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SPRINGS OF CATAWBA	2010 29TH AVENUE DRIVE NE HICKORY, NC 28601

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D 000	Initial Comments The Adult Care Licensure Section and the Catawba County Department of Social Services conducted an annual survey and compliant investigation from May 23, 2017 through May 30, 2017. The county initiated the complaint investigation on April 4, 2017.	D 000		
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: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure referral and follow-up for 1 of 6 sampled residents (#6) related to informing the resident's primary care provider of a critical missed medication for 7 consecutive days. The findings are: Review of Resident #6's current FL2 dated 9/27/16 revealed: -Diagnoses included Alzheimer's dementia, hypertension, cardiac dysrhythmia, and elevated blood lipids. -A medication order for warfarin 3mg daily Monday through Friday, and 2.5mg on Saturday and Sunday. (Warfarin is an anticoagulant used to prevent blood clots.) Review of a subsequent order dated 12/20/16	D 273		

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revealed:
-An increase in the dose of warfarin to 3mg daily due to an INR (International Normalized Ratio) of 1.7. (The INR is a lab test used to determine the dose and effectiveness of warfarin. A normal range for an anti-coagulated patient is 2.0 to 3.5).
-The dose of warfarin continued at 3mg per day until a dosage increase on 3/7/17 to 3mg daily Monday through Friday, and 3.5mg daily on Saturday and Sunday, due to an INR of 1.5.

Review of Resident #6's electronic Medication Administration Record (eMAR) for March 2017 revealed:
-An entry for warfarin 3mg, 1 tablet daily, with a scheduled administration time of 5pm.
-The warfarin 3mg was documented as administered daily from 3/1/17 through 3/4/17.
-The administration slot for 3/5/17 was blank with no Medication Aide's (MA) initials.
-The warfarin 3mg was initialed and circled from 3/6/17 through 3/11/17 indicating the warfarin was not administered.
-There was no entry for the warfarin dosage change from the order dated 3/7/17 to increase the Saturday and Sunday doses to 3.5mg daily.

Review of the exception sheet on the March 2017 eMAR for Resident #6 revealed:
-Entries on 3/6/17, 3/7/17, and 3/9/17 indicated the resident refused the warfarin 3mg on those days.
-Entries on 3/8/17, 3/10/17 and 3/11/17 indicated the warfarin 3mg was not administered due to "med not in facility."

Review of a facility incident and accident report dated 3/11/17 for Resident #6 revealed:
-EMS was called back to the facility at 11:00pm.
-Resident #6 was observed "having slurred

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speech."
-The resident was taken to the ER (Emergency Room) and hospitalized.
-The POA and primary care provider were notified.

Review of Resident #6's hospital ER report dated 3/11/17 at 11:46pm revealed:
-"Female seen in ER with a history of hypertension, elevated blood lipids, dementia, and TIA" (Transient Ischemic Attack.)
-"She fell in her assisted living facility and is seen in the ER with family members for evaluation due to difficulty with speech."
-"Subsequent to fall, they (unspecified) noted her speech was abnormal," and "onset time of abnormal speech unknown."
-"She is prescribed Coumadin (brand name warfarin) but for some reason has not had Coumadin for the last 5 days."
-"A subtherapeutic INR of 1.1" for an anticoagulated resident.
-A head CT (computerized tomography) noted no evidence of infarction, mass or hemorrhage.
-"Still aphasic, concern for stroke, probably secondary to subtherapeutic INR with atrial fibrillation."

Review of Resident #6's hospital record with an admission date of 3/12/17 at 12:01am revealed:
-Resident seen in ER after being found on the floor at the facility last evening.
-"She was noted to have subtherapeutic INR of 1.1, and EKG (electrocardiogram) revealed atrial fibrillation with a rate in the 70s."
-An "MRI (magnetic resonance imaging) of the brain was consistent with acute infarct (stroke)involving the left parietal and temporal lobes consistent with left posterior MCA" (middle cerebral artery) stroke.

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D 273	Continued From page 3 Interview with pharmacy staff at the provider pharmacy on 5/26/17 at 11:55am revealed: -The most recent order they had for Resident #6's warfarin was 3mg daily. -The last two refills for Resident #6's warfarin were for 30 tablets each on 1/27/17 and 2/25/17. Interview with a MA staff on 5/25/17 at 12:30pm revealed: -She had not worked at the facility very long prior to the incident with Resident #6's warfarin. -She did not realize how important the warfarin administration was to residents. -The warfarin 3mg was on the March 2017 eMAR, but it was not in the medication cart. -She did not give the resident her warfarin and documented on the eMAR the medication was not in the building. -She told the Resident Care Manager (RCM) Resident #6 was out of her warfarin and did not receive her warfarin during the medication pass on 3/9/17. -She did not follow-up with any other staff after she told the RCM. -During her training, she had been told by management staff not to document medications were not given because they were not available, but instead to document residents refused medications. Interview with the Executive Director Pro Tem (EDPT) on 5/26/17 at 3:48pm revealed: -She was told by staff (unspecified) Resident #6 had fallen in the facility on the evening of 3/11/17 and Emergency Medical Services (EMS) was called. -As far as she knew, this was the first time Resident #6 had fallen in the facility. -The resident later developed sluggish speech	D 273		

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and was sent out to the Emergency Room (ER).
-No MA or the RCM had informed her Resident #6 did not receive her warfarin because the MA staff believed it was not available.
-Staff eventually found the warfarin for Resident #6 on the bottom shelf of the medication cart with the overstock medications.

Review of an undated written statement from one MA regarding the incident with Resident #6's warfarin revealed:
-Staff stated she did not see the warfarin in the medication cart in it's designated place, and did not look anywhere else for the medication.
-Staff reordered medication from the eMAR system, but did not follow-up to see if the medication came in from the pharmacy.

Review of a written statement dated 3/13/17 from the second MA regarding the incident with Resident #6's warfarin revealed:
-She noticed Resident #6's warfarin was not available and looked in all the regular places, including the narcotic box, "regular patient medication area," and the overstock area in the bottom of the medication cart.
-She did not find the warfarin and hit the reorder button on the eMAR.
-"I noted the resident had been without her warfarin for 5 days, not including mine."
-"I was concerned, but still had many medications to pass."
-"I wrote the information on a little note pad so that I could follow-up, but I did not that night."

Review of a written statement dated 3/13/17 from a third MA regarding the incident with Resident #6's warfarin revealed:
-She had given Resident #6 her last dose of warfarin on Saturday 3/4/17, and reordered it on

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the computer (eMAR.)
-"Apparently it came in, but was put in wrong spot in cart."

Interview with the Special Care Unit Coordinator (SCC) on 5/26/17 at 2:55pm revealed:
-The warfarin was supposed to be kept in the narcotic drawer.
-This practice started "sometime last year to make sure the counts were right."
-If a MA could not find a medication, they are supposed to call the supervisor on duty or at least another MA."

Interview via telephone with the RCM on 5/26/17 at 2:58pm revealed:
-No MA had told her Resident #6 was out of her warfarin and had not been administered for days.
-MA staff kept trying to order the warfarin for Resident #6 by the eMAR, but it was not delivered from the pharmacy.
-She contacted the pharmacy provider (no date specified) about Resident #6's warfarin, and was told it wasn't sent because it was already there at the facility.

Review of Resident #6's hospital discharge record dated 3/20/17 revealed the documentation "due to the resident's profound dementia, recent strokes, and the likelihood of decline in heath, the family decided to proceed with placement in the skilled nursing facility with hospice to follow."

Interview with Resident #6's primary care provider on 5/26/17 at 10:40am revealed:
-She was not aware Resident #6 had missed doses of her warfarin until she got a call from the emergency room physician on 3/11/17,
-She had not gotten a call from the facility about Resident #6's missed doses of warfarin.

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-The missed doses of warfarin could have contributed to the resident's strokes.

Interview with Resident #6's POA and family member on 5/30/17 at 11:30am revealed:
-The family member had received a call on 3/11/17 at 9:23pm from the county EMS worker who stated Resident #6 had fallen in the facility and wanted to know if we wanted her transported to the hospital.
-The family member asked the EMS worker if the resident had received her medications.
-The EMS worker conferred with facility staff and was told Resident #6 had not taken her Coumadin for 5 days because "they were out, and none had been ordered."
-The POA decided not to transport Resident #6 to the hospital at that time because she had a do not resuscitate directive, and the POA and family member would be right down to the facility.
-When the POA and family member arrived at the facility approximately 30 minutes later, they found Resident #6 in her bed "confused and unable to speak any coherent words."
-The POA then requested EMS be called to transport the resident to the local hospital.
-At the hospital, the ER physician told the family Resident #6 had two strokes.
-The resident stayed in the hospital 8 days until she was transferred to a skilled nursing rehabilitation facility on 3/20/17.
-The skilled nursing facility attempted rehabilitation for 2 days, but stopped due to lack of progress.
-Resident #6 passed away on 3/25/17.

Review of Resident #6's Death Certificate dated 3/27/17 revealed the immediate cause of death as stroke.

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D 273	Continued From page 7 Review of the facility policy and procedures revealed no specific instructions related to informing a resident's primary care provider when a resident refuses medications or when when residents miss their medications due to the medications not being available. Review of facility policy and procedures revealed: -"If you see that you are getting low on medications-REORDER. -"If you find you are out of a medication-NOTIFY PHARMACY ASAP." -"NOTIFY RCD (RESIDENT CARE DIRECTOR) ASAP." -"Document in Med Tech Reporting Notebook." The facility failed to assure referral and follow-up to Resident #6's primary care provider in the area of a critical missed medication (warfarin) for 7 days. The missed doses of warfarin exposed Resident #6 to an increased risk of stroke and death. Had the primary care provider been informed, labwork could have been performed and the dose of warfarin adjusted if needed to protect the resident from stroke and death. Therefore the failure to report the missed doses of warfarin for Resident #6 constitutes a Type A1 violation. --- Review of a Plan of Protection provided by the facility on 5/26/17 revealed: -The facility will review policies and procedures with all medication aides as it relates to medication administration, medication refusals and follow-ups as it pertains to healthcare referrals such as labs and appointments. -The Executive Director and care managers will complete weekly cart audits. -The Executive Director will monitor for on-going	D 273		

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D 273	Continued From page 8 compliance. -Care managers will review the eMAR exceptions report daily and on-going for any required follow-up with physicians, medication refusals, and missed medications. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 29, 2017.	D 273		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations, interviews, and review of the facility's Activity Program calendar for May 2017, the facility failed to ensure a minimum of 14 hours per week of a variety of planned group activities that promoted socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of	D 317		

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new skills for residents were implemented.

The findings are:

Review of the activity calendar for May 2017 revealed:
-At least 14 hours of activities per week was listed.
-Activities included: devotions and current events, reminisce cube, gentle exercise, corn hole, short stories parachute fun, bingo, patio snacks paint and crafts, musical movie and snack, draw with chalk garden club and church services- were all offered, five times a week, every week on the same day each week.

The Activity Calendar for 5/23/17 revealed:
-8:00am Devotions and Current events
-11:00am Reminisce cube
-11:30am Gentle Exercise
-2:30pm Corn Hole Toss and snack
-6:30pm Healing Springs Church

Observation on 5/23/17 from 10:00 to 12:30pm revealed:
-No activities were offered on the small special care unit.
-There were three residents sitting in the living room, asleep, with the TV on.

Observation on 5/23/17 from 2:20pm to 5:00pm revealed no activities were offered on the small special care unit.

The Activity Calendar for 5/24/17 revealed:
-8:00am Devotions and Current events
-10:30am Short Story
-11:30am Gentle Exercise
-2:30pm Parachute Fun
-3:00pm Snacks

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D 317	Continued From page 10 Observation on 5/24/17 from 9:00am to 10:30pm revealed: -No activities were offered on the small special care unit. -There were four residents sitting in the living room area, asleep with the TV on. Observation of the Activity Director (AD) 5/24/17 at 10:30am explaining to Staff H, Personal Care Assistant (PCA) the activity and supplies needed for 5/25/17. Observation on 5/24/17 at 10:40am to 11:00am revealed: -The AD reading a short story to four residents on the small special care unit. -Staff did not ask any other residents to join the activity. -AD sat down in the living room and told the residents already in the living room she was going to read them a short story and turned the TV off. Observation on 5/24/17 from 11:30am to 12:15pm revealed no activities were offered on the small special care unit. Observation on 5/24/17 from 2:30pm to 5:00pm revealed no activities were offered on the small special care unit. The Activity Calendar for 5/25/17 revealed: -8:00am Devotions and Current events -10:30am Gospel Sing -11:30am Gentle Exercise -3:00pm Patio snacks Observation on 5/25/17 from 8:00am to 10:15am revealed no activities were offered on the small special care unit.	D 317		

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D 317	Continued From page 11 The Activity Calendar for 5/26/17 were: -8:00am Devotions and Current events -10:00am Paint and Craft -11:30am Gentle Exercise -2:00pm Musical Movie and Snack Observation on 5/26/17 from 10:15am to 11:30am revealed 4 residents making door hangers with Staff H, Personal Care Assistant (PCA). Interview with Staff H, PCA on 5/24/16 at 9:00am revealed: -"Everybody is sleeping in this am." -After the residents eat breakfast they usually go back to bed and then about 10:00am some will get coffee and a snack. -Some of the residents would watch TV. Interview with a resident on 5/25/17 at 9:25am revealed: -"They occasionally do activities." -"They didn't play corn hole yesterday." -The AD had taken the note off the bulletin board that "they were not doing bingo" on 5/24/17 for 5/25/17. Interview with a second resident on 5/25/17 at 10:01am revealed: -"Sometimes they do activities but not everyday." -He does not leave the special care unit. -"They keep the TV on." -Staff did not ask him to do any activities. A follow up interview with Staff H, PCA on 5/25/17 at 10:30am revealed: -The Activity Director was responsible for the activities. -She does things like "devotions, singing, reading	D 317		

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and they go up front for Bingo".
-She enjoyed being with the residents and "volunteered to help with activities".

Interview with a third resident on 5/25/17 at 10:38am revealed:
-She was unaware of any activities the facility provided.
-"They may, I don't know."

Interview with a second Staff K, PCA on 5/25/17 at 11:15am revealed:
-The AD was responsible for doing resident activities and outings.
-She was unaware of where the activity supplies were kept.

Attempted interview with the Activity Director on 5/24/17 and 5/25/17 was unsuccessful.

Interview with the Executive Director (ED) on 5/26/17 at 9:18am revealed:
-The AD was responsible for the three activity calendars for each unit, the activities and for transportation.
-The AD would be meeting with the ED prior to the beginning of each month to review the calendar and budgetary items for that month.
-At that time they would discuss any outings.
-The AD "would attend whatever activity required the most assistance, like bingo which is a facility activity."
-The AD was to gather the supplies, educate the PCA's about the day's activities when she will not be there.
-She was to be made aware when an activity or outing did not take place.
-She had not been made aware that scheduled activities on the activity calendar were not taking place.

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D 317	Continued From page 13 -"I do know bingo did not happen yesterday", the AD "was off yesterday and I didn't even think about it. We have it scheduled for today." -"We have a problem and we will fix it."	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on interviews and review of the facility's Activity Program calendar for May 2017, the facility failed to ensure all residents were offered and encouraged to participate in at least one outing every other month. The findings are: Review of the activity calendar for May 2017 revealed there were no outings listed on the calendar. Interview on 5/25/17 at 9:25am with a resident revealed: -"I've never been asked to go on an outing." -"I'd go if they would ask." Interview with a second resident on 5/25/17 at 10:01am revealed: -He does not leave the special care unit.	D 319		

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D 319	Continued From page 14 -He was unaware of any outings. -Staff did not ask him to go on any outings. Interview with Staff H, Personal Care Assistant (PCA) on 5/25/17 at 10:30am revealed: -The Activity Director was responsible for the activities and outings. -The facility had a van to take residents on outings but she was not aware of the residents being offered to go on any outings. Interview with a third resident on 5/25/17 at 10:38am revealed: -She was unaware of any outings or activities the facility provided. -"They may, I don't know." -She was not sure if she would participate or not but the outings "sounded nice". Interview with Staff K, PCA on 5/25/17 at 11:15am revealed: -The AD was responsible for doing resident activities and outings. -She was unaware of any outings. Attempted interview with the Activity Director on 5/24/17 and 5/25/17 was unsuccessful. Interview with the Executive Director (ED) on 5/26/17 at 9:18am revealed: -The AD is responsible for the three activity calendars for each unit, the activities and for transportation. -The AD would be meeting with the ED prior to the beginning of each month to review the calendar and budgetary items for that month. -At that time they would discuss any outings. -"We have a 6 passenger van and a bus that is able to accommodate wheelchairs." -The AD is to gather the supplies, educate the	D 319		

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D 319	Continued From page 15 PCA's about the day's activities when she will not be there. -She was to be made aware when an activity or outing did not take place. -She had not been made aware that residents were not being offered an outing at least every other month. -She was unaware if there had been any outings. -"We have a problem and we will fix it." On 5/30/17 at 11:27am the facility provided a copy of an outing log from 11/30/16 through 5/19/17 that revealed: -The outing for 5/19/17 was not on the May activity calendar. -There were 8 assisted living residents who had been on outings from November to May and only 1 resident from the special care units that had been on 2 outings in December. -No other residents from the special care units had been on any outings from November to May.	D 319		
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 A1 VIOLATION	D 358		

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Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner to 2 of 5 residents observed during a medication pass (#7 and #8) and 5 of 6 (#1, #2, #3, #4, and #6) sampled residents. (Seroquel, warfarin, temazepam, loratadine, methotrexate, autologous eye drop, sertraline, docusate/senna, pantoprazole, and cephalexin.)

The findings are:

A. Review of Resident #6's current FL2 dated 9/27/16 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, cardiac dysrhythmia, and elevated blood lipids.
-A medication order for warfarin 3mg daily Monday through Friday, and 2.5mg on Saturday and Sunday. (Warfarin is an anticoagulant used to prevent blood clots.)

Review of a subsequent order dated 12/20/16 revealed:
-An increase in the dose of warfarin to 3mg daily due to an INR (International Normalized Ratio) of 1.7. (The INR is a lab test used to determine the dose and effectiveness of warfarin. A normal range for an anti-coagulated patient is 2.0 to 3.5).
-The dose of warfarin continued at 3mg per day until a dosage increase on 3/7/17 to 3mg daily Monday through Friday, and 3.5mg daily on Saturday and Sunday, due to an INR of 1.5.

Review of Resident #6's record revealed INRs were checked weekly from 1/10/17 through 3/7/17 with a range of 1.5 to 3.6.

Review of Resident #6's electronic Medication Administration Record (eMAR) for February 2017

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revealed:
-An entry for warfarin 3mg, 1 tablet daily, with a scheduled administration time of 5pm.
-The warfarin 3mg was documented as administered daily.

Review of Resident #6's eMAR for March 2017 revealed:
-An entry for warfarin 3mg, 1 tablet daily, with a scheduled administration time of 5pm.
-The warfarin 3mg was documented as administered daily from 3/1/17 through 3/4/17.
-The administration slot for 3/5/17 was blank with no Medication Aide's (MA) initials.
-The warfarin 3mg was initialed and circled from 3/6/17 through 3/11/17 indicating the warfarin was not administered.
-There was no entry for the warfarin dosage change from the order dated 3/7/17 to increase the Saturday and Sunday doses to 3.5mg daily.

Review of the exception sheet on the March 2017 eMAR for Resident #6 revealed:
-Entries on 3/6/17, 3/7/17, and 3/9/17 indicated the resident refused the warfarin 3mg on those days.
-Entries on 3/8/17, 3/10/17 and 3/11/17 indicated the warfarin 3mg was not administered due to "med not in facility."

Review of an EMS report from 3/11/17 at 9:23pm revealed:
-Resident #6's vital signs were stable, with a blood pressure of 138/80, pulse of 70, and a blood glucose of 139.
-Resident had "no obvious injuries."
-The resident's Power of Attorney (POA) was contacted and a decision was made not to transport Resident #6 to the hospital at that time.

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Review of a facility incident and accident report dated 3/11/17 for Resident #6 revealed:
-EMS was called back to the facility at 11:00pm.
-Resident #6 was observed "having slurred speech."
-The Resident was taken to the ER (Emergency Room) and hospitalized.
-The POA and primary care provider were notified.

Review of Resident #6's hospital ER report dated 3/11/17 at 11:46pm revealed:
-"Female seen in ER with a history of hypertension, elevated blood lipids, dementia, and TIA" (Transient Ischemic Attack.)
-"She fell in her assisted living facility and was seen in the ER with family members for evaluation due to difficulty with speech."
-"Subsequent to fall, they (unspecified) noted her speech was abnormal," and "onset time of abnormal speech unknown."
-"She is prescribed Coumadin (brand name warfarin) but for some reason has not had Coumadin for the last 5 days."
-"History from patient is unobtainable due to aphasia."
-Physical exam noted elevated blood pressure of 171/92, and "irregularly irregular heart rhythm," and expressive aphasia.
-A "subtherapeutic INR of 1.1" for an anticoagulated resident.
-A head CT (computerized tomography) noted no evidence of infarction (stroke), mass or hemorrhage.
-"Still aphasic, concern for stroke, probably secondary to subtherapeutic INR with atrial fibrillation."
-"Will admit to hospital for observation and further evaluation and treatment."

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Review of Resident #6's hospital record with an admission date of 3/12/17 at 12:01am revealed:
-Resident seen in ER after being found on the floor at the facility last evening.
-"Staff reported resident was much more confused than normal, she was talking gibberish, CT of the head was unremarkable.
-"She was noted to have subtherapeutic INR of 1.1, and EKG (electrocardiogram) revealed atrial fibrillation with a rate in the 70s."
-Resident was admitted for observation, and stroke protocol initiated.
-An "MRI (magnetic resonance imaging) of the brain was consistent with acute infarct (stroke)involving the left parietal and temporal lobes consistent with left posterior MCA (middle cerebral artery) distribution infarct" (stroke).
-There was also "an area of possible hemorrhage in the left temporal lobe region of the infarct (stroke)."

Review of Resident #6's hospital discharge record dated 3/20/17 revealed:
-Due to the resident's profound dementia, recent strokes, and the likelihood of decline in heath, the family decided to proceed with placement in a skilled nursing facility with hospice to follow.
-The resident was originally to be discharged from the hospital on 3/17/17, but this was delayed to 3/20/17 due to a room not being available at the preferred facility.

Interview with pharmacy staff at the provider pharmacy on 5/26/17 at 11:55am revealed:
-The most recent order they had for Resident #6's warfarin was 3mg daily.
-The last two refills for Resident #6's warfarin were for 30 tablets each on 1/27/17 and 2/25/17.

Interview with pharmacy staff at the provider

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pharmacy on 5/26/17 at 3:00pm revealed:
-Routine oral solid dose medications are sent monthly automatically, unless the facility tells us not to send them.
-The MA can reorder medications directly from the eMAR.
-If a medication cannot be refilled due to the refill request being too early, an automated fax is sent to the facility to inform staff the medication will not be sent because the refill was too early.
-The only time Resident #6's warfarin 3mg was reordered via the eMAR system was on 3/21/17 at 9:03am, 10 days after the resident had left the facility.

Interview with a MA on 5/25/17 at 12:30pm revealed:
-She had not worked at the facility very long prior to the incident with Resident #6's warfarin.
-She did not realize how important the warfarin administration was to residents.
-She was competency validated by a registered nurse to administer medications.
-She shadowed a MA for 3 days, and trained with a MA for 3 days before she was allowed to pass medications by herself.
-The warfarin 3mg was on the March 2017 eMAR, but it was not in the medication cart.
-She did not give the resident her warfarin and documented on the eMAR the medication was not in the building.
-She told the Resident Care Manager (RCM) Resident #6 was out of her warfarin and did not receive her warfarin during the medication pass on 3/9/17.
-She did not follow-up with any other staff after she told the RCM.
-The MA can order medications on the eMAR, but "I was new and didn't know how to order meds on the computer."

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D 358	Continued From page 21 -During her training, she had been told by management staff (unspecified) not to document medications were not given because they were not available, but instead to document residents refused medications. Interview with the Executive Director Pro Tem (EDPT) on 5/26/17 at 3:48pm revealed: -She was told by staff (unspecified) Resident #6 had fallen in the facility on the evening of 3/11/17 and Emergency Medical Services (EMS) was called. -As far as she knew, this was the first time Resident #6 had fallen in the facility. -The resident later developed sluggish speech and was sent out to the Emergency Room (ER). -No MA nor the RCM informed her Resident #6 did not receive her warfarin because the MA staff believed it was not available. -Staff eventually found the warfarin for Resident #6 on the bottom shelf of the medication cart with the overstock medications. -MA staff tried to order the warfarin from the provider pharmacy, but it didn't come. -The provider pharmacy did not let the facility know why the warfarin wasn't being sent when it was reordered. -When she found out about the missed warfarin doses, she completed a medication error report and began to investigate the incident. -She took statements from staff involved in the incident. -After the incident, the facility did training with the MAs related to medication administration, reordering procedures, and the importance warfarin administration. -She heard the RCM tell the MA staff not to document on the eMAR medication was not available, just to document resident refused the medication.	D 358		

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-The EDPT corrected the RCM and informed MA staff the documentation on the eMAR was to be accurate and not to document resident refused as opposed to medication not available.

Review of an undated written statement from one MA regarding the incident with Resident #6's warfarin revealed:
-Staff stated she did not see the warfarin in the medication cart in it's designated place, and did not look anywhere else for the medication.
-Staff reordered medication from the eMAR system, but did not follow-up to see if the medication came in from the pharmacy.

Review of a written statement dated 3/13/17 from the second MA regarding the incident with Resident #6's warfarin revealed:
-She did not normally work as a medication aide but was filling in for staff that had called in sick, (no date mentioned).
-She noticed Resident #6's warfarin was not available and looked in all the regular places, including the narcotic box, "regular patient medication area," and the overstock area in the bottom of the medication cart.
-She did not find the warfarin and hit the reorder button on the eMAR.
-"I noted the resident had been without her warfarin for 5 days, not including mine."
-"I was concerned, but still had many medications to pass."
-'I wrote the information on a little note pad so that I could follow-up, but I did not that night."
-She was told there was a medication incident while working on a different hall on 3/11/17, and that night she was notified by phone at about 10pm Resident #6 was sent out with a possible stroke.
-"When I arrived the morning of 3/13/17, I

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checked to see about the medicine (warfarin) because I was told it was found in the cart."
-"It took two people searching to find it."
-"It (warfarin) had not been signed in, according to facility procedure, and was to be in the narcotic lock box."
-"I found the warfarin in Resident #6's regular medications and then filled out a narcotic sheet and put it into the narcotics box."
-She did not believe there was any reporting from shift to shift.

Review of a written statement dated 3/13/17 from a third MA regarding the incident with Resident #6's warfarin revealed:
-She had given Resident #6 her last dose of warfarin on Saturday 3/4/17, and reordered it on the computer (eMAR.)
-"Apparently it came in, but put in wrong spot in cart."
-"Me and (named staff) tore cart apart, and could not find it,"
-"When it (warfarin) was still not in on 3/11/17, I reordered it again."

Interview with the Special Care Unit Coordinator (SCC) on 5/26/17 at 2:55pm revealed:
-The warfarin was supposed to be kept in the narcotic drawer.
-This practice started "sometime last year to make sure the counts were right."
-If a MA could not find a medication, they are supposed to call the supervisor on duty or at least another MA."

Telephone interview with the RCM on 5/26/17 at 2:58pm revealed:
-No MA had told her Resident #6 was out of her warfarin and had not been administered for days.
-MA staff kept trying to order the warfarin for

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Resident #6 by the eMAR, but it was not delivered from the pharmacy.
-She contacted the pharmacy provider about Resident #6's warfarin, and was told it wasn't sent because it was already there at the facility.
-A MA found Resident #6's warfarin in the bottom drawer of the medication cart.
-The warfarin was supposed to be in the narcotic drawer and a narcotic count sheet kept so the doses administered can be monitored.
-Someone had placed the warfarin for Resident #6 in the overstock area of the medication cart.
-She was responsible for monitoring the accuracy of the eMARs.

In a subsequent telephone interview with the RCM on 5/30/17 at 12:10pm revealed:
-She instructed the MAs not to document a medication was unavailable, but instead to document the resident refused.
-That was the way she was trained in her previous job.
-The EDPT corrected her on documenting on the eMARs that residents were refusing their medications when actually the medications were not available.

Interview with Resident #6's primary care provider on 5/26/17 at 10:40am revealed:
-She was not aware Resident #6 had missed doses of her warfarin until she got a call from the emergency room physician on 3/11/17.
-The missed doses of warfarin could have contributed to the resident's strokes.
-She and her assistant come into the facility every Tuesday and check the INRs for residents on warfarin.
-She wrote orders for warfarin dosages weekly based on the INRs prior to leaving the facility, including the dosage change on 3/7/17.

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D 358	Continued From page 25 Review of Resident #6's Coumadin (brand name warfarin) worksheet revealed: -On 3/7/17 the INR was 1.5, with a current dose of 3mg warfarin daily, and an dosage adjustment to 3mg Monday through Friday, and 3.5mg on Saturday and Sunday. -On 2/28/17 the INR was 1.8, with a current dose of warfarin of 3mg daily, and no dosage adjustment. -On 2/21/17 the INR was 2.8, with a current dose of warfarin of 3mg daily, and no dosage adjustment. -On 2/14/17 the INR was 2.4, with a current dose of warfarin of 3mg daily, and no dosage adjustment. -on 2/7/17 the INR was 2.1, with a current dose of warfarin of 3mg daily, and no dosage adjustment. Review of Resident #6's eMAR from March 2017 revealed the last documented dose of warfarin 3mg administered was 3/4/17. Interview with Resident #6's POA and family member on 5/30/17 at 11:30am revealed: -The family member had received a call on 3/11/17 at 9:23pm from the county EMS worker who stated Resident #6 had fallen in the facility and wanted to know if we wanted her transported to the hospital. -The EMS worker told the family member based on their stoke protocol, the resident "has not had a stroke." -The family member asked the EMS worker if the resident had received her medications. -The EMS worker conferred with facility staff and was told Resident #6 had not taken her Coumadin for 5 days because "they were out, and none had been ordered." -The POA decided not to transport Resident #6 to	D 358		

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the hospital at that time because she had a do not resuscitate directive, and the POA and family member would be right down to the facility.
-When the POA and family member arrived at the facility approximately 30 minutes later, they found Resident #6 in her bed "confused and unable to speak any coherent words."
-The POA then requested EMS be called to transport the resident to the local hospital.
-At the hospital, the ER physician told the family Resident #6 had two strokes.
-The resident stayed in the hospital 8 days until she was transferred to a skilled nursing rehabilitation facility on 3/20/17.
-The skilled nursing facility attempted rehabilitation for 2 days, but stopped due to lack of progress.
-Resident #6 passed away on 3/25/17.

Review of Resident #6's Death Certificate dated 3/27/17 revealed the immediate cause of death as stroke.

Review of facility policy and procedures revealed:
-No specific details about the storage of warfarin tablets.
-A notation stated "Coumadin (warfarin) dosage may change daily, be sure to check MAR and medication pack to insure proper dose if given daily.
-"If you see that you are getting low on medications-REORDER.
-"If you find you are out of a medication-NOTIFY PHARMACY ASAP."
-"NOTIFY RCD (RESIDENT CARE DIRECTOR) ASAP."
-"Document in Med Tech Reporting Notebook."

Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am.

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D 358	Continued From page 27 B. Review of Resident #1's current FL-2 dated 1/10/17 revealed diagnoses included Alzheimer's Dementia, diabetes mellitus, depression and rheumatoid arthritis. 1. Review of Resident #1's current FL-2 dated 1/10/17 revealed a medication order for Methotrexate 2.5mg, 8 tablets by mouth every Friday. (Methotrexate is a medication used to treat rheumatoid arthritis.) Telephone interview with a family member of Resident #1 on 4/4/17 revealed: -The family member had concerns that Resident #1 had not been receiving her medications properly. -The family member had gone into the facility last week and asked to see her methotrexate tablets. -The bottle they were using had been filled on 2/3/17 and there were 5 tablets left in the bottle. -She got 32 tablets in each refill which was enough for 4 doses of 8 tablets on every Friday, a month's supply. -She should have already been completely out of tablets and had a new refill if she were getting the tablets as ordered. -Resident #1 had complained to the family member of swelling and pain in her joints for several weeks. -She was being treated by her rheumatologist for a flare. Observation of Resident #1's methotrexate tablets on 4/10/17 at 4:25pm revealed: -The bottle had been filled on 3/30/17 with 32 tablets. -There were 27 tablets left in the bottle. Review of Resident #1's April 2017 electronic	D 358		

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Medication Administration Record (eMAR) on 4/10/17 revealed:
-An entry for methotrexate 2.5mg, Take 8 Tabs by mouth Friday.
-In the month of April 2017 only one dose had been given on 4/7/17.

Interview with the Resident Care Manager (RCM) on 4/10/17 at 4:25pm revealed:
-She had removed 3 tablets on 3/31/17 from the bottle of methotrexate dispensed on 3/30/17 to combine with the 5 tablets that were left from the previous bottle to administer 8 tablets on 3/31/17.
-That left 29 tablets in the bottle.
-There should have been only one dose of 8 tablets given since the dose administered on 4/7/17, which should have left 21 tablets in the bottle of methotrexate.
-There were still 27 tablets left in the bottle, meaning the Medication Aide (MA) who administered the 4/7/17 dose gave 2 tablets instead of 8 tablets as ordered.
-The RCM would address the medication error with that staff person so that it wouldn't happen again.

Observation of Resident #1's methotrexate tablets on 5/4/17 revealed:
-The current bottle of methotrexate in use was dispensed on 3/30/17 with 32 tablets.
-There were 7 tablets left in the bottle.

Review of Resident #1's April 2017 and May 2017 eMars on 5/4/17 revealed:
-An entry for methotrexate 2.5mg, Take 8 Tabs by mouth Friday.
-Since 4/10/17, 3 doses had been documented as administered on 4/14/17, 4/21/17, and 4/28/17.
-The first Friday in May 2017 was on 5/5/17, therefore, no doses had yet been documented as

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administered in the month of May.

Interview with a MA on 5/4/17 at 3:15pm revealed:
-She had not recently checked the bottle of methotrexate for Resident #1, so she didn't realize there weren't enough tablets in the bottle for the dose due 5/5/17.
-She would order a refill immediately so that they would be in and the next dose could be given correctly.

Due to both the Executive Director Pro Tem (EDPT) and the RCM being unavailable on 5/4/17, the Business Office Manager (BOM) was informed on 5/4/17 at 4:15pm the count for the bottle of methotrexate for Resident #1 was incorrect, and 24 tablets should have been administered since 4/10/17 and only 20 tablets had been administered.

Observation of Resident #1's methotrexate tablets on 5/11/17 revealed:
-The bottle had been filled on 5/4/17 with 32 tablets.
-There were 32 tablets left in the bottle.

Review of Resident #1's May 2017 eMar on 5/11/17 revealed:
-An entry for methotrexate 2.5mg tablets, take 8 tablets by mouth Friday.
-One dose of 8 tablets had been documented as administered on 5/5/17.

Based on the observed methotrexate bottle counts on 5/4/17 and 5/11/17, Resident #1 could not have received the full dose of 8 tablets of methotrexate on 5/5/17, because only 7 tablets remained from the bottle of methotrexate dispensed on 3/30/17.

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D 358	Continued From page 30 The EDPT was notified on 5/11/17 at 2:15pm that count for the bottle of methotrexate for Resident #1 was incorrect, and the resident only received 7 tablets on 5/5/17 from the bottle dispensed on 3/30/17. Telephone interview with Resident #1's pharmacy on 5/24/17 at 8:54am revealed: -A bottle containing 32 tablets of the methotrexate was filled on 2/3/17. -A bottle containing 32 tablets of the methotrexate was filled on 3/30/17. -A bottle containing 32 tablets of the methotrexate was filled on 5/4/17. Review of a progress note from Resident #1's rheumatologist dated 3/23/17 revealed: -Resident #1 was diagnosed with rheumatoid arthritis in 1980. -She started as a patient of her current rheumatologist in October of 2010. -She had a right eye corneal perforation in 2008. -She was seen on 3/23/17 due to hand/wrist swelling for 2 weeks. -Her son is concerned about possible missed doses of her methotrexate. -The rheumatologist agreed with the son because Resident #1 has not flared in years with her current treatment. -Prednisone that had recently been prescribed had provided relief of symptoms. (Prednisone is a steroid used to treat inflammation and pain.) Review of Resident #1's record revealed: -An order prescribed by the rheumatologist dated 3/8/17 for Prednisone 10mg Take 3 tablets for 4 days, 2 tablets for 4 days, 1 tablet for 4 days, and ½ tablet for 4 days, once a day all together in the morning.	D 358		

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-An order prescribed by the rheumatologist dated 4/3/17 for Prednisone 10mg Take 3 tablets for 4 days, 2 tablets for 4 days, 1 tablet for 4 days, and ½ tablet for 4 days, once a day all together in the morning.

Review of Resident #1's lab work completed on 4/3/17 revealed:
-Sedimentation rate of 65, which had increased from 27 on 11/21/16. (The normal range for a sedimentation rate for females is 0-29 mm/hr and is used to determine general inflammation in the body.)
-C-Reactive Protein of 52.2, which had increased from 3 on 11/21/16. (A normal C-Reactive Protein level is any reading below 3mg/L. C-Reactive Protein is another measure of general inflammation in the body.)

Telephone interview with Resident #1's rheumatologist on 5/24/17 at 2:45pm revealed:
-Resident #1 had been a patient since 2010.
-She had not had an active flare of her rheumatoid arthritis since taking her on as a patient until this most recent one.
-The lab work done on 4/3/17 was to judge Resident #1's liver and kidney function, as well as gross inflammatory changes.
-The C-reactive Protein and sedimentation rates show inflammatory changes.
-Both measurements were elevated much higher than normal levels.
-Since she has been treating Resident #1, those levels have never been above normal until the labs drawn on 4/3/17.
-She feels like the flare has most likely been caused by missed doses of her methotrexate.
-Missed doses of the methotrexate will cause painful swelling in her joints.
-Compliance with her methotrexate was vital in

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Resident #1's case.
-If Resident #1 continued to flare, the outcome could be more deformities in her joints.
-Resident #1 has already lost her right eye due to her rheumatoid arthritis going uncontrolled.
-Vision loss and possibly losing her left eye is a risk factor for her because of that history.

Interview with Resident #1 on 5/4/17 at 3:35pm revealed:
-Her hands stay sore and swollen most of the time lately
-She wasn't sure what medications she took were supposed to help with joints.

Interview with the RCM on 5/24/17 at 4pm revealed:
-When the problem with Resident #1's methotrexate was brought to her attention on 4/10/17, she immediately talked with all medication aides about ensuring they were giving all 8 tablets as prescribed.
-When it was brought to her attention a second time that the count still continued to be off, she did further education with all medication aides.
-She also took a marker and wrote the number 8 on the lid of the bottle of tablets.
-For the past 2 weeks, she has been going to the medication aide working Resident #1's hall prior to the morning medication pass and reminding them to be sure they are giving 8 tablets of methotrexate.
-She is unsure is any medication error reports were ever done regarding the methotrexate for Resident #1, but she would check and see if she could find one.

Telephone interview with the EDPT on 5/26/17 at 4:15pm revealed:
-She assigned the responsibility to the RCM to

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ensure the medication was being given correctly.
-She would at times go behind and check the MARs to ensure the medication was being documented as given.

2. Review of Resident #1's current FL-2 dated 1/10/17 revealed a medication order for Autologous serum 50% ophthalmic drops instill 1 drop into left eye every hour while awake. (Autologous serum 50% ophthalmic drops is a medication used to treat severe dry eyes.)

Telephone interview with Resident #1's family member on 5/4/17 at 2:50pm revealed:
-Resident #1 had recently complained to him about her eye bothering her.
-He had the medication aide check her Autologous serum 50% eye drops, and the bag of eye drop bottles was still almost full.
-He had gotten the eye drops filled at the beginning of April, and the bag should be almost gone by now.
-Each day a new bottle should be used.
-The drops expire around 45 days after they are made.
-He will soon have to take Resident #1 back to the pharmacy to have blood drawn to have new drops made.
-He is concerned that Resident #1 isn't getting her eye drops as prescribed.

Observation of Resident #1's Autologous serum 50% eye drops on 5/4/17 revealed:
-According to the label, there had been 45 bottles of the drops dispensed on 3/22/17.
-There were 43 bottles still in the bag in the freezer in main medication room.
-There was one bottle in the refrigerator in the medication room that was currently being used.
-Unopened bottles were to be kept frozen, and

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D 358	Continued From page 34 open bottles were to be kept refrigerated. Review of Resident #1's April 2017 eMar revealed: -An entry for Autologous "Blood" Eye Drops to be administered hourly beginning at 6am and ending at 9pm. -A new bottle should be used each morning. -Only once on 4/16/17 at 12pm was the Autologous eye drop documented as not given due to the resident being out of the facility. Interview with a MA on 5/4/17 at 3:15pm revealed: -Each day she works she takes a new bottle out of the refrigerator and throws the one from the previous day away. -She tries her best to give the medication every hour as ordered, but when you have to run carts on 2 or 3 halls, it is often not possible to do it every hour. Interview with Resident #1 on 5/4/17 at 3:35pm revealed: -She knows she gets 2 or 3 different types of eye drops each day in her left eye. -She knows that the drops that are made of her blood are the ones in the small bottle that have to be kept in the freezer, and then once thawed, kept in the refrigerator. -She only gets the drops in the small bottle about 4 times per day most days. Observation of Resident #1's Autologous serum 50% eye drops on 5/23/17 revealed: -According to the label, there had been 45 bottles available for administration on 5/10/17. -The drops expire 45 days from the date they were filled. -The bottle should be discarded 24hrs after it is	D 358		

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opened.
-There were 28 bottles in the freezer in the main medication room.
-There were 10 bottles in the freezer in in the other medication room.
-There was 1 bottle in the refrigerator in another medication room that was currently being used.
-There was a total of 38 unused bottles remaining out of the 45 bottles filled on 5/10/17.
-Only 7 bottles had been used since the new supply was filled on 5/10/17.

Review of Resident #1's May 2017 eMAR revealed:
-An entry for Autologous "Blood" Eye Drops-hourly beginning at 6am and ending at 9pm.
-A new bottle should be used each morning.
-Only 4 times up through 3pm on 5/23/17 had it been documented that the Autologous eye drop was not given.
-5/1/17 at 9am it was documented that the resident refused the eye drop.
-5/12/17 at 4pm, 5pm, and 6pm it was documented that the resident was out of the facility.

Interview with a medication aide on 5/26/17 at 4:35pm revealed when the new supply of Autologous serum 50% eye drops was filled on 5/10/17, all the bottles from the previous fill were discarded because they had expired.

Telephone interview with Resident #1's compounding pharmacy on 5/24/17 at 9:10am revealed:
-The Autologous serum 50% eye drops are often prescribed for either post-surgical healing or chronic dry eye therapy.
-The pharmacy had been making the eye drops

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for Resident #1 since 2007.
-The eye drops are made from her own blood that has to be drawn each time the eye drops are made.
-The drops are made under sterile conditions, and are considered "no good after 45 days" due to the sterility of the drops no longer being certain.
-After the drops are thawed and opened, they should be discarded after 24hrs due to possible growth of bacteria in the drops.
-If drops are left out of the refrigerator after they are opened and they get warm, they will start growing bacteria.
-If they are not used as ordered then the patient's vision can be affected, and it can be harder to blink.
-A bag of 45 bottles had been dispensed on 1/30/17.
-A bag of 45 bottles had been dispensed on 3/22/17.
-A bag of 45 bottles had been dispensed on 5/10/17.

Telephone interview with Resident #1's ophthalmologist on 5/25/17 at 8:45am revealed:
-Resident #1 was prescribed the Autologous serum 50% drops due to her having severe and chronic dry eye.
-It is important for her to get the drops at least 10-16 times per day.
-The dry eye does affect her vision at times to the point that she can't read anything on the eye chart.
-Her vision fluctuates from office visit to office visit.
-If the severe dryness persists then scarring in the eye can occur.

Review of Resident #1's patient summary from

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her appointment to see her ophthalmologist on 2/21/17 revealed:
-Resident #1 was complaining that both her eyes were extremely dry.
-No changes in her vision were reported.

Interview with the RCM on 5/11/17 at 3:12pm revealed:
-She was auditing 5 residents on the carts each week.
-Audits are to look and see if resident has medications and if the MARs are reflecting the medications are being given.
-At the end of each shift, each MA is supposed to check to see if there have been any missed medications and fill out a report if there has.
-She had been working with staff to ensure that Resident #1 was getting her eye drops as ordered.

Telephone interview with the EDPT on 5/26/17 at 4:15pm revealed:
-She assigned the responsibility to the RCM to ensure the medication was being given correctly.
-She would at times go behind and check the MARs to ensure the medication was being documented as given.
-She did not count the bottles of medication to ensure it was being used as prescribed, she left that up to RCM and the Memory Care Manager.

3. Review of Resident #1's current FL-2 dated 1/10/17 revealed a medication order for pantoprazole Sodium 40mg tablet take 1 by mouth twice a day. (Pantoprazole is a medication used to treat gastric reflux.)

Review of Resident #1's record revealed an order to change the pantoprazole 40mg from twice daily to once daily on 5/15/17.

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D 358	Continued From page 38 Review of Resident #1's May 2017 eMAR revealed: -An entry for pantoprazole sodium 40mg, take 1 tab by mouth twice daily. -A new entry dated 5/17/17 on the eMAR for pantoprazole 40mg once daily, with a discontinue entry for the pantoprazole 40mg twice daily. -The pantoprazole sodium 40mg was changed from being given twice daily to being given once daily on 5/17/17. -Resident #1 did not receive the 8am dose on 5/13/17, 5/14/17, and 5/15/17 due to the medication not being available in the facility. -Resident #1 did not receive the 8pm dose on 5/11/17, 5/12/17, and 5/13/17 due to the medication not being available in the facility. Telephone interview with Resident #1's pharmacy on 5/24/17 at 4:48pm revealed: -The pantoprazole sodium 40mg to be given twice daily had last been filled on 3/30/17 with 60 tablets. -The new order for pantoprazole sodium 40mg once daily was filled on 5/15/17 with 30 tablets. -The facility had called and requested a refill a day or two prior to the new order on 5/15/17, but there were no refills available so it could not be filled. Interview with a MA on 5/24/17 at 11:50am revealed: -She did not remember exactly what had happened with the pantoprazole sodium for Resident #1. -If she signed the eMar and indicated that the medication was not in facility, then she could not find it in the cart and didn't give it. Interview with the RCM on 5/24/17 at 4pm	D 358		

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revealed:
-She had talked with staff and no one could tell her what had happened with the pantoprazole sodium for Resident #1.
-Most likely the tablets were not available in the building during the times the eMar reflects that the medications were not given.
-She had not been notified by staff that the medication needed to be reordered.
-Staff is supposed to either call Resident #1's pharmacy and reorder the medications themselves, or let the RCM know so that she can do it.
-Somewhere there was a breakdown where neither of those things happened.

Interview with the resident's primary care provider on 5/24/17 at 4:30pm revealed:
-She changed Resident #1's pantoprazole sodium 40mg from twice daily to once daily because it was recommended by the pharmacy.
-She was not aware that Resident #1 had missed several doses between 5/11/17 and 5/15/17.
-She had seen Resident #1 on 5/23/17 when she was in the building and Resident #1 had not mentioned any problems that would have been related to the missed doses.

Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am.

C. Review of Resident #7's current FL2 dated 4/4/17 revealed diagnoses included Alzheimer's Dementia, myelodysplastic syndrome, and gout.

Review of Resident #7's hospital laboratory work dated 5/8/17 revealed:
-Resident #7 had a urinary tract infection with bacteria sensitive to cephalexin type antibiotics.
-Review of a medication order dated 5/9/17 for

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Keflex 500mg, 1 every 6 hours as needed for 10 days.
-Review of a subsequent medication order dated 5/23/17, "please restart Keflex 500mg, 1 every 6 hours and complete remaining."

Observation of the morning medication pass on 5/24/17 at 8:40am revealed Resident #7 received 4 oral medications including cephalexin 500mg (generic Keflex).

Observation of Resident #7's medications on hand at 9am on 5/24/17 revealed:
-A bubble package of cephalexin 500mg, labeled 1 capsule every 6 hours, with a dispense date of 5/10/17 for 40 capsules.
-Thirteen capsules of cephalexin 500mg remained in the package.

Review of Resident #7's electronic Medication Administration Record (eMAR) for May 2017 revealed:
-An entry for cephalexin 500mg capsules, 1 every 6 hours for 10 days, with scheduled administration times of 8am, 2pm, and 8pm, and an original date of 5/11/17.
-The cephalexin 500mg had been documented as administered daily at 8am, 2pm, and 8pm, 3 times a day from 5/11/17 at 8am through 5/20/17 at 8am.
-The doses at 2pm and 8pm on 5/20/17 were initialed and circled as not administered.
-The eMAR exception sheet noted the last two doses on 5/20/17 were refused by resident.
-A second entry for cephalexin 500mg, 1 every 6 hours, (need stop date, complete remaining.)
-The second cephalexin 500mg entry had an original date of 5/24/17 with scheduled administration times of 2am, 8am, 2pm, and 8pm.
-A single dose had been documented as

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administered on the second cephalexin order at 8am on the morning of 5/24/17.
-This was the morning dose of cephalexin 500mg observed on the medication pass observation on 5/24/17.

Interview with the Medication Aide on 5/24/17 at 8:50am revealed:
-She administered medications according to the times on the eMAR.
-She believed Resident #7 had a brand new order for cephalexin in her record.
-Resident #7's urinary tract infection (UTI) symptoms were improved.
-She was not sure whose responsibility it was to fax orders to the pharmacy or to check the accuracy of the MARs.

Interview with the Resident Care Manager (RCM) on 5/24/17 at 3:20pm revealed it was her responsibility to check the accuracy of the eMARs.

Interview with the Executive Director on 5/24/17 at 3:40am revealed the RCM was supposed to check the accuracy of the eMARs.

Interview with the pharmacist at the provider pharmacy on 5/26/17 at 11:40am revealed:
-Resident #7's cephalexin 500mg was dispensed on 5/10/17 for 40 capsules with directions for use of 1 capsule every 6 hours for 10 days.
-The administration times on the 5/10/17 order were 8am, 2pm, 8pm, and 2am.
-She could not explain why the eMAR on the facility end only showed 8am, 2pm, and 8pm administration times.
-The pharmacy puts in the administration times of medications on the eMAR, but "the facility can change those."

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D 358	Continued From page 42 Interview with Resident #7's primary care provider on 5/26/17 at 10:40am revealed: -She was angry when she found out about Resident #7's cephalexin only being given 3 times a day. -She saw Resident #7 on 5/23/17, and she had improved from her UTI. -She wanted Resident #7 to finish the remaining cephalexin 500mg capsules. -She would recheck Resident #7's urinalysis on her facility visit next week to make sure the UTI did not require further treatment. Based on record review and observations on 5/24/17, Resident #7 was determined not to be interviewable. Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am. D. Review of Resident #4's current FL2 dated 1/16/17 revealed: -Diagnoses included chronic bronchitis, chronic obstructive pulmonary disease, a malignant neoplasm of the lower lobe (lung), and a secondary malignant neoplasm. -A medication order for temazepam 30mg, 1 capsule at night as needed for sleep. (Temazepam is a medication used to treat insomnia.) Review of Resident #4's record revealed: -An order to admit resident to local hospice on 11/18/16 with a diagnosis of lung cancer. -A subsequent order dated 3/8/17 to discontinue the prn (as needed) dosing of temazepam 30mg and use a scheduled dose of 30mg of temazepam at bedtime for sleep.	D 358		

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D 358	Continued From page 43 Review of Resident #4's electronic Medication Administration Record (eMAR) for March 2017 revealed: -An entry for temazepam 30mg, 1 capsule at bedtime, with a scheduled administration time of 8pm. -The temazepam 30mg was documented as administered daily from 3/10/17 through 3/31/17. Review of Resident #4's eMAR for April 2017 revealed: -An entry for temazepam 30mg, 1 capsule at bedtime, with a scheduled administration time of 8pm. -The temazepam 30mg had been documented as administered daily at 8:00pm except for the 4/22/17 through 4/25/17, which were initialed and circled. -The exception sheet of the April 2017 eMAR noted "med not in facility" for temazepam 30mg for 4/22/17 through 4/25/17. Review of Resident #4's eMAR for May 2017 revealed: -An entry for temazepam 30mg, 1 capsule at bedtime, with a scheduled administration time of 8pm. -The temazepam 30mg had been documented as administered daily except for 5/11/17 and 5/15/17, which were initialed and circled. -The slot for 5/23/17 administration was blank. -The exception sheet of the May 2017 eMAR noted "med not in facility" for temazepam 30mg for 5/11/17 and "resident refused" for 5/15/17. Observation of Resident #4's medications on hand at 4:50pm on 5/24/17 revealed: -A bubble package of temazepam 30mg, labeled 1 capsule at bedtime, with a dispense date of 5/5/17 for 14 capsules.	D 358		

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D 358	Continued From page 44 -Two capsules remained in the bubble pack. Review of the current narcotic count sheet for Resident #4's temazepam 30mg revealed 3 capsules should have remained in the bubble package. Interview with the Medication Aide (MA) on 5/24/17 at 4:55pm revealed: -The temazepam 30mg dose for the previous evening had not been signed out on the narcotic count sheet. -The resident received her dose last evening (5/23/17). -She could not explain why the temazepam dose from last evening was not documented on the eMAR. -She did not recall Resident #4 ever running out of her temazepam. -The hospice nurse checked on her medications and ordered them. -The resident would occasionally refuse her temazepam. Interview with Resident #4 on 5/25/17 at 9:55am revealed: -She had not missed any doses of temazepam this month (May 2017) including the dose night before last (5/23/17.) -They ran out of her temazepam 30mg "3 or 4 days" last month (April 2017.) -Staff told her the temazepam was "on order." -She refused her temazepam sometimes "when they try to give it too early." -The MA start passing out bedtime medications just after 7pm. -She didn't sleep well when they ran out of her temazepam 30mg, but "it doesn't work all that well anyway."	D 358		

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Interview with the hospice nurse on 5/25/17 at 11:40am revealed:
-She ordered the controlled medications for Resident #4 from the hospice pharmacy provider.
-The MA could make her aware of medications needed, but they cannot order them.
-"I check on the hospice residents at least once a week, and check medications to see if they need to be reordered."
-She did not recall Resident #4 ever running out of any of her medications.
-She always checked the narcotic counts when she came into a facility to order medications.
-She had never had any discrepancies in Resident #4's narcotic counts.

Interview with staff from the hospice pharmacy provider on 5/26/17 at 12:10pm revealed:
-Only the hospice nurse can reorder medications for hospice residents.
-The pharmacy only dispensed a 14 day supply.
-They had dispensed temazepam 30mg, 14 capsules on 2/28/17, 3/16/17, 3/29/17, 4/26/17, 5/5/17, and 5/25/17.

Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am.

E. Review of Resident #8's current FL2 dated 9/27/16 revealed:
-Diagnoses included Alzheimer's Dementia, hypertension, and a history of stroke.
-A medication order for loratadine 10mg, 1 tablet daily. (Loratadine is a medication used to treat seasonal allergies.)

Observation of the morning medication pass on 5/24/17 at 8:45am revealed Resident #8 received 8 oral medications, but no loratadine was administered.

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D 358	Continued From page 46 Review of Resident #8's electronic Medication Administration Record (eMAR) for May 2017 revealed: -An entry for loratadine 10mg, 1 tablet daily, with a scheduled administration time of 8am. -The loratadine 10mg had been documented as administered daily from 5/1/17 through 5/23/17. Observation of Resident #8's medications on hand at 11:15am on 5/24/17 revealed: -A bubble package of loratadine 10mg, labeled 1 tablet daily, with a dispense date of 5/22/17 for 30 tablets. -No tablets had been administered from the bubble package. Interview with the Medication Aide (MA) on 5/24/17 at 11:30am revealed: -She "missed" giving Resident #8 her loratadine this morning. -Usually the family provides the loratadine, but the bubble package was ordered from the backup pharmacy. Based on record review and observations on 5/24/17, Resident #8 was determined not to be interviewable. Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am. F. Review of Resident #2's previous FL2 dated 12/6/16 revealed: -Diagnoses included dementia, intracerebral hemorrhage, hypertension, anxiety and chronic pain. -A medication order for Seroquel 25mg by mouth at bedtime. (Seroquel is an antipsychotic used to treat behavoirs.)	D 358		

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Review of Resident #2's physicians orders revealed:
-A subsequent order dated 2/2/17 to discontinue the dosing of Seroquel 25mg at bedtime.
-A subsequent order dated 2/28/17 to restart Seroquel 25mg at bedtime.

Review of Resident #2's electronic Medication Administration Record (eMAR) for February 2017 revealed:
-An entry for Seroquel 25mg, 1 by mouth at bedtime, with a scheduled administration time of 8pm.
-The Seroquel 25mg was documented as administered daily from 2/1/17 through 2/8/17.

Review of Resident #2's eMAR for March 2017 revealed:
-An entry for Seroquel 25 mg, 1 by mouth at bedtime, with a scheduled administration time of 8pm.
-The Seroquel 25mg had been documented as administered daily 3/2/17 through 3/31/17.
-The exception sheet of the March 2017 eMAR noted "med not in facility" for Seroquel 25mg for 3/1/17.

Review of Resident #2's eMAR for April 2017 revealed:
-An entry for Seroquel 25 mg, 1 by mouth at bedtime, with a scheduled administration time of 8pm.
-The Seroquel 25mg had been documented as administered daily 4/1/17 through 4/30/17.

Review of Resident #2's eMAR for May 2017 revealed:
-An entry for Seroquel 25 mg, 1 by mouth at bedtime, with a scheduled administration time of 8pm.

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-The Seroquel 25mg had been documented as administered daily 5/1/17 through 5/16/17 with a scheduled administration time of 8pm..
-A subsequent order dated 5/17/17 for Seroquel 25mg tablet at bedtime, evening and every am with a scheduled administration time of 8am, 2pm and 8pm.
The exception sheet of the May 2017 eMAR noted "resident in hospital" 5/17/17 through 5/22/17.
-The Seroquel 25mg dose for the evening of 5/22/17 was blank on the eMAR.
-The Seroquel 25mg dose for the morning of 5/23/17 was documented as administered.

Observation of Resident #2's medications on hand at 10:30am on 5/25/17 revealed:
-A bubble package of Seroquel 25mg, labeled 1 by mouth in the am scheduled for 8am, 1 by mouth in the evening scheduled for 2pm and 1 by mouth at bedtime, with a dispense date of 5/17/17 for 30 tablets.
-Twenty nine tablets remained in the bubble pack.

Interview with Resident #2's family on 5/26/17 at 10:35am revealed:
-Had met with the Nurse Practitioner regarding discontinuing the residents Seroquel as she was more alert in the hospital and was not on it.
-The Nurse Practitioner had tried to stop the Seroquel but Resident #2 began having more behaviors and "we asked for the medication to be restarted."

Interview with Staff A, Medication Aide (MA) on 5/26/17 at 2:30pm revealed:
-The facility faxes the new orders or the FL2 to the pharmacy.
-The pharmacy puts the new orders on the eMAR.

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-"I really don't know about her meds I just go by what's on the screen."
-She could not explain why the Seroquel 25mg dose from 5/22/17 was not documented on the eMAR.
-She did not recall Resident #2 not having the medication available or ever having run out of her Seroquel.
-She was not aware of Resident #2 refusing her Seroquel.

Telephone interview with staff from the pharmacy provider on 5/26/17 at 8:24am revealed:
-The pharmacy had dispensed 90 tabs of the Seroquel 25mg on 12/31/17.
-The pharmacy had dispensed 30 tabs of the Seroquel 25mg on 3/1/17.
-The pharmacy had dispensed 30 tabs of the Seroquel 25mg on 4/28/17.
-The pharmacy had received a new order for Seroquel 25mg tablet at bedtime, evening and every am and dispensed a 90 tabs supply of the Seroquel 25mg on 5/17/17 for an administration time of 8am, 2pm and 8pm.
-The pharmacy had a discontinuation order for Seroquel on 2/2/17.

Telephone interview with Resident #2's Nurse Practitioner (NP) on 5/26/17 at 2:36pm revealed:
-She had met with Resident #2's family after she came back from the hospital in December.
-The family had requested that the Seroquel be discontinued as Resident #2 had not received it in the hospital and the family thought she was more alert.
-She was unaware the facility had given the Seroquel through 2/8/17 after the order to discontinue the medication was written on 2/2/17.
- She stated she could not go back and double check every order she writes to see if the facility

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does what she asked them to do.
-Resident #2 did not go through any withdrawal.
-"I have major concerns about medications that I order not being given in this building."
-Resident #2 began exhibiting an increase in behaviors and the family requested the Seroquel to be restarted.

Interview with the Executive Director on 5/26/17 at 3:50pm revealed:
-She had been the Executive Director since 5/15/17 and had been in training until 5/22/17.
-She had met the Nurse Practitioner this week for the first time but she did not mention any medications issues to her at the time.
-She was not aware of residents not getting their medications as ordered.
-She had not had time to recognize any issues.
-She would have expected Staff G to have shared the NP's concerns with her.

Based on record review and observations on 5/23/17, Resident #2 was determined not to be interviewable.

Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am.

G. Review of Resident #3's current FL2 dated 12/6/16 revealed diagnoses included Alzheimer's Dementia, urinary tract infection, insomnia, hip femoral neck fracture, and gastroesophageal reflux disease.

1. Review of Resident #3's signed physician order sheet dated 11/15/16 revealed an order for sertraline (used to treat depression) 100mg 1 tablet twice a day at 8am and 8pm.

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Review of Resident #3's current FL2 dated 12/6/16 revealed there was no physician's order to continue sertraline.

Review of Resident #3's December 2016 through April 2017 electronic Medication Administration Record (eMARs) revealed:
-A computer generated entry for sertraline 100mg 1 tablet twice a day at 8am and 8pm.
-The sertraline was documented as having been administered twice daily at 8am and 8pm.
-On 3/14/17, the 8pm dose was documented as not administered due to 'Med not in facility.'
-On 4/15/17, the 8pm dose was documented as not administered due to 'Resident Refused.'

Review of Resident #3's May 2017 eMAR revealed:
-A computer generated entry for sertraline 100mg 1 tablet twice a day at 8am and 8pm.
-The sertraline was documented as having been administered for 43 occurrences out of 44 opportunities from 5/1/17 to 5/22/17 twice daily at 8am and 8pm.
-On 5/20/17, the 8pm dose was documented as not administered due to 'Resident Refused.'

Observation of Resident #3's medication supply on 5/24/17 at 10:15am revealed:
-There was 1 pharmacy labeled bubble pack of sertraline 100mg tablets labeled with Resident #3's name.
-There were 22 sertraline 100mg tablets remaining in the pack.
-The instructions on the label were sertraline 100mg take 1 tablet twice daily.

Interview with the Resident Care Manager (RCM) on 5/24/17 at 11:20am revealed:
-Resident #3's sertraline had been discontinued

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"yesterday."
-"She's been getting it."
-"It's on all the physician orders."
-"It just got left off the FL2."
-"We've been administering it."

Telephone interview with Resident #3's Nurse Practitioner on 5/24/17 at 4:10pm revealed:
-Resident #3 was "not supposed to be getting the sertraline" after the FL2 orders dated 12/6/16.
-"I would have written a discontinue order (for the sertraline), however I saw that it was not on the FL2, so I didn't write the discontinue order."
-"I had already noticed a decline, and it was just an extra medication for them to try to get into her."

Telephone interview with the facility pharmacy on 5/24/17 at 4:40pm revealed:
-The most current order they had on file for Resident #3's sertraline was a signed physician order sheet dated 12/1/16 for sertraline 100mg 1 tablet twice daily.
-They had not received a copy of the FL2 dated 12/6/16.
-They had dispensed sertraline 100mg tablets for Resident #3 on the following dates: 1/27/17 60 tablets, 2/25/17 60 tablets, 3/21/17 30 tablets, 4/3/17 60 tablets, and 5/2/17 60 tablets.
-There were no documented returns of sertraline for Resident #3.

Based on record review and observations on 5/23/17, Resident #3 was determined not to be interviewable.

Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am.

2. Review of Resident #3's current FL2 dated

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D 358	Continued From page 53 12/6/16 revealed a physician's order for docusate/senna (used to prevent constipation) 8.6mg-50mg 2 tablets daily. Review of Resident #3's physician order dated 12/27/16 revealed docusate/senna 8.6mg-50mg 2 tablets twice a day. Review of Resident #3's December 2016 through April 2017 eMARs revealed: -A computer generated entry for docusate/senna 8.6mg-50mg 2 tablets daily at 8am. -The docusate/senna was documented as having been administered once daily at 8am. Review of Resident #3's May 2017 eMAR revealed: -A computer generated entry for docusate/senna 8.6mg-50mg 2 tablets daily at 8am. -The docusate/senna was documented as having been administered once daily at 8am from 5/1/17 to 5/22/17. -On 5/23/17, the 8am dose was documented as not administered due to 'Resident Refused.' Observation of Resident #3's medication supply on 5/24/17 at 10:15am revealed: -There was 1 pharmacy labeled bubble pack of docusate/senna 8.6mg-50mg tablets labeled with Resident #3's name. -There were 26 docusate/senna 8.6mg-50mg tablets remaining in the pack. -The instructions on the label were docusate/senna 8.6mg-50mg 2 tablets daily. Interview with the Resident Care Manager on 5/24/17 at 11:20am revealed she was not employed in the facility when the docusate/senna order was changed on 12/27/16 for Resident #3.	D 358		

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Telephone interview with Resident #3's Nurse Practitioner on 5/24/17 at 10:54am revealed:
-There was no detriment to the resident not receiving the docusate/senna twice daily.
-She could not remember why she had written to increase the dose on 12/27/16.
-It was "better" for Resident #3 "not to have so many stools, because of the wounds" the resident had on her buttock.

Telephone interview with the facility pharmacy on 5/24/17 at 9:50am revealed:
-The most current order they had on file for Resident #3's docusate/senna 8.6mg-50mg was for 2 tablets daily.
-They had not received a copy of the docusate/senna order dated 12/27/16.
-They had dispensed docusate/senna 8.6mg-50mg tablets for Resident #3 on the following dates: 12/30/16 60 tablets, 1/27/17 60 tablets, 2/25/17 60 tablets, 4/22/17 60 tablets, and 5/21/17 60 tablets.

Based on record review and observations on 5/23/17, Resident #3 was determined not to be interviewable.

Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am.

3. Review of Resident #3's current FL2 dated 12/6/16 revealed a physician's order for prednisone (used to stimulate appetite) 10mg 1 tablet every other day.

Review of Resident #3's December 2016 through April 2017 eMARs revealed:
-A computer generated entry for prednisone 10mg 1 tablet every other day at 8am.
-The prednisone was documented as having

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been administered once every other day at 8am.
-On 1/26/17, the 8am dose was documented as not administered due to 'Med not in facility.'
-On 3/17/17, the 8am dose was documented as not administered due to 'Med not in facility.'
-On 4/26/17, the 8am dose was documented as not administered due to 'Med not in facility.'

Review of Resident #3's May 2017 eMAR revealed:
-A computer generated entry for prednisone 10mg 1 tablet every other day at 8am.
-The prednisone was documented as having been administered once every other day at 8am from 5/1/17 to 5/22/17.

Observation of Resident #3's medication supply on 5/24/17 at 10:15am revealed:
-There was 1 pharmacy labeled bubble pack of prednisone 10mg tablets labeled with Resident #3's name.
-There were 10 prednisone 10mg tablets remaining in the pack.

Interview with the Resident Care Manager on 5/24/17 at 11:20am revealed:
-The prednisone "should have been here" referring to the missed doses documented on 1/26/17, 3/17/17, and 4/26/17.
-The missed dose on 1/26/17 either "wasn't here and they ordered it or it was here and they just didn't see it" in the medication cart.
-The missed dose on 3/17/17 "I would say it was overlooked, but since it wasn't me on the cart and I didn't witness it I can't say for sure."
-The missed dose on 4/26/17 she felt was overlooked because "that one is here because she has an extra card."

Telephone interview with Resident #3's Nurse

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D 358	Continued From page 56 Practitioner on 5/24/17 at 10:54am revealed: -Resident #3 was taking the prednisone as an appetite stimulant. -There was no detrimental effect to the resident for missing the doses on 1/26/17, 3/17/17, and 4/26/17. Telephone interview with the facility pharmacy on 5/24/17 at 9:50am revealed: -The most current order they had on file for Resident #3's prednisone 10mg was for 1 tablet every other day. -They had dispensed prednisone 10mg tablets for Resident #3 on the following dates: 2/25/17 15 tablets and 4/3/17 15 tablets. Based on record review and observations on 5/23/17, Resident #3 was determined not to be interviewable. Refer to the interview with the Resident Care Manager on 5/24/17 at 11:22am. _____ Interview with the Resident Care Manager (RCM) on 5/24/17 at 11:22am revealed: -The Nurse Practitioner was in the facility weekly on Tuesdays. -"I give her the physician's notebook and at the end of the day she gives me all the new orders she wrote for that day." -"I fax the new orders to the pharmacy." -The pharmacy "uploads" the orders to the eMAR system. -She then had to go into the eMAR system and review each new order entered by the pharmacy to "ensure start dates and end dates are right." -"Then from there I have to make sure the medication comes in."	D 358		

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D 358	Continued From page 57 -The medications "come in the same day that the order has been entered." -Pharmacy staff were available to receive and enter new orders "up to 8pm at night." -The Pharmacy "can make deliveries 24 hours a day. Anytime I can call if I need something stat or if it wasn't in the previous delivery." -Medication cart audits were being done once a week on Sundays by third shift staff . -A weekly audit entailed choosing 5 residents (different residents each week), printing their eMARs, and matching the medications on hand to the entries on the residents' eMARs. -"When I got here the medication cart overflow was in the bottom of the cart and it was crowded." -"So the pharmacy came in and reorganized the overflow, so now it's easier for them to find the medications." _____ The facility failed to administer medications as ordered by a licensed prescribing practitioner to 2 of 5 residents observed during a medication pass (#7 and #8) and 5 of 6 (#1, #2, #3, #4, and #6) sampled residents. These medication errors and omissions exposed residents to a variety of adverse and potentially adverse effects including stroke and death (warfarin), impaired sleep (temazepam), ineffective treatment of a UTI (cephalexin), worsening of allergy symptoms (loratadine), worsening of rheumatoid arthritis symptoms (methotrexate), severe dry eyes with corneal scarring (autologous eye drops), excessive sedation or psychotic symptoms (Seroquel), ineffective treatment of constipation (docusate/senna), poor appetite (prednisone), insomnia, agitation, and anxiety (sertraline), and taking an excessive dose (pantoprazole). Due to the many adverse effects, both permanent and temporary, and including stroke and death,	D 358		

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D 358	Continued From page 58 (Resident #6), affecting a large portion of the sampled residents, this citation constitutes a Type A1 Violation. _____ Review of a Plan of Protection provided on 5/11/17 and updated on 5/26/17 revealed: -Employees will be counseled and written up. -MAs will be trained on Coumadin. -We will implement a medication overflow basket in the med room. -Medication carts will be monitored daily by the RCM, SCC, or the Executive Director. -MAs will be inserviced on all medication policies and procedures. -When a medication cannot be located or is not available, pharmacy "lost medication" form will be completed to receive medication. -Coumadin will be located with narcotics (separate) so not to be missed. -eMAR will be audited daily by each shift, RCM, and SCC. -Facility will complete a 100% chart audit and follow-up as indicated. -Facility will refer Pharmacy Consultant to provide training on medication administration and follow-up. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 29, 2017.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These	D 392		

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records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure narcotic count record sheets were maintained for 1 of 5 (#4) residents sampled.

The findings are:

Review of Resident #4's current FL2 dated 1/16/17 revealed:
-Diagnoses included chronic bronchitis, chronic obstructive pulmonary disease, a malignant neoplasm of the lower lobe (lung), and a secondary malignant neoplasm.
-A medication order for temazepam 30mg, 1 capsule at night as needed for sleep. (Temazepam is a medication used to treat insomnia.)

Review of Resident #4's record revealed:
-An order to admit resident to local hospice on 11/18/16 with a diagnosis of lung cancer.
-A subsequent order dated 3/8/17 to discontinue the prn (as needed) dosing of temazepam 30mg and use a scheduled dose of 30mg of temazepam at bedtime for sleep.

Review of Resident #4's electronic Medication Administration Record (eMAR) for March 2017 revealed:
-An entry for temazepam 30mg, 1 capsule at bedtime, with a scheduled administration time of 8pm.
-The temazepam 30mg was documented as administered daily from 3/10/17 through 3/31/17.

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Review of Resident #4's eMAR for April 2017 revealed:
-An entry for temazepam 30mg, 1 capsule at bedtime, with a scheduled administration time of 8pm.
-The temazepam 30mg had been documented as administered daily except for the 4/22/17 through 4/25/17. which were initialed and circled.
-The exception sheet of the April 2017 eMAR noted "med not in facility" for temazepam 30mg for 4/22/17 through 4/25/17.

Review of Resident #4's eMAR for May 2017 revealed:
-An entry for temazepam 30mg, 1 capsule at bedtime, with a scheduled administration time of 8pm.
-The temazepam 30mg had been documented as administered daily except for 5/11/17 and 5/15/17, which were initialed and circled.
-The slot for 5/23/17 administration was blank.
-The exception sheet of the May 2017 eMAR noted "med not in facility" for temazepam 30mg for 5/11/17 and "resident refused" for 5/15/17.

Observation of Resident #4's medications on hand at 4:50pm on 5/24/17 revealed:
-A bubble package of temazepam 30mg, labeled 1 capsule at bedtime, with a dispense date of 5/5/17 for 14 capsules.
-Two capsules remained in the bubble pack.

Review of the current narcotic count sheet for Resident #4's temazepam 30mg revealed 3 capsules of temazepam 30mg should have remained in the bubble package.

Interview with the Medication Aide (MA) on 5/24/17 at 4:55pm revealed:
-The temazepam 30mg dose for the previous

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evening had not been signed out on the narcotic count sheet.
-Resident #4 received her dose of temazepam last evening (5/23/17).
-She could not explain why the temazepam dose from last evening was not documented on the eMAR.

Interview with Resident #4 on 5/25/17 at 9:55am revealed:
-She had not missed any doses of temazepam this month (May) including the dose night before last (5/23/17.)
-They ran out of her temazepam 30mg "3 or 4 days" last month (April 2017.)
-She refused her temazepam sometimes "when they try to give it too early."

Interview with the hospice nurse on 5/25/17 at 11:40am revealed:
-She ordered the controlled medications for Resident #4 from the hospice pharmacy provider.
-"I check on the hospice residents at least once a week, and check medications to see if they need to be reordered."
-She did not recall Resident #4 ever running out of any of her medications.
-She always checked the narcotic counts when she came into a facility to order medications.
-She had never had any discrepancies in Resident #4's narcotic counts.

Interview with staff from the hospice pharmacy provider on 5/26/17 at 12:10pm revealed:
-Only the hospice nurse can reorder medications for hospice residents.
-The pharmacy only dispensed a 14 day supply to hospice residents.
-They had dispensed temazepam 30mg, 14 capsules on 2/28/17, 3/16/17, 3/29/17, 4/26/17,

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D 392	Continued From page 62 5/5/17, and 5/25/17. Review of facility narcotic count records for Resident #4 revealed: -There were only 3 narcotic count sheets in the facility for Resident #4's temazepam 30mg including the one currently being used. -One narcotic count sheet for 14 capsules started with the first dose given on 4/8/17 and the last dose given on 4/21/17. -One narcotic count sheet for 13 capsules started with the first dose given on 4/27/17 and the last dose given on 5/10/17. Interview with the Executive Director on 5/26/17 at 3:45pm revealed those 3 narcotic count sheets were the only narcotic count sheets they could find in the facility for Resident #4's temazepam 30mg. Review of the facility's policy and procedure manual revealed: -Documentation of controlled substances will be maintained by the facility and will be available for review. -The record of documentation will be kept in the resident's record, ex. MAR or controlled drug sign-out record. -The documentation will be maintained within the facility for a minimum of 3 years.	D 392		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during	D 400		

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(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 400	Continued From page 63 monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure quarterly on-site medication reviews, that identified and prevented medication related problems for 1 of 6 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated	D 400		

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D 400	Continued From page 64 12/6/16 revealed: -Diagnoses included Alzheimer's dementia, urinary tract infection, insomnia, hip femoral neck fracture, and gastroesophageal reflux disease. -Medications which included cetirizine 5mg (used to treat allergy symptoms) 2 tablets daily at bedtime; docusate/senna 8.6mg-50mg (used to prevent constipation) 2 tablets daily; fluticasone 50mcg (used to treat allergy symptoms) 1 spray in each nostril daily at bedtime; mirtazapine 15mg (used to treat depression) 1 and 1/2 tablets daily at bedtime; olanzapine 5mg (used to treat depression and psychosis) 1 tablet daily at bedtime; and prednisone 10mg (used to stimulate appetite) 1 tablet every other day. Review of Resident #3's physician orders revealed: -An order dated 12/27/17 to change docusate/senna to 8.6mg-50mg 2 tablets twice daily -No current order for sertraline 100mg 1 tablet twice a day. Review of Resident #3's December 2016 through May 2017 electronic Medication Administration Record (eMARs) revealed: -The sertraline was documented as having been administered twice daily at 8am and 8pm. -The docusate/senna was documented as having been administered once daily at 8am. -The prednisone was documented as having been administered once every other day at 8am. -On 1/26/17, the prednisone 8am dose was documented as not administered due to 'Med not in facility.' -On 3/14/17, the sertraline 8pm dose was documented as not administered due to 'Med not in facility.' -On 3/17/17, the prednisone 8am dose was	D 400		

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D 400	Continued From page 65 documented as not administered due to 'Med not in facility.' Observation of Resident #3's medication supply on 5/24/17 at 10:15am revealed: -There was 1 pharmacy labeled bubble pack of sertraline 100mg tablets labeled with Resident #3's name. The instructions on the label were sertraline 100mg take 1 tablet twice daily. -There was 1 pharmacy labeled bubble pack of docusate/senna 8.6mg-50mg tablets labeled with Resident #3's name. The instructions on the label were docusate/senna 8.6mg-50mg 2 tablets daily. Review of Resident #3's Medication Review dated 3/29/17 revealed there were no recommendations made to the facility. Telephone interview on 5/26/17 at 2:25pm with the Pharmacy Consultant who performed the Medication Review for Resident #3 on 3/29/17 revealed: -The review on 3/29/17 was the first review she had done in that facility. -"I have access to their eMARs" and "I download those the night before" coming to the facility for the review. -"If their FL2 is not new, I try to focus on what's happened or changed since the last review." -She would have noticed if she had seen 'Med not in facility' documented as reasons for the missed doses of prednisone and "I would address that with them verbally and remind them they have 24 hour pharmacy services." -"We try to make sure they have what they need." -She had discussed the medications not being in the facility issue verbally with a staff person on her visit and she thought the staff was the Resident Care Manager. -She was unaware of the issues with the	D 400		

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D 400	Continued From page 66 sertraline and docusate/senna orders not having been changed as ordered on her last review of Resident #3's record. -"I will help work with them on these issues when I return in June." Interview with the Special Care Coordinator (SCC) on 5/26/17 at 3:00pm revealed: -"I haven't been here when the Pharmacy Consultants have come in." -She had been there once when the pharmacy came in to perform a medication cart audit. -During the medication cart audit "they make sure there's not an overstock of medications, that medications are not expired, and medications that have been discontinued are removed." -"I just started the SCC position 3 weeks ago." -The Resident Care Manager had been responsible for follow up on all medication review recommendations. Interview with the Executive Director on 5/26/17 at 3:10pm revealed: -"My expectations would be for follow up in a reasonable timeframe by my Resident Care Manager on all pharmaceutical medication review recommendations." -"I was not working in the facility at the time these issues occurred." -"I can only say we will implement changes going forward to ensure this doesn't happen again."	D 400		
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	D912		

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D912	Continued From page 67 regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, 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 in the areas of health care referral, medication administration, and examination and screening. The findings are: A. Based on observations, record reviews, and interviews, the facility failed to assure referral and follow-up for 1 of 6 sampled residents (#6) related to informing the resident's primary care provider of a critical missed medication for 7 consecutive days. [Refer to tag D273, 10A NCAC 13F .0902(b) Health Care, (Type A1 Violation.)] B. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner to 2 of 5 residents observed during a medication pass (#7 and #8) and 5 of 6 (#1, #2, #3, #4, and #6) sampled residents. (Seroquel, warfarin, temazepam, loratadine, methotrexate, autologous eye drop, sertraline, docusate/senna, pantoprazole, and cephalexin.) [Refer to tag D358 10A NCAC 13F .1004(a) Medication Administration, (Type A1 Violation.)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:	D914		

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D914	Continued From page 68 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure each resident was free from the risk of exploitation by failing to perform a controlled drug screening on a staff member with access to residents' controlled drugs prior to beginning employment. The findings are: Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 7 sampled staff, the Resident Care Manager, hired after 10/1/13 before the employee began working as a medication aide in the facility. [Refer to tag D992 G.S. 131D-45(a) Examination and Screening, (Type B Violation.)]	D914		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening	D992		

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D992	Continued From page 69	D992		

of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 7 sampled staff, Resident Care Manager (RCM) hired after 10/1/13 before the employee began working as a medication aide in the facility.

The findings are:

Review of the RCM's employment record revealed:
-The date of hire was 2/13/17.
-No documentation of completion of controlled

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D992	Continued From page 70 substance examination and screening. Interview with RCM on 5/24/17 at 11:20am revealed she had been working in the facility since February 2017. Interview with the Executive Director (ED) on 5/25/17 at 9:30am revealed: -She had suspended RCM last night (5/24/17). -During an audit of staff records the night before (5/24/17), the ED discovered no controlled substances screening had been completed on RCM prior to her being hired. -The audit of RCM's record was triggered by an irregularity noted in the documentation of a narcotic medication on the electronic Medication Administration Record. -The ED had taken RCM for a drug test the night before (5/24/17) and she tested positive for controlled substances. -RCM had a physician's order for some of the controlled substances. -The business office manager and ED were both responsible for ensuring controlled substances screenings were performed on new employees. Interview with the RCM on 5/30/17 at 12:10am revealed: -She had not been "drug tested" when she started at the facility. -She was not sure why she was not tested, and was aware it was a requirement of employment. -She did not know the previous business office manager prior to starting work at the facility. Review of RCM Drug Test Consent and Testing Results dated 5/24/17 revealed: -The consent to allow for a pre-employment and/or reasonable suspicion drug test screen was electronically signed by RCM on 1/18/17.	D992		

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D992	Continued From page 71 -A drug test was performed on 5/24/17. -The test was positive for known controlled substances.. The facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 7 sampled staff (RCM) hired after 10/1/13 before the employee began working as a medication aide in the facility. This failure to screen a new employee for controlled substances with access to narcotics in the med room and medication cart created the potential for drug diversion and exploitation of resident's resources and constitutes a Type B Violation. A plan of protection was received from the facility on 5/25/17 as follows: -The Executive Director and the Business Office Manager will perform a review of all employee files to ensure a controlled substance examination and screening was performed upon hire for all employees hired after 10/1/13. -Immediate testing of all staff as a result of review, where controlled substance examination and screening was not performed. -The Executive Director and Business Office Manager will review all new staff files for controlled substance examination and screening for the presence of controlled substances before an offer of employment is made. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 2017.	D992		