STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041030	A. BUILDING: _____ B. WING _____	R 07/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 6-7, 2017.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Non-compliance continues Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing licensed practitioner for 2 of 5 sampled residents (Resident #5 and #1) with orders for an anti-depressant (#5) and an anticoagulant (#1). The findings are: A. Review of Resident #5's current FL dated 4/19/17 revealed: -Diagnoses included hypertension, adult onset diabetes mellitus, hypothyroidism, chronic pain, insomnia, anemia, hyperlipidemia, and incontinence. -A physician's order for Cymbalta 30 mg daily. Review of Resident #5's May, June and July 2017	{D 358}		

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electronic Medication Administration Record (eMAR) revealed there were was no entry for Cymbalta 30 mg daily.

Observation of Resident #5's medications on hand on 7/6/17 at 3:30 pm revealed Cymbalta 30 mg was available for administration.

Interview on 7/6/17 at 3:30 pm with a second shift Medication Aide (MA) revealed:
-She had worked at the facility for about 6 months.
-She was unaware Cymbalta was ordered.
-She had never given Cymbalta to Resident #5.
-The RCC/MAs were responsible for entering new orders onto the eMAR.
-She was unsure who was responsible for checking for accuracy of the eMAR monthly.

Interview on 7/6/17 at 3:45 pm with Resident #5's family member revealed:
-The family member was unaware if Resident #5 was receiving Cymbalta or not as ordered.
-The family member spoke with the Executive Director (ED) on 7/6/17 and requested the medication be started as soon as possible.
-The family member stated the resident had not exhibited signs of depression.

Interview on 7/6/17 at 4:00 pm with the Resident Care Coordinator (RCC) revealed:
-The MAs were responsible for entering orders into the eMAR system.
-She was not aware Cymbalta was ordered or that Resident #5 had not received Cymbalta as ordered.
-She was responsible for reviewing new orders and checking the eMARs for accuracy.

Telephone interview on 7/7/17 at 10:30 am with

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the Nurse at Resident #5's physician's office revealed:
-The physician was unaware the resident was not receiving Cymbalta as ordered.
-The physician did not feel the resident was in danger due to not receiving Cymbalta as ordered.

Interview on 7/7/17 at 12:00 pm with the Executive Director revealed:
-He was unaware that Resident #4 was to receive Cymbalta daily and was not receiving the medication as ordered.
-The RCC was responsible for checking orders and making sure the eMARs were correct.
-No one checked behind her to make sure orders were on the eMARs.

B. Review of Resident #1's current FL dated 3/15/17 revealed:
-Diagnoses included hypertension, congested heart failure, and cardiac arrhythmia.
-There was no Coumadin ordered on the FL2.

Review on 7/7/17 of Resident #1's record revealed:
-A subsequent signed physician's ordered dated 3/15/17 to administer Coumadin (an anticoagulant used to treat cardiac arrhythmia) 5 mg every Wednesday and 2.5 mg on Monday, Tuesday, Thursday, Friday, Saturday and Sunday.
-Another signed subsequent physician's order dated 5/23/17 to administer Coumadin 2.5 mg on Thursday and Saturdays and 5 mg on Monday, Tuesday, Wednesday, Friday and Sunday.

Review of Resident #1's June 2017 electronic Medication Administration Record (eMAR) revealed there were no documentation Resident #1 had been administered Coumadin for three

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consecutive days 6/22/17 Thursday 2.5 mg Coumadin, 6/23/17 Friday 5 mg Coumadin and 6/24/17 Saturday 5mg Coumadin.

Review of Resident #1's Home Health progress notes revealed:
-The home health notes included laboratory blood work INR (International Normalized Ratio) (laboratory result used with Coumadin to evaluate the thinnest of the blood).
-An INR was documented on 6/13/17 with a result of 1.6 (normal INR 2.0-3.0).
-A second INR was documented on 6/28/17 with a result of 1.8.

Telephone interview on 7/7/17 at 2:30 pm with the Home Health Nurse revealed:
-She was responsible for obtaining the INR from Resident #1.
-She had taken the lab draw via fingerstick and immediately obtained the results on 6/13/17 and 6/28/17.
-She sent the results to the physician for review and obtained new orders for the Coumadin administration.
-She was not aware Resident #1 missed 3 days of Coumadin on 6/22/17, 6/23/17, and 6/24/17.
-Resident #1's current Coumadin dose order as of 6/28/17 was Coumadin 5 mg every day.

Interview on 7/7/17 at 4:00 pm with the second shift Medication Aide (MA) revealed:
-She had worked in the facility for about 6 months.
-She always compared the medications to the eMAR prior to administering medications to the residents.
-She could not recall missing any days in the month of June 2017 administering Resident #1's Coumadin.

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-"There were many changes in the last few weeks to Resident #1's Coumadin dose, maybe someone was unsure how much to give."
-She was unsure who was responsible for checking holes in the eMAR monthly, or if they were checked at all.

Interview on 7/7/17 at 3:05 pm and on 7/8/17 at 9:00 am with the Resident Care Coordinator (RCC) revealed:
-The MAs were responsible for putting orders in the eMAR system and verifying they were correct.
-She was not aware Resident #1 had 3 consecutive missed doses of Coumadin on 6/22/17, 6/23/17, and on 6/24/17.
-She thought the MAs were administering the medications as ordered by the physician.
-"Maybe it was a new MA and they were unsure of the dose of Coumadin."
-"I am not sure what happened."
-She was responsible for overseeing the clinical staff and reviewing resident's records and new orders.
-The facility had no current system in place for tracking Coumadin or INR levels.

Telephone interview on 7/8/17 at 11:30 am with Resident #1's physician revealed:
-The physician was unaware Resident #1 had 3 consecutive missed doses of Coumadin on 6/22/17, 6/23/17 and on 6/24/17.
-He relied on the facility staff to administer the medications to Resident #1 as ordered.
-He was aware Resident #1's INR result was 1.6 on 6/13/17 and on 6/28/17 the INR result was 1.8.
-He assumed since the INR had increased the facility staff had administered the Coumadin as ordered.
-The three missing doses of Coumadin were not detrimental to Resident #1 because the INR had

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{D 358}	Continued From page 5 increased, but he expected the facility staff to give the medications as prescribed to Resident #1. Interview on 7/8/17 at 12:00 pm with the Executive Director revealed: -He was not aware Resident #1 had 3 consecutive missed doses of Coumadin on 6/22/17, 6/23/17 and on 6/24/17. -The RCC was responsible for the clinical staff which included the MAs and reviewing the resident record. -He worked at a previous facility where the nurse kept a Coumadin tracking log book, and had mentioned it to the RCC about a week ago. -A Coumadin tracking book would be implemented as of 7/7/17 by the RCC for tracking Coumadin orders and the INR results. -He would be responsible for following up with the RCC on the administration of Coumadin, new orders, and laboratory work for the residents in the facility.	{D 358}		