Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077010	A. BUILDING: _____ B. WING _____	01/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMLET HOUSE	632 FREEMAN MILL ROAD HAMLET, NC 28345

(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 an annual survey on January 25, 26, 27 and 30, 2017.	D 000		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 2 of 5 residents had access to a call bell or signaling device within reach for 2 of 5 sampled residents who were bedridden (#2) or had dementia (#5). The findings are: A. Review of Resident #2's current FL2 dated 12/16/16 revealed diagnoses included altered mental status, depression, and anxiety; semi-ambulatory. Review of Resident #2's Care Plan dated 03/14/2016 revealed resident required extensive assistance with transfers. Interview with a Medication Aide (MA) on 01/30/17 at 11:25 am revealed: -Each resident should have a call bell in their room or a pendant around their neck. -MA was not aware Resident #2 did not currently have a call pendant. Observations at various times on 01/27/2017	D 119	Responses to the citied deficiencies do not constitude an admission or aggreement by the facility of truth of the facts alleged or defiencies or corrective action report the Plan of Correction prepared solely as a matter of compliance with State Law Completion Date is March 6, 2017 per Telephone conversation on 5-3-2017 = corporate Regional executive HHP	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Melissa Brown — Executive Director — 3-9-17

STATE FORM 6899 DLD511 If continuation sheet 1 of 38

Reviewed and accepted with Revisions on 5/3/2017 HHP

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D 119	Continued From page 1 revealed the resident was laying flat on his back with no attempt to move around in the bed. Observation of Resident #2's room on 01/30/17 at 11:25 am revealed: -A call bell system was on the wall and accessible by a pull cord in Resident #2's bathroom. -There was no call bell system in Resident #2's room. -Resident #2's call pendant was not found. Interview with Resident #2's Responsible Person (RP) on 01/30/27 at 11:30 am revealed: -The RP had never seen a call bell in the resident's room. -Resident #2 depended on staff for repositioning. -There was a call bell with a pull cord in the resident's bathroom. Observation of Resident #2 on 01/30/17 at 11:40 am revealed: -The resident was in a wheelchair in the activity room. -Resident #2 was unable to propel self due to right sided paralysis. -A call bell pendant was not on the resident. Based on observation and record review, it was determined Resident #2 was not interviewable. Refer to interview with Executive Director on 01/30/17 at 11:55 am. B. Review of Resident #5's current FL2 dated 08/11/16 revealed diagnoses included dementia; ambulatory. Interview with a Medication Aide (MA) on 01/30/17 at 11:35 am revealed: -Each resident in the facility should have a call	D 119		

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D 119	Continued From page 2 bell in their room or a pendant to keep around their neck or in their pocket. -Some residents keep the pendant in their wheelchair basket. -Residents take their pendants off and lose them. -Resident #5 was mainly in the activity room or walked the halls. -MA was not aware Resident #5 did not currently have a call pendant. Observation of Resident #5's room on 01/30/17 at 11:35 am revealed: -A call bell/pendant was not found in Resident #5's room. -A call bell system was on the wall with a pull cord in Resident #5's bathroom. Observation of Resident #5 on 01/30/17 at 11:45 am revealed the resident was sitting in the activity room with no call bell/pendant found on the resident. Based on observation and record review Resident #5 was determined to be not interviewable. Attempted Interview with Resident #5's Responsible Party was unsuccessful. Refer to Interview with Executive Director on 01/30/17 at 11:55 am Interview with Executive Directive on 01/30/17 at 11:55 am revealed: -All residents had a call bell/pendants but some lost them. -If a call bell was lost the facility would replace the device. -The rooms were not checked regularly for call bells/pendants.	D 119	Each resident will be given call bell upon admission to facility by executive director Resident Care Manager will monitor that call bells are in working order and have not been misplaced by resident Med Techs will check call bells are with resident and in working order every shift ED will develop and implement tracking log RCC will monitor weekly that checks are being completed. ED/RCC will initial tracking log for checks	

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D 119	Continued From page 3 -No call bell policy was available. -ED was not aware that Resident #2 or Resident #5 did not have a call pendant.	D 119		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the physician of 1 of 6 sampled resident's (Resident #5) refusal of medications. The findings are: Review of Resident #5's current FL2 dated 08/11/16 revealed: -Diagnoses included dementia, hypertension, and pure cholesterolemia. -Medications included Amlodipine/Benazepril 5-20 mg daily (used for high blood pressure), Aspirin 81 mg EC daily (used for blood thinner), Cerovite Senior daily (used for supplement), Fish Oil 1000 mg daily (used for supplement), Ibandronate150 mg (used for osteoporosis), Namenda XR 28 mg daily (used for Alzheimer's Disease), and Simvastatin 20 mg at bedtime (used for high cholesterol). Review of Resident #5's November 2016 Electronic Medication Administration Record (eMAR) revealed: -An entry for Amlodipine/Benazepril 5-20 mg daily	D 273	RCC to inservice all med techs on resident refusals of medication and notification of PCP RCCto monitir refusals per MAR weekly and followup notification of PCP EDto monitor refusal per MAR monthly and ensure PCP follow up completion date is March 16. 2017 pertaining corrective action with Corporate Approval 4-4-17 5/3/17 Hap	

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D 273	Continued From page 4 at 8:00 am and documented as administered for 18 of 30 days. There was documentation Amlodipine/Benazepril was refused 12 of 30 days. -An entry for Aspirin 81 mg EC daily at 8:00 am and documented as administered for 18 of 30 days. There was documentation Aspirin was refused 12 of 30 days. -An entry for Cerovite Senior daily at 8:00 am and documented as administered for 10 of 30 days. There was documentation Cerovite Senior was refused 20 of 30 days. -An entry for Fish Oil 1000 mg daily at 8:00 am and documented as administered for 10 of 30 days. There was documentation Fish Oil was refused 20 of 30 days. -An entry for Namenda XR 28 mg daily at 8:00 am and documented as administered for 18 of 30 days. There was documentation Namenda was refused 12 of 30 days. -An entry for Simvastatin 20 mg daily at 8:00 pm and documented as administered for 27 of 30 days. There was documentation Simvastatin was refused 13 of 30 days. Review of Resident #5's December 2016 eMAR revealed: -An entry for Amlodipine/Benazepril 5-20 mg daily at 8:00 am and documented as administered for 8 of 31 days. There was documentation Amlodipine/Benazepril was refused 23 of 31 days. -An entry for Aspirin 81 mg EC daily at 8:00 am and documented as administered for 7 of 31 days. There was documentation Aspirin was refused 24 of 31 days. -An entry for Cerovite Senior daily at 8:00 am and documented as administered for 2 of 31 days. There was documentation Cerovite Senior was refused 29 of 31 days.	D 273		

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D 273	Continued From page 5 -An entry for Fish Oil 1000 mg daily at 8:00 am and documented as administered for 2 of 31 days. There was documentation Fish Oil was refused 29 of 31 days. -An entry for Ibandronate 150 mg monthly at 8:00 am and documented as not administered for 1 of 31 days. There was documentation Ibandronate was refused. -An entry for Namenda XR 28 mg daily at 8:00 am and documented as administered for 8 of 31 days. There was documentation Namenda was refused 23 of 31 days. -An entry for Simvastatin 20 mg daily at 8:00 pm and documented as administered for 28 of 31 days. There was documentation Simvastatin was refused 3 of 31 days. Review of Resident #5's January 2017 eMAR revealed: -An entry for Amlodipine/Benazepril 5-20 mg daily at 8:00 am and documented as administered for 7 of 25 days. There was documentation as to why Amlodipine/Benazepril was refused 18 of 25 days. -An entry for Aspirin 81 mg EC daily at 8:00 am and documented as administered for 6 of 25 days. There was documentation Aspirin was refused 19 of 25 days. -An entry for Centrum daily at 8:00 am and documented as administered for 3 of 25 days. There was documentation Centrum was refused 22 of 25 days. -An entry for Fish Oil 1000 mg daily at 8:00 am and documented as administered for 3 of 25 days. There was documentation Fish Oil was refused 22 of 25 days. -An entry for Namenda XR 28 mg daily at 8:00 am and documented as administered for 8 of 25 days. There was documentation Namenda was refused 17 of 25 days.	D 273	E	

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D 273	Continued From page 6 -An entry for Simvastatin 20 mg daily at 8:00 pm and documented as administered for 4 of 25 days. There was documentation Simvastatin was refused 21 of 25 days. Observation of medications on hand on 01/26/17 at 10:00 am revealed all of the above medications were available for administration. Interview with a representative at the Physician's Office on 01/30/17 at 10:25 am revealed the physician was not made aware by the facility that Resident #5 was refusing medications frequently. Interview with Resident #5's Responsible Party on 01/30/17 at 10:50 am revealed: -The facility had not made the Responsible Party aware the resident was refusing medication. -The Responsible Party had seen the resident refuse medication on occasion in the past. Interview with a Medication Aide on 01/30/17 at 10:55 am revealed: -Once a resident has refused their medication three times staff must document on the situation and notify the physician that the resident has refused the medication. Interview with the Executive Director on 01/30/17 at 1:50 pm revealed: -The physician should be notified if a resident refused medications. -The facility did not have a Refusal of Medications Policy.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 287		

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D 287	Continued From page 7 (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that residents who received meals in their rooms were served on non-disposable table ware. The findings are: Observation during facility tour on 01/25/17 at 9:45 am revealed two residents were served breakfast in their rooms and served on disposable table ware plates, cups, forks, knives, and spoons. Interview during the initial tour on 01/25/17 at 9:10 am with a resident who was served in her room revealed: -She preferred to eat meals in her room. -The staff would bring her meals to her room. -Her meals were "always" served on disposable plates and bowls with plastic forks, knives and spoons. Observation during lunch service on 01/25/17 at 12:30 pm revealed: -Two residents were served in their rooms. -Both residents' meals were served on disposable table ware, including styrofoam plates, cups and plastic forks, knives and spoons.	D 287	ED will immediately inservice dietary manager and dietary staff on regulation concerning meal service Any residents requesting disposable dinnerware will be listed in dietary and RCCwill care plan this requaest Dietary manger will monitir meal service for two weeks and then ongoing ED to monitor randomly ongoing Completion date is March 16, 2017 per telephone conversation on 5/3/17 with Corporate nurse executive HR	

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D 287	Continued From page 8 Observation of facility pantry on 01/25/17 at 3:25 pm revealed: -There was 3000 disposable cups, 500 disposable plates, 144 disposable bowls, 144 small plates, and an open case of disposable forks/spoons/knives. Observation of kitchen area on 01/25/17 at 3:30 pm revealed: -There was an ample supply of non-disposable table ware available for residents including large plates, dessert plates, salad plates, bowls, cups, glasses, forks, knifes, and spoons. Interview with the facility Executive Director (ED) on 01/26/17 at 3:25 pm revealed: -All residents being served in their room are served on non-disposable table ware unless requested otherwise. -Resident #5 had on occasion requested to receive disposable table ware so they can dispose of them after the meal. -The ED had not maintained a list of residents that had requested disposable tableware. Interview with Medication Aide (MA) on 01/30/17 at 10:55 am revealed: -When residents were served in their rooms they were served on regular plates and food was taken into the residents rooms on a tray. -The MA was unsure if some residents requested their meals be served on styrofoam dinner ware. Interview with the Dietary Services Supervisor on 01/30/17 at 11:50 am revealed: -Some residents have requested to have their meals delivered on Styrofoam dinner ware. -If they do not request styrofoam dinner ware then the meal would be delivered on	D 287		

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D 287	Continued From page 9 non-disposable dinner ware. -There was no list available for residents who requested styrofoam.	D 287		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve 8 ounces of pasteurized milk at least twice a day to residents. The findings are: Review of the weekly menu spreadsheet provided by the Dining Services Supervisor on 01/25/17 at 10:10 am revealed milk (no quantity specified) was to be served at breakfast and dinner. Milk was to be offered at every meal. Observation of the lunch meal service on 01/25/17 at 12:05 pm revealed: -49 residents were served lunch in the dining room and 2 residents were served in their rooms. -None of the residents were served or offered milk.	D 299	ED to inservice dietary manager and all dietary staff on requlations for milk requirements Dietary is to offer milk to all residents twice a day Any resident who refuses milk will have PCP notified and milk refusal order obtained RCC to care plan for residents who do not want to receive milk and have a milk refusal order. List for milk refusal orders will be located in dietary.Dietary manger to monitor meals for milk refusal ED to monitor meals randomly and ongoing completion date is finished 4/2017 per telephone communication with regional executive on 5/3/2017 AHP	

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D 299	Continued From page 10 -None of the residents requested milk. -Milk was not made available to the residents. Observation of the kitchen area on 01/25/17 at 3:30 pm revealed: -1 opened gallon of 2% pasteurized milk -4 unopened gallons of 2% pasteurized milk. Interview with facility staff on 01/25/17 at 5:05 pm revealed: -The facility had two residents that liked milk but those two residents passed away and since then milk was provided only at breakfast and offered at other meals. Observation of dinner service on 01/25/17 at 5:15 pm revealed: -49 residents were served lunch in the dining room and 2 residents were served in their rooms. -None of the residents were served or offered milk. -None of the residents requested milk. -Milk was not made available to the residents. Observation of the breakfast meal service on 1/26/17 at 8:15 am revealed: -No milk was served during breakfast. -No residents requested milk. -No staff seen offering milk or made any milk available to the residents. Interview with Dining Services Supervisor on 1/26/17 at 9:40 am revealed: -Only one or two people had asked for milk and they had since passed away. -Staff do not provide milk but it is available for the residents. -Milk was on the menu for every other meal. - "We can't waste the milk". - "If they (residents) ask for milk, it is available".	D 299		

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D 299	Continued From page 11 Confidential interviews with three residents on 1/26/17 regarding milk being offered at meals revealed: - "Milk is served at breakfast only". - "We may could have milk at other meals if we ask permission from the cook or the activity coordinator". - "I did not get milk because I did not get cereal". - "I don't get milk with any meal". - "I did not know milk was available". - "Milk is offered at breakfast but I'm aware I can ask for it at other meals". Interview with facility Executive Director (ED) on 1/26/17 at 10:10 am revealed: -Milk was served at every meal. -A gallon of milk was made available every meal on a beverage cart. -Residents with dementia get milk with breakfast and family provide preferences for other meals.	D 299		
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: TYPE B VIOLATION	D 358		

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D 358	Continued From page 12 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by the physician for 4 of 6 sampled residents with orders for lutein 10 mg (Resident #4), Advair 250/50 discus, Lasix 20 mg and 40 mg, Spiriva 18 mcg, and pravastatin 80 mg (Resident #1), carbamazepine 250 mg (Resident #6), and latanoprost 0.005% ophthalmic drops, trazodone 50 mg, and docusate sodium 100 mg (Resident #3). The findings are: A. Review of Resident #3's current FL-2 dated 11/03/16 revealed diagnoses included hypercalcemia, cerebral infarct, cognitive communication deficiency, sepsis, anemia, toxic encephalopathy, and general muscle weakness. Review of Resident #3's Resident Register revealed as admission date of 11/04/16. 1. Review of Resident #3's record revealed physician's orders dated 11/21/16, and 12/28/16 ordering trazadone 50 mg (used to treat anxiety, pain and trouble sleeping) one tablet at bedtime to help with sleep. Review of Resident #3's November 2016 and December 2016 electronic Medication Administration Record (eMARs) revealed trazodone 50 mg was listed and scheduled for administration at 8:00 pm daily, and documented as administered from 11/23/16 to 12/31/16. Review of Resident #3's January 2017 eMAR revealed: -Trazodone 50 mg was listed and scheduled for administration at 8:00 pm daily. -Trazodone 50 mg was documented as	D 358	RCC/designee to reveiw MAR for any medications not in facility daily fir 30 days and then weekly ongoing. RCC to inservice all med techs on immediately reporting any medication not in facility and contacting pharmacy for any clarification needed inorder to receive medication in a timely manner. ED to inservice RCC and med tech on notifivcation of PCP of any medicationnot in facility and documentation of notification.Facility management will care plan any resident who chooses to acquire medications using other sources besides facility pharmacy	

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D 358	Continued From page 13 "med(ication) not in the facility" for administration on 01/01/17, 01/03/17, 01/04/17, 01/06/17, 01/07/17, and from 01/09/17 to 01/23/17 (a total of 19 of 24 opportunities). Observation of medication on hand for administration on 01/26/17 at 12:00 pm revealed a bubble pack for trazadone 50 mg dispensed for 14 tablets on 1/23/17 with 13 tablets remaining. Interview on 01/26/17 at 4:00 pm with a representative from the current pharmacy provider revealed: -The pharmacy had started providing services to the facility at the end of December 2016. -Trazodone 50 mg was dispensed from the pharmacy on 01/22/17 for a 14 day supply (there was no previous dispensing). -The pharmacy did not know why the trazodone was not dispensed prior to 01/22/17. Interview on 01/25/16 at 4:55 pm with the Resident Care Manager (RCM) revealed: -Medication Aide staff were trained to document any medication not administered on the eMAR for the reason not administered. -The facility changed pharmacy providers on 12/29/16. -She was aware Resident #3 had not been receiving trazadone 50 mg at bedtime as ordered until 01/24/17. -She had contacted the current pharmacy provider on at least 2 occasions trying to get trazodone for Resident #3. -The current pharmacy provider told her the trazadone for Resident #3 needed clarification before they would send the medication. -The RCM had not tried to obtain Resident #3's trazadone from any other source. -The current pharmacy provider sent trazadone	D 358		

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D 358	Continued From page 14 50 mg for Resident #3 with the pharmacy order received in the facility on 01/24/17. Review of medication dispensing information, obtained on 01/27/16, for the previous pharmacy provider revealed Resident #3 was dispensed a quantity of 30 tablets of trazadone 50 mg on 12/01/16. Interview on 01/27/16 at 3:15 pm with Resident #3's primary care physician revealed: -The physician was not aware Resident #3 was not receiving trazadone 50 mg at bedtime as prescribed. -The trazodone had been prescribed to help Resident #3 with sleeping. -The facility should be administering medications as ordered, if not then the physician should be notified. Interview on 01/30/17 at 9:50 am with Resident #3 revealed: -She was not familiar with all the medications she took. -She was having trouble sleeping, but she had been sleeping better the last couple of nights. Refer to Interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to Interview on 01/26/17 at 11:30 am with the Executive Director (ED). 2. Review of Resident #3's record revealed physician's order dated 11/21/16, and 12/28/16 ordering Colace (docusate sodium) 100 mg 2 capsules at bedtime (used to treat constipation).	D 358		

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D 358	Continued From page 15 Review of Resident #3's December 2016 electronic Medication Administration Record (eMARs) revealed docusate sodium 100 mg 2 capsules at bedtime was listed, and scheduled for administration at 8:00 pm daily and documented as administered from 12/01/16 to 12/31/16. Review of Resident #3's January 2017 eMAR revealed: - Docusate sodium 100 mg 2 capsules at bedtime was listed and scheduled for administration at 8:00 pm daily. - Docusate sodium 100 mg 2 capsules at bedtime was documented as "med(ication) not in the facility" for administration from 01/01/17 to 01/24/17 (24 of 24 opportunities). Observation of medication on hand for administration on 01/26/17 at 12:00 pm revealed no docusate 100 mg was available for administration on the medication cart. Interview on 01/25/16 at 4:55 pm with the Resident Care Manager (RCM) revealed: -Medication Aide staff were trained to document any medication not administered on the eMAR for the reason not administered. -The facility changed pharmacy providers on 12/29/16. -She was not aware Resident #3 had not been receiving docusate sodium 100 mg 2 capsules at bedtime as ordered. -Medication Aide staff had not informed her Resident #3 did not have docusate sodium 100 mg capsules. -Resident #3 had a friend that would go shopping for her if she needed over the counter items (like docusate 100 mg). -Resident #3 had requested to purchase the	D 358		

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D 358	Continued From page 16 Items available over the counter instead of getting them through the pharmacy because it would be less expensive. -The facility had a small supply of over the counter medications, including docusate sodium 100 mg, that could be used if a resident ran out. -The RCM obtained a bottle of thirty Colace 100 mg (Docusate Sodium) from the medication room and put it on the medication cart for Resident #3. Interview on 01/26/17 at 4:00 pm with a representative from the current pharmacy provider revealed: -The pharmacy had started providing services to the facility at the end of December 2016. -The pharmacy computer indicated that Resident #3 was scheduled to receive a month supply with the next cycle fill on 01/29/17. -The pharmacy did not know why the docusate 100 mg was not due to be dispensed prior to 01/29/17. Review of medication dispensing information obtained on 01/27/16, from the previous pharmacy provider revealed the pharmacy had not supplied Resident #3's docusate 100 mg. Interview on 01/27/16 at 3:15 pm with Resident #3's primary care physician revealed; -The physician was aware Resident #3 was not receiving docusate 100 mg 2 capsules at bedtime as prescribed because the resident had mentioned it at her last office visit. -The facility should be administering medications as ordered, if not then the physician should be notified. Interview on 01/30/17 at 9:50 am with Resident #3 revealed: -She was not familiar with all the medications she	D 358		

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D 358	Continued From page 17 took. -She was having trouble with her bowels up until the last couple of days, but she was doing better now. -She had informed her physician about not receiving her constipation medication (docusate sodium) the last time she saw her physician. Refer to interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). 3. Review of Resident #3's record revealed physician's orders, dated 11/08/16 and 12/28/16, ordering Xalatan (latanoprost) 0.005% drops instill one drop in left eye at bedtime. (Latanoprost drops are used to lower pressure in the eye.) Interview during the initial tour on 01/25/17 at 11:25 am revealed Resident #3 had an eye drop that she was not receiving as ordered. She had been several days without the eye drop. Review of Resident #3's November 2016 and December 2016 electronic Medication Administration Record (eMARs) revealed Xalatan (latanoprost) 0.005% drops instill one drop in left eye at bedtime was listed and scheduled for administration at 8:00 pm daily and documented as administered from 11/09/16 to 12/31/16. Review of Resident #3's January 2017 eMAR revealed: -Latanoprost 0.005% drops instill one drop in left eye at bedtime was listed and scheduled for	D 358		

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D 358	Continued From page 18 administration at 8:00 pm daily. -Latanoprost 0.005% drops instill one drop in left eye at bedtime was documented as "med(ication) not in the facility" for administration from 01/13/17 to 01/25/17, except on 01/14/17, 01/17/17, and 01/23/17 (10 of 13 opportunities). Interview on 01/26/17 at 4:00 pm with a representative from the current pharmacy provider revealed: -The pharmacy had started providing services to the facility at the end of December 2016. -The pharmacy computer indicated that Resident #3 was sent a refill of the latanoprost 0.005% on 01/11/17. -Resident #3 should have the eye drops for administration. Observation of medication administration on 01/26/17 at 8:10 am revealed there was no latanoprost 0.005% on hand for administration. Interview on 01/26/17 at 4:45 pm with an evening shift medication aide revealed: -She had not been administering Resident #3's latanoprost 0.005% drops because there was no medication on the medication cart. -The eye drops had been reordered from the pharmacy, but the facility was waiting on the pharmacy to deliver. Interview on 01/26/16 at 4:55 pm with the Resident Care Manager (RCM) revealed: -Medication Aide staff were trained to document any medication not administered on the eMAR for the reason not administered. -The facility changed pharmacy providers on 12/29/16. -She was aware Resident #3 had not been receiving latanoprost 0.005% drops instill one	D 358		

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D 358	Continued From page 19 drop in left eye at bedtime as ordered because staff informed her on 01/13/17. -Latanoprost 0.005% drops had been reordered for Resident #3 before she ran out of drops (on 01/11/17), but the drops were not on the medication cart for administration. -The RCM had contacted the current pharmacy provider on 01/13/17 and was told the pharmacy sent the latanoprost 0.005% drops on 01/11/17 and could not send more because of insurance payment. -The RCM found the pharmacy packing list dated 01/11/17 indicating the eye drops were received by the facility on 01/11/17. -The RCM looked in the refrigerator and retrieved a bottle of latanoprost 0.005% drops dispensed for Resident #3 on 01/11/17. -The RCM stated she had not checked the refrigerator prior to today (01/26/17 at 5:00 pm). Interview on 01/27/16 at 3:30 pm with a representative at Resident #3's ophthalmic physician's office revealed: -There was no documentation at the office regarding Resident #3 not receiving latanoprost 0.005% drops as ordered. -The physician's office expected the facility should be administering medications as ordered, if not then the physician should be notified in case the resident needed to be seen. Interview on 01/30/17 at 9:50 am with Resident #3 revealed she was receiving her eye drops at bedtime now, and her eyes felt better. Refer to Interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM).	D 358		

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D 358	Continued From page 20 Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). B. Review of Resident #6's current hospital FL-2 dated 01/03/17 revealed diagnoses included urinary tract infection, anxiety, bipolar disorder, and hypertension. Review of Resident #6's "Patient Medication Discharge Instructions" from the current hospital discharge dated 01/06/17 revealed physician's orders for carbamazepine 200 mg one-half tablet (100 mg) every morning and one and one-half tablets (300 mg) every day at bedtime. (Carbamazepine used to treat seizures, certain types of pain and bipolar disorders.) Observation of medication administration on 01/26/17 at 8:10 am revealed: -The dayshift Medication Aide (MA) checked Resident #6's electronic Medication Administration Record (eMAR) and prepared oral medications including one-half carbamazepine 200 mg (100 mg) and one tablet (200 mg) for a total of 300 mg of carbamazepine. -The computer screen displaying Resident #6's eMAR and medications scheduled for administration at 8:00 am revealed 2 orders for carbamazepine 200 mg; one order for carbamazepine 200 mg one-half tablet (100 mg) every morning and one order for carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime. Interview on 01/26/17 at 8:10 am the dayshift MA revealed she was giving one-half tablet of carbamazepine 200 mg from the bubble pack labeled and pre-split by the pharmacy, and one tablet of carbamazepine 200 mg from the bubble	D 358		

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D 358	Continued From page 21 pack dispensed from the pharmacy containing one whole tablet (labeled for one and one-half tablets (300 mg) every day at bedtime) to Resident #6. Review of Resident #6's printed copy of the January 2017 eMAR revealed: -Carbamazepine 200 mg take one-half tablet (100 mg) every morning was listed and scheduled for administration at 8:00 am. -Carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime was listed and scheduled for administration at 8:00 am (instead of in the evening). -Carbamazepine 200 mg take one-half tablet (100 mg) every morning was documented for administration at 8:00 am daily from 01/07/17 to 01/26/17. -Carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime was documented for administration at 8:00 am (morning) daily from 01/07/17 to 01/26/17. -There was no order on the eMAR for carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime scheduled for the evening or documented for administration in the evening from 01/07/17 to 01/26/17. Telephone interview on 01/26/17 at 10:00 am with a representative from the pharmacy provider revealed: -The facility was converted over to the current pharmacy provider in late December 2016 and orders were entered and scheduled by the current pharmacy provider during the transition. -The medications orders for the facility were entered by the pharmacy in one area of the pharmacy and reviewed in another area of the pharmacy. -The medication orders for Resident #6's	D 358		

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D 358	Continued From page 22 carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime was incorrectly scheduled for 8:00 am (morning) daily. -The facility was responsible for reviewing orders entered by the pharmacy for accuracy in addition to the pharmacy checking the order entry. -The facility should report any incorrect orders to the pharmacy for corrections. Review on 01/26/17 at 12:10 pm with the dayshift MA of Resident #6's carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime order entry history in the eMAR system and for the carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime revealed the order was entered by pharmacy staff and was released by the pharmacy staff without a facility staff member sign off. Second interview on 01/26/17 at 12:10 pm with the dayshift MA revealed: -She was a Lead Medication Aide for the dayshift medication aides. -She worked the dayshift routinely and administered medications to Resident #6 when she worked. -She did not enter orders in the computer eMAR system. -She overlooked the directions on the carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime bubble pack when she prepared Resident #6's medications. -She had overlooked the medication's label being for bedtime because the pharmacy assigned the incorrect time to the medication order on the eMAR and she focused on the medications in the assigned time slot. -She administered medications according to the eMAR and the times assigned by the pharmacy. -She had been administering Resident #6's	D 358		

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D 358	Continued From page 23 carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime scheduled for 8:00 am with the morning medications as displayed on the eMAR screen. Telephone interview on 01/27/17 at 3:00 pm with Resident #6's physician office representative revealed: -There was no documentation for Resident #6 receiving carbamazepine 200 mg one and one-half tablets (300 mg) every day at bedtime in the morning and not receiving the additional 100 mg of carbamazepine ordered each day. -The physician would expect medications to be administered as ordered. Interview on 01/30/17 at 10:00 am with Resident #6 revealed: -She received carbamazepine (Tegretol) for her bipolar condition. -She was not aware of the exact dosage she should be taking. -She had not experienced any bipolar mood changes (increased anxiety or depression) that she was aware. Refer to interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). C. Review of Resident #1's current FL2 dated 01/05/17 revealed: -Diagnoses included congestive heart failure, atrial fibrillation, hypertension, renal disease, hyperlidemia, hypothyroidism, chronic obstructive	D 358		

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D 358	Continued From page 24 pulmonary disease and cerebral vascular accident. Review of Resident #4's Resident Register revealed an admission date of 11/04/16. 1. Review of Resident #1's record revealed a physician's order dated 01/05/17 for Advair 250/50 dose inhaler (used to improve breathing and prevent asthma attacks), 1 puff every 12 hours. Review of Resident #1's November 2016 Electronic Medication Administration (eMAR) revealed: -Advair 250/50 was electronically transcribed for administration, 1 puff every 12 hours, and scheduled for 8:00 am and 8:00 pm. -Advair 250/50 was documented as administered every day since admission, for the month of November 2016 except for 11/14/16 and 11/24/16 with documentation Resident #1 refused the Advair. Review of Resident #1's December 2016 eMAR revealed: -Advair 250/50 was electronically transcribed for administration, 1 puff every 12 hours, and scheduled for 8:00 am and 8:00 pm. -Advair 250/50 was documented as administered every day for the month of December 2016, except for 12/04/16, 12/05/16, 12/06/16, 12/07/16 with documentation Resident #1 was hospitalized. Review of Resident #1's January 2017 eMAR revealed: -Advair 250/50 was electronically transcribed for administration, 1 puff every 12 hours, and scheduled for 8:00 am and 8:00 pm. -Advair 250/50 was documented as administered	D 358		

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D 358	Continued From page 25 01/01/17, 01/02/17, 01/03/17. -Resident #1 was hospitalized 01/04/17, 01/05/17, and 01/06/17. -The electronic transcription for Advair 250/50 was discontinued on 01/06/17. -Another electronic transcription, dated 01/06/17 for administration of Advair 250/50, 1 puff every 12 hours, and scheduled as prn. -There was no order to change the administration to prn. -No further administration of Advair 250/50 was documented for the month of January 2017. -Advair 250/50 was only administered on 01/01/17, 01/02/17, 01/03/17. Observation of medication on hand for Resident #1 on 01/26/17 at 10:00 am revealed Advair 250/50 was available. Interview on 01/26/17 at 2:10 pm with a representative from the physician's office revealed: -The medication had not been discontinued by the physician. -The physician was not aware the Advair 250/50 had not been administered as ordered for the month of January 2017, until 01/25/16. -Resident #1 had been assessed by a nurse with home health on 01/25/16. -The facility had a new pharmacy and had to clarify several medications with the physician this month. -The physician wrote another order for Advair 250/50 to be administered twice daily and faxed it to the pharmacy on 01/25/17. Interview with Resident #1 on 01/30/17 at 12:00 pm revealed: -She did not know what medications she took every day.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 26 -She depended on the facility to provide her medications as ordered by her physician. -No difficulty was observed in her breathing. Refer to Interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). 2. Review of Resident #1's record revealed a physician's order dated 01/05/17 for lasix 20 mg (used to reduce edema), 1 tablet on Monday, Wednesday and Friday. Review of Resident #1's November 2016 Electronic Medication Administration (eMAR) revealed: -Lasix 20 mg was documented for administration, take 1 tablet three times a week, and scheduled for 8:00 am. -Lasix 20 mg was documented as administered every Monday, Wednesday and Friday at 8:00 am, since admission for the month of November, except for 11/14/16, with documentation Resident #1 refused Lasix. Review of Resident #1's December 2016 eMAR revealed: -Lasix 20 mg was transcribed for administration, take 1 tablet by mouth three times a week, and scheduled for 8:00 am. -Lasix 20 mg was not documented as administered for 12/05/16 and 12/07/16 with documentation Resident #1 was hospitalized. -Lasix 20 mg was documented as administered on 12/01/16, 12/09/16, 12/12/16, 12/14/16,	D 358		

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D 358	Continued From page 27 12/16/16, and 12/19/16. -The electronic transcription for Lasix 20 mg, take 1 tablet by mouth three times a week, was discontinued on 12/20/16. -There was no d/c order in the record. -No additional administration for Lasix 20 mg was documented for the month of December 2016. Review of Resident #1's January 2017 eMAR revealed: -Lasix 20 mg was electronically transcribed for administration, take 1 tablet every Monday, Wednesday, and Friday and scheduled at 8:00 am. -Lasix 20 mg was documented as administered on 01/18/17, 01/20/17, 01/23/17, and 01/25/17 at 8:00 am. -Resident #1 was hospitalized 01/04/17, 01/05/17, and 01/06/17. Observation of medication on hand for Resident #1 on 01/26/17 at 10:00 am revealed Lasix 20 mg was available. Interview on 01/26/17 at 2:10 pm with a representative from the physician's office revealed: -The Lasix 20 mg had not been discontinued by the physician. -The physician was not aware the Lasix 20 mg had not been administered as ordered for the month of January 2017, until 01/25/16. -The facility had a new pharmacy and the facility had to clarify several medications with the physician this month. -The physician wrote another order for Lasix 20 mg to be administered every Monday, Wednesday and Friday and faxed it to the pharmacy on 01/25/17.	D 358		

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D 358	Continued From page 28 Interview with Resident #1 on 01/30/17 at 12:00 pm revealed: -She did not know what medications she took every day. -She depended on the facility to provide her medications as ordered by her physician. Refer to interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). 3. Review of Resident #1's record revealed a physician's order dated 01/05/17 for Spiriva 18 mcg (used to increase air flow to the lungs), 1 capsule by inhalation every day. Review of Resident #1's November 2016 Electronic Medication Administration (eMAR) revealed: -Spiriva 18 mcg was electronically transcribed for administration, inhale entire contents of 1 capsule (for a total of 2 puffs) via handihaler once daily, and was scheduled for administration at 8:00 am. -Spiriva 18 mcg was documented as administered every day since admission, for the month of November 2016, except for 11/14/16 and 11/24/16 with documentation Resident #1 refused spiriva. Review of Resident #1's December 2016 eMAR revealed: -Spiriva 18 mcg was electronically transcribed for administration, inhale entire contents of 1 capsule (for a total of 2 puffs) via handihaler once daily, and was scheduled for administration at 8:00 am.	D 358		

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D 358	Continued From page 29 -Spiriva 18 mcg was documented as administered every day for the month of December 2016, except for 12/04/16, 12/05/16, 12/06/16, 12/07/16 with documentation Resident #1 was hopsitalized. Review of Resident #1's January 2017 eMAR revealed: -Spiriva 18 mcg was electronically transcribed for administration, inhale entire contents of 1 capsule (for a total of 2 puffs) via handihaler once daily, and was scheduled for administration at 8:00 am. -Spiriva 18 mcg was documented as administered on 01/01/17, 01/02/17, and 01/03/17. -Resident #1 was hospitalized on 01/04/17, 01/05/17, and 01/06/17. -The electronic transcription for Spiriva 18 mcg was discontinued 01/06/16. -There was no order to discontinue Spiriva. -Another electronic transcription dated 01/06/17 for administration of Spiriva 18 mcg, inhale the contents of 1 orally once every day (by taking 2 separate inhalations via handihaler device), and scheduled as prn. -No further administration of Spiriva 18 mcg was documented for the month of January 2017. Observation of medication on hand for Resident #1 on 01/26/17 at 10:00 am revealed Spiriva 18 mcg was available. Interview on 01/26/17 at 2:10 pm with a representative from the physician's office revealed: -The Spiriva 18 mcg had not been discontinued by the physician. -The physician was not aware the Spiriva 18 mcg had not been administered as ordered for the month of January 2017, until 01/25/16.	D 358		

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D 358	Continued From page 30 -The facility had a new pharmacy and the facility had to clarify several medications with the physician this month. -The physician wrote another order for Spiriva 18 mcg, to be administered daily, and faxed it to the pharmacy on 01/25/17. Interview with Resident #1 on 01/30/17 at 12:00 pm revealed: -She did not know what medications she took every day. -She depended on the facility to provide her medications as ordered by her physician. Refer to interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). 4. Review of Resident #1's record revealed a physician's order dated 01/05/17 for pravastatin 80 mg (used to lower serum cholesterol), take 1 tablet by mouth every day. Review of Resident #1's November 2016 Electronic Medication Administration (eMAR) revealed: -Pravastatin 80 mg was electronically transcribed for administration, 1 tablet orally every day at bedtime, and scheduled for 8:00 pm. -Pravastatin was documented as administered every day, since admission, for the month of November 2016, except for 11/11/16, 11/16/16, 11/18/16 and 11/23/16 when it was documented that medication was not in the facility.	D 358		

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D 358	Continued From page 31 Review of Resident #1's December 2016 eMAR revealed: -Pravastatin 80 mg was electronically transcribed for administration, take 1 tablet by mouth every night at bedtime, and scheduled for 8:00 pm. -Pravastatin 80 mg was documented as administered every day, for the month of December 2016, except for 12/04/16, 12/05/16 and 12/06/16, when Resident #1 was hospitalized; and 12/10/16 and 12/20/16 when it was documented medication was not in facility. Review of Resident #1's January 2017 eMAR revealed: -Pravastatin 80 mg was electronically transcribed for administration, take 1 tablet by mouth at bedtime, and scheduled for 8:00 pm. -Pravastatin 80 mg was documented as administered 01/01/17, 01/02/17, and 01/03/17. -Resident #1 was hospitalized 01/04/17, 01/05/17, and 01/06/17. -The electronic transcription for pravastatin 80 mg was discontinued 01/06/16. -Another electronic transcription, dated 01/06/17 for administration of pravastatin 80 mg, take 1 tablet by mouth at bedtime, and scheduled as prn. -No further administration of pravastatin 80 mg was documented for the month of January 2017. -Pravastatin 80 mg was only administered 01/01/17, 01/02/17, 01/03/17. Observation of medication on hand for Resident #1 on 01/26/17 at 10:00 am revealed pravastatin 80 mg was available. Interview on 01/26/17 at 2:10 pm with a representative from the physician's office revealed: -The pravastin had not been discontinued by the	D 358		

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D 358	Continued From page 32 physician. -The physician was not aware the pravastatin not been administered as ordered for the month of January 2017, until 01/25/16. -The facility had a new pharmacy and had to clarify several medications with the physician this month. -The physician wrote another order for pravastatin 80 mg, to be administered daily at bedtime, and faxed it to the pharmacy on 01/25/17. Interview with Resident #1 on 01/30/17 at 12:00 pm revealed: -She did not know what medications she took every day. -She depended on the facility to provide her medications as ordered by her physician. Refer to interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). D. Review of Resident #4's current FL2 dated 08/15/16 revealed: -Diagnoses included cerebral vascular accident, hypertension, vitamin B deficiency and back ache. -Medications ordered included lutein (used to improve lutein deficiency) 10 mg, 1 tablet by mouth every day. Review of Resident #4's November 2016 Electronic Medication Administration (eMAR) revealed:	D 358		

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D 358	Continued From page 33 -An entry for lutein 10 mg, take one tablet by mouth daily. -Lutein had been documented as administered 30 times from November 1 through November 30. Review of Resident #4's December 2016 eMAR revealed: -An entry for lutein 10 mg, take one tablet by mouth daily. -Lutein had been documented as administered 30 times from December 1 through December 31. Review of Resident #4's January 2017 eMAR revealed: -An entry for lutein 10 mg, take one tablet by mouth every day. -Lutein 10 mg was not documented as administered 01/01/17 or 01/02/17. -"Med not in facility" was documented on the dates of 01/01/17 and 01/02/17 as the reason the medication was not administered. -Lutein 10 mg was documented as administered 01/03/17. -Lutein 10 mg was discontinued 01/02/17. -The was no additional documentation of administration of lutein 10 mg after 01/03/17. Interview on 01/26/17 at 2:10 pm with a representative from the physician's office revealed: -The lutein 10 mg had not been discontinued by the physician. -The physician was not aware the lutein 10 mg had not been administered for the month of January 2017 -The facility had a new pharmacy and had to clarify several medications with the physician this month. -The physician wrote another order for lutein 10 mg daily and faxed it to the pharmacy on	D 358		

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D 358	Continued From page 34 01/26/17. Observation on 01/25/17 at 4:15 pm of the medications on hand for Resident #4 revealed no lutein 10 mg was available for administration. Based on record review, observations and interviews, it was determined Resident #4 was not interviewable. Refer to interview on 01/26/17 at 10:10 am with a Medication Aide (MA). Refer to Interview on 01/26/17 at 11:00 am with the Resident Care Manager (RCM). Refer to interview on 01/26/17 at 11:30 am with the Executive Director (ED). Interview on 01/26/17 at 10:10 am with a Medication Aide (MA) revealed: -She administered medications as the medications appeared on the eMAR. -The facility had changed pharmacies recently. -The pharmacy had entered all the transcriptions for administration of medication. Interview on 01/26/17 at 11:00 am with the RCM revealed: -The facility had changed to a different pharmacy at the end of December 2016. -The pharmacy had transcribed all of the orders to the January 2017 eMARS. -Some errors had been found by herself and the MAs on the eMARs. -She notified the pharmacy and corrections had been made. -Some transcription errors probably still existed. -The MAs administered medications as transcribed on the eMARs.	D 358		

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D 358	Continued From page 35 Interview on 01/26/17 at 11:30 am with the ED revealed: -The facility changed to a new pharmacy in December 2016. -The facility had notified the pharmacy "multiple times" to correct transcription errors on the eMARs. -The facility did not have a process for comparing the new eMARs to the existing eMARs. -She and the RCD performed a medication administration audit every quarter. This consisted of direct observation of medication administration. -When the facility received a new order, the MA on duty faxed it to the pharmacy. The pharmacy electronically transcribed the order to the eMAR. The RCM approved the order. The medication arrived during 3rd shift and was stocked on the medication cart. The RCM confirmed the order the next day and administation would begin as ordered. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by the physician for 4 of 6 sampled residents regarding Resident #1 not receiving Advair 250/50 discus and Spiriva 18 mcg that could result in respiratory distress, Lasix 20 mg and 40 mg that could lead to fluid overload and pravastin 80 that could lead to clogged arteries; Resident # 3 not receiving latanoprost 0.005% ophthalmic drops that could result in increased occular pressure and eye damage, trazadone 50 mg that could result in increased insomnia, and docusate sodium that could result in discomforts of constipation; and Resident #6 not receiving the correct dose of carbamazepine 250 mg that could result in increased bipolar behaviors like agitation and depression; and, Resident #4 not receiving lutein 10 mg that could	D 358		

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D 358	Continued From page 36 improve health of the eyes. This noncompliance was detrimental to the health and safety of the residents which constitutes a Type B Violation. The facility's Executive Director provided a Plan of Protection on 01/27/16 as follows: -Staff will review records with physicians' orders and eMARs to assure medications are administered as ordered. -The Resident Care Manager (RCM) and Lead Medication Aides (LMA) will review all new orders to make sure the Pharmacy has orders that match the eMARS. -The RCM and LMA will contact the Pharmacy to clarify for errors. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 16, 2017.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related medication administration.	D912	ED to inservice all staff (all staff housekeeping care staff dietary activities) on resident rights and have all staff sign declaration of resident rights. ED to contact and schedule regional Ombudsman for inservice concerning resident right	

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D912	Continued From page 37 The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by the physician for 4 of 6 sampled residents with orders for lutein 10 mg (Resident #4), Advair 250/50 discus, Lasix 20 mg and 40 mg, Spiriva 18 mcg, and pravastatin 80 mg (Resident #1), carbamazepine 250 mg (Resident #6), and latanoprost 0.005% ophthalmic drops, trazodone 50 mg, and docusate sodium 100 mg (Resident #3). [Refer to Tag D 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		