheter bag. Interview with the SIC on 3/21/17 at 2:00 p.m. revealed: -The morning of 3/21/17, the resident wanted her to switch the catheter bag from the right leg to the left leg. -The resident snatched the bag from her hand and she told him, "that's the problem, you won't let us finish." -"It was nothing personal with the resident." -"I just had to walk off." -The resident "lashes out at staff." -In the past, Resident #2 had threatened to throw his walker. -She knew her tone with Resident #2 the morning of 3/21/17 was inappropriate. -"He pushes you to the limit." -"He pushed me to the limit" the morning of 3/21/17. -She had training on how to handle resident behaviors either the end of 2016 or the beginning of 2017. -She was told a way to handle behaviors was to walk off and to not argue with the residents. -She had had training in residents' rights in 2016. She did not know the date. -She was aware her tone with the resident did not calm him down. -She had spoken with the Clinical Director about the resident's behavior on 3/20/17. -The resident's behaviors had increased within the passed two days. -She would inform Resident #2's primary care physician.	C 311		

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C 311	Continued From page 5 Interview with a PCA on 3/21/17 at 2:30 p.m. revealed: -Resident #2 thinks staff does not know what they are doing when doing his personal care. -The resident's left hand was paralyzed. -When the resident thought she was doing his personal care wrong, she would ask him to tell her how he wanted it to be done and do it to his satisfaction. -She does not argue with the resident. -He liked the catheter bag changed from one leg to the other leg sometimes. -On the morning of 3/21/17 was the first time she had heard Resident #2 and the SIC getting into an argument. -She had never heard any other staff getting into an argument with Resident #2. Observation on 3/21/17 between 2:45 p.m. to 3:00 p.m. revealed the Administrator had come to the facility and was informed of the incident that happened between the SIC and Resident #2 the morning of 3/21/17. Interview with the Administrator on 3/21/17 between 2:45 p.m. to 3:00 p.m. revealed the SIC getting into an argument with Resident #2 should not have happened. Interview with a Medication Aide (MA) on 3/22/17 at 3:15 p.m. revealed: -When Resident #2 wanted something done a certain way, she just listened to him. -She had never seen any staff fussing or arguing with the resident. -Sometimes when the resident had cursed at staff, he later apologized. -She had never seen the SIC raise her voice at Resident #2.	C 311		

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C 311	Continued From page 6 Interview with Resident #2 on 3/23/17 at 12:00 p.m. revealed: -He could not remember the incident that happened with the SIC the morning of 3/21/17. -Within the past week, he and the SIC had gotten into some disagreements. -He liked to change the catheter bag from the right leg to the left leg, because the right leg had sores. Observation of Resident #2 on 3/23/17 at 12:00 p.m. revealed there were 3 dime sized reddened scabs on the resident's right upper thigh. Interview with the SIC on 3/23/17 at 12:34 p.m. revealed she was not aware Resident #2 had three scabs on the right upper thigh. Interview with the Administrator on 3/23/17 at 2:50 p.m. revealed: -She was not aware Resident #2 had reddened sores on his right upper thigh. -Staff had to approach Resident #2 a certain way, because he was a proud man and he would get agitated. -She expected staff to treat residents with dignity and respect. -She had not had any complaints from residents or family members about the SIC. -The SIC had training on residents' rights October 2016. -The SIC has had sensitivity training. -There was no excuse to why the SIC had gotten into an argument with Resident #2 and the Administrator could not justify the SIC's behavior. -She was "appalled" by the SIC's behavior. -"That's not what we stand for." -"I will take care of it." -She was embarrassed of the incident that happened between Resident #2 and the SIC.	C 311		

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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: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to administer medications as ordered by the primary care physician for 2 of 3 sampled residents as ordered by physician; including Florinef for Resident #2 and Paxil and Seroquel for Resident #1. The findings are: 1. Review of Resident #2's current FL-2 dated 2/10/17 revealed: -The resident's diagnoses included chronic back pain, benign prostatic hyperplasia, depression and atrial fibrillation. -There was an order for blood pressures to be taken once daily standing and sitting and to fax the results to the primary care physician on Fridays. -If the standing blood pressure was less than 90/60, give Florinef 0.1 milligrams (mg) daily, as needed (used to help normalize low blood pressures). Review of Resident #2's Resident Register	C 330		

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revealed the resident was admitted to the facility on 10/6/16.

Review of Resident #2's medication orders revealed:
-There was an order dated 11/21/16 to check blood pressures sitting and standing daily. If the sitting blood pressure was less than 100/60, give Florinef 0.1 mg daily, as needed.
-There was a subsequent order dated 1/30/17 to check blood pressures sitting and standing daily. If the standing blood pressure was less than 90/60, give Florinef 0.1 mg daily, as needed.

Review of the "Blood Pressure Record" revealed:
-From 1/1/17 to 1/30/17, the sitting systolic blood pressures ranged from 62-162 and the diastolic blood pressures ranged from 46-101.
-The systolic sitting blood pressure on 1/2/17, 1/3/17, 1/5/17, 1/6/17, 1/7/17 to 1/13/17, 1/15/17, 1/18/17, 1/24/17, 1/26/17, 1/29/17 and 1/30/17 ranged from 63-99 and the diastolic blood pressures ranged from 49-77.
-On 1/31/17, the standing systolic blood pressure was 73 and the diastolic blood pressure was 61.

Review of the January 2017 Electronic Medication Administration Record (eMAR) revealed:
-Florinef 0.1 mg give one tablet by mouth daily as needed, if sitting blood pressures was less than 100/60, was transcribed on the eMAR. There was a discontinuation of the medication dated 1/31/17.
-Florinef 0.1 mg give one tablet by mouth daily as needed, if standing blood pressures was less than 90/60, was transcribed on the eMAR. It was dated 1/31/17.
-On 1/2/17, 1/3/17, 1/5/17, 1/6/17, 1/7/17 to 1/13/17, 1/15/17, 1/18/17, 1/24/17, 1/26/17,

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C 330	Continued From page 9 1/29/17, 1/30/17 and 1/31/17, there was no documentation the medicine was administered to the resident as ordered by the primary care physician. Review of the standing "Blood Pressure Record" revealed: -From 2/1/17 to 2/28/17, the systolic blood pressures ranged from 61-128 and the diastolic blood pressures ranged from 44-87. -The systolic blood pressures on 2/2/17, 2/5/17, 2/6/17, 2/12/17, 2/16/17, 2/18/17, 2/22/17 to 2/24/17, 2/26/17 and 2/27/17 ranged from 61-106 and the diastolic blood pressures ranged from 44-64. -On 2/13/17, there was no documentation of blood pressure checks, because the resident refused to have blood pressure checks done. Review of Resident #2's February 2017 MAR revealed: -Florinef 0.1 mg give one tablet by mouth daily as needed, if standing blood pressures was less than 90/60, was transcribed on the eMAR. -On 2/2/17, 2/5/17, 2/6/17, 2/12/17, 2/16/17, 2/18/17, 2/22/17 to 2/24/17, 2/26/17 and 2/27/17, there was no documentation the medicine was administered to the resident as ordered by the primary care physician. Review of Resident #2's March 2017 MAR revealed: -Florinef 0.1 mg give one tablet by mouth daily as needed, if standing blood pressures was less than 90/60, was transcribed on the eMAR. -The eMAR included to check and record blood pressure standing daily at 10:00 a.m. -From 3/1/17 to 3/23/17, the standing systolic blood pressure ranged from 66-131 and the diastolic blood pressure ranged from 52-79.	C 330		

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-The standing systolic blood pressure on 3/4/17, 3/7/17, 3/9/17 to 3/17/17 and 3/20/17 to 3/22/17 ranged from 66-131 and the diastolic blood pressure ranged from 52-79 and there was no documentation the medicine was administered to the resident on those dates as ordered by the primary care physician.

Review of Resident #2's medications on hand revealed:
-Florinef 0.1 mg take daily as needed if the standing blood pressure was less than 90/60.
-The medication label was dated 1/31/17, 30 tablets were dispensed and 16 tablets were on hand.

Interview with the Supervisor-in Charge (SIC) on 3/22/17 at 10:06 a.m. revealed:
-Resident #2 received Florinef if his blood pressure was less than 90/60.
-The MAs documented on the MAR when residents received medications.
-She did not know why on the days she administered the Florinef to Resident #2, it was not documented on the MAR.

Interview with the same SIC on 3/23/17 at 1:57 p.m. revealed:
-When the orders are received from the resident's primary care physician, the orders are faxed to the pharmacy and the Administrator.
-The SIC or MA contacted the pharmacy to make sure the orders had been received.
-Every month she looked at all of the residents' FL-2s, MARs and medications and made sure it was matching.
-The third shift MA should be checking to make sure the resident's medications are on hand and if medications needed to be refilled.
-Sometimes Resident #2 complained of having

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dizziness.
-The resident last complained of dizziness one month ago.
-The days she checked Resident #2's blood pressure, if he needed the Florinef she gave it to him.
-She had forgotten to document on the MAR some of the days the resident needed the Florinef.

Telephone interview with Resident #2's Power of Attorney (POA) on 3/22/17 at 2:08 p.m. revealed:
-She liked the facility.
-Resident #2 had blood pressures taken daily.
-If the blood pressures were less than 90, the resident received a medication.
-She did not know which medicine the resident received for the low blood pressures.
-The resident's blood pressure dropped "20 points" when he stood up.
-The POA did not have a problem with the resident receiving his medications.

Interview with a Medication Aide (MA) on 3/22/17 at 3:15 p.m. revealed:
-She mainly worked second shift.
-When she worked first shift, she took Resident #2's blood pressures sitting down and standing.
-When Resident #2's blood pressure was low, she administered Florinef.
-She was unsure of which parameters to administer Florinef to the resident.

Telephone interview on 3/23/17 at 10:30 a.m. with Resident #2's Triage nurse from primary care physician's office revealed:
-The resident had an order dated 1/30/17 for Florinef 0.1 mg take daily, as needed if the standing blood pressure was less than 90/60.
-She did not see any prior orders for the Florinef.

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C 330	Continued From page 12 -She did not see any documentation in the resident's record and she did not know if the primary care physician was aware the resident had not received the medication as ordered. Interview with Resident #2 on 3/23/17 at 12:00 p.m. revealed: -When he first gets up in the morning, he felt dizzy and light headed and it usually lasted for 10 minutes. -Sometimes he felt he would black out during the day. When he felt like that, he usually informed staff and they checked his blood pressure. -Staff took his blood pressure daily, when he was sitting and standing. -If the blood pressure was below a certain figure, they gave him a pill. Telephone interview with Quality Assurance Technician from Resident #2's local pharmacy on 3/23/17 at 1:21 p.m. revealed: -The local pharmacy provided all the medications for Resident #2. -There was an order dated 1/30/17 for Florinef 0.1 mg give 1 tablet daily as needed, if standing blood pressure was less than 90/60. -Thirty tablets was last dispensed on 1/31/17. -The order was entered on the MAR on 1/31/17. -When the pharmacy received orders for blood pressure checks from the facility or a resident's primary care physician, the pharmacy entered the information on the resident's profile so that it could show up on the MAR. Interview with the Administrator on 3/23/17 at 2:50 p.m. revealed: -When the SIC or MA received orders from the resident's primary care physician, staff faxed the orders to the pharmacy and to her. -The facility called the pharmacy within 15	C 330		

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	FCL092192	A. BUILDING: _____ B. WING _____	03/23/2017

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minutes to make sure the order was received.
-The facility's pharmacy placed the orders in Accuflo (the system used to view the eMARs).
-The SIC was responsible for making sure the MA's documented administration of medications.
-The SIC was supposed to check the MARs daily to make sure the MA's documented the administration of medications.
-The Administrator checked the MARs 2 to 3 times weekly to make sure staff documented as ordered.
-Her expectations was for staff to administer medications as ordered by the resident's primary care physician.
-Resident #2 received a medication, if his blood pressure was less than 90/60.
-She was not aware staff had not documented the Administration of Resident #2's Florinef.

Resident #2's primary care physician or the physician's Triage Nurse did not call back by the end of the survey.

2. Review of Resident #1's current FL-2 dated 1/27/17 revealed the resident's diagnoses included dementia, history of abdominal pain, delirium, hypertension, confusion, vertigo, depression, CAD (coronary artery disease), hyperlipidemia, thyroid disease, and hypercholesterolemia.

Review of Resident #1's Resident Register revealed the resident was admitted to facility on 1/16/17.

A. Review of Resident #1's medication orders revealed:
-The resident had an order dated 11/30/16 for Paxil 10 milligram (mg) tablets (used to help treat depression): take two tablets (20mg) by mouth

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every day (8:00 p.m.) On 1/27/17, this order was discontinued.
-Resident #1 had a new order dated 1/27/17 for Paxil 10 mg: take one tablet by mouth every morning (8:00 a.m.)

Review of Resident #1's January 2017 electronic Medication Administration Records (eMARs) revealed:
-Paxil 20 mg was documented as administered from 1/16/17 at 8:00 p.m. to 1/26/17 at 8:00 p.m.
-On 1/27/17 and 1/28/17 the order for 20 mg of Paxil was documented as discontinued.
-On 1/27/17 a new order for Paxil, one 10 mg tablet daily at 8:00 a.m., was transcribed on the eMAR by the pharmacy.
-From 8:00 a.m. on 1/27/17 until 8:00am on 1/31/17, there was no documented administration of Paxil for Resident #1.
-The first documented administration of Paxil 10 mg was at 8:00 a.m. on 1/31/17.

Review of Resident #1's medications on hand revealed Paxil 10 mg take daily (one 10 mg tablet daily at 8:00 a.m.) was on the medication label and was dated 2/23/17.

Telephone interview with a Pharmacy Technician from Resident #1's local pharmacy on 3/23/17 at 9:18 a.m. revealed:
-The new order for Paxil 10 mg daily at 8:00 a.m. was received on 1/27/17.
-On 1/27/17, the pharmacy transcribed the new Paxil order onto the eMAR, dispensed 27 tablets, and delivered the medication to the facility.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 3/22/17 at 4:21 p.m. revealed:
-The resident's neuropsychiatrist adjusted the

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orders for Paxil on 1/27/17.
-The resident's neuropsychiatrist adjusted the orders for Paxil on 1/27/17.
-The physician's assistant (PA) visited Resident #1 at the facility on 1/31/17.
-The PA documented that the resident was doing well with the medication changes and there were no complaints from the resident.
-The NP stated that based on the PA's observation on 1/31/17, the missed doses of Paxil did not seem to have a noticeable effect on the resident.

Interview with Administrator on 3/23/17 at 2:55 p.m. revealed she was not aware of the missed Paxil doses for Resident #1.

Refer to interview with Resident #1 on 3/22/17 at 4:10 p.m.

Refer to interviews with Supervisor in Charge (SIC)/Medication Aide (MA) on 3/22/17 at 11:30 a.m. and on 3/23/17 at 1:56 p.m.

Refer to interview with Administrator/Owner on 3/23/17 at 2:55 p.m.

Resident #1's primary care physician could not be reached by the end of the survey.

Resident #1's neuropsychiatrist could not be reached by the end of the survey.

B. Review of Resident #1's medication orders revealed:
-The resident had an order dated 1/12/17 for Seroquel 50 mg (an anti-psychotic drug used to help treat certain mental/mood conditions): take one tablet by mouth twice a day (8:00 a.m. and 8:00 p.m). On 1/27/17, this order was

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discontinued.
-Resident #1 had a new order dated 1/27/17 for Seroquel 25 mg: take one tablet by mouth twice a day (8:00 a.m. and 8:00 p.m).

Review of Resident #1's January 2017 Electronic Medication Administration Record (eMAR) revealed:
-Seroquel 50 mg was documented as administered on 1/16/17 at 8:00 p.m. to 1/27/17 at 8:00 a.m.
-At 8:00 p.m. on 1/27/17 and at 8:00 a.m. and 8:00 p.m. on 1/28/17, the order for 50 mg of Seroquel was documented as discontinued.
-On 1/27/17 a new order for Seroquel, one 25 mg tablet twice daily at 8:00 a.m. and 8:00 p.m., was transcribed on the eMAR by the pharmacy.
-From 8:00 p.m. on 1/27/17 until 8:00 p.m. on 1/30/17, there was no documented administration of Seroquel for Resident #1.
-The first documented administration of Seroquel 25 mg was at 8:00 p.m. on 1/30/17.

Review of Resident #1's February 2017 and March 2017 eMARs revealed that all medications were administered as ordered by the physician.

Review of Resident #1's medications on hand revealed Seroquel 25 mg take twice daily (1 tablet at 8:00 a.m. and 8:00 p.m.) was on the medication label and was dated 2/23/17.

Telephone interview with a Pharmacy Technician from Resident #1's local pharmacy on 3/23/17 at 9:18 a.m. revealed:
-The initial order for Seroquel 50 mg twice daily (8:00 a.m. and 8:00 p.m.) was last filled on 1/12/17 (60 tablets).
-The new order for Seroquel 25 mg twice daily (8:00 a.m. and 8:00 p.m.) was received by the

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pharmacy on 1/27/17.
-The pharmacy transcribed the new Seroquel order onto the electronic MAR on 1/27/17.
-On 2/2/17, the pharmacy dispensed 54 tablets (27 day supply) and delivered the medication to the facility.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 3/22/17 at 4:21 p.m. revealed:
-The resident's neuropsychiatrist adjusted the orders for Seroquel on 1/27/17.
-The physician's assistant (PA) visited Resident #1 at the facility on 1/31/17.
-The PA documented that the resident was doing well with the medication changes and there were no complaints from the resident.
-The NP stated that based on the PA's observation on 1/31/17, the missed doses of Seroquel did not seem to have a noticeable effect on the resident.

Interview with Administrator on 3/23/17 at 2:55pm revealed she was not aware of the missed Seroquel doses for Resident #1.

Refer to interview with Resident #1 on 3/22/17 at 4:10 p.m.

Refer to interviews with Supervisor in Charge (SIC)/Medication Aide (MA) on 3/22/17 at 11:30 a.m. and on 3/23/17 at 1:56 p.m.

Refer to interview with Administrator on 3/23/17 at 2:55 p.m.

Resident #1's primary care physician could not be reached by the end of the survey.

Resident #1's neuropsychiatrist could not be

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C 330	Continued From page 18 reached by the end of the survey. _____ Interview with Resident #1 on 3/22/17 at 4:10 p.m revealed staff gave her medications at night and in the morning. Interviews with Supervisor in Charge (SIC)/Medication Aide (MA) on 3/22/17 at 11:30 a.m. and on 3/23/17 at 1:56 p.m. revealed: -Resident #1 slept a lot and has not had any changes in behavior. -SIC said she had "no explanation" for missed doses of Paxil and Seroquel. -Both medications were in stock so there was "no reason not to give". -She said it could have been a "technical issue with the Accuflow system" (computer program for medication administration). -"When I pass meds, I click off that it's been given." -SIC completed chart audits monthly to ensure that medications were on the cart and Accuflow order information was correct. -If incorrect, staff would contact pharmacy. -"Only significant events and changes" were documented in the resident's progress notes. -Resident #1 had been "stable". Interview with Administrator on 3/23/17 at 2:55 p.m. revealed: -Her expectations for staff were to administer medications as ordered by the physician and to check for accuracy. -She expected her staff to follow rules and guidelines and check off on Accuflow for medication administration. -The SIC should be checking MAR documentation daily. -The Clinical Director (RN) should be checking	C 330		

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C 330	Continued From page 19 MAR documentation every 2 to 3 weeks. -"We need to be extra careful to make sure meds are double checked and administered correctly." The facility failed to administer a medication as ordered by the primary care physician for 2 of 3 Residents (#1, #2). Resident #1 failed to get 4 doses Seroquel and 6 doses of Paxil. The resident had a diagnoses of depression, but did not have increased depression due to missed dosages. Resident #2 failed to get 43 dosages of Florinef, which is used to normalize low blood pressures and the resident received 2 doses of the same medication not as ordered. The resident had low blood pressure readings. The failure of the facility results in detriment to the health, safety, and welfare of the resident. The facility submitted a Plan of Protection dated 3/23/17, as follows: -Immediately, the Clinical Director, Vice President and Administrator will review each resident's chart and primary care physician's orders to assure accuracy of the administration of the orders. -The Administrator will assure the Medication Administration Record (MAR) was accurate and the medications are documented on the MAR as administered, accurately. -The Administrator will check medications on hand and do record audits weekly. -The Administrator will assure the Medication Aides are trained on proper medication administration, medication techniques and documentation on an "on-going basis." CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 7, 2017	C 330		

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C 912	Continued From page 20	C 912		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record review, the facility failed to administer medications as ordered by the primary care physician for 2 of 3 sampled residents as ordered by physician; including Florinef for Resident #2 and Paxil and Seroquel for Resident #1. [Refer to Tag C330, 10A NCAC 13G .1004 (a). (Type B Violation)]	C 912		