STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050017	A. BUILDING: _____ B. WING _____	R 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERMITAGE	185 BRICKFARM ROAD DILLSBORO, NC 28725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Jackson County Department of Social Services conducted annual and follow-up surveys on July 12-13, 2017.	D 000	D 276 The Hermitage Responses to the citied deficiencies do not constitute an admission or agreement by facility of the truth of facts alleged or conclusions set forth in Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure a physician's order for laboratory work was implemented for 1 of 5 sampled residents (#3) in the special care unit. The findings are: Review of Resident #3's current FL2 dated 3/29/17 revealed diagnoses included Alzheimer's dementia, cognitive muscle weakness, angina, generalized pain, and hypertension. Review of the Nurse Practitioner's (NP) progress note dated 6/7/17 revealed: -This was a follow-up visit for laboratory studies completed for Resident #3 showing a potassium level of 3.0mmol/L. (The normal range for potassium for this lab is 3.6 to 5.0 mmol/L)	D 276	D 276 (C) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. 1. The facility and FNP have coordinated procedure to ensure follow up for labs. FNP will write all lab orders on same day as medicial visit, FNP will give written lab orders directly to RCC/SCC before exiting the facility on that day. 2. SCC/RCC will enter follow up visit into EMAR schedule for	

8-17-17
REVIEWED + APPROVED

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D 276	Continued From page 1 -"Starting on June 1, the resident was started on 20meq every 4 hours for 5 doses followed by daily potassium chloride (KCl) doses." (KCl is a supplement used to treat low serum potassium levels.) -"This has been completed, and resident is currently on a chronic daily dose of potassium chloride 20meq." -"With respect to hypokalemia (low potassium), a BMP (basic metabolic panel is a lab that contains a potassium level) will need to be completed at the next regular lab date." Interview with the facility Administrator on 7/13/17 at 12:15pm revealed: -Lab draws were obtained monthly, "usually toward the end of the month." -The Special Care Coordinator (SCC) that would have been responsible for coordinating the BMP for Resident #3 no longer worked for the facility. -The Administrator believed the lab draw for Resident #3's BMP was missed in June 2017, and would be drawn today (7/13/17.) Review of the results of the lab draw on 7/13/17 at 12:13pm revealed: -All values on the BMP were within normal limits. -Resident #3's potassium level was 4.8mmol/L, with a reference range 3.6 to 5.0mmol/L. Interview with the NP on 7/13/17 on 3:30pm revealed: -She expected the BMP for Resident #3 would be drawn on the next regular lab day during the month she ordered it. -She believed labs were drawn at the facility in June 2017 toward the end of the month, "around the 29th." -She was not aware Resident #3's lab had not been drawn in June 2017.	D 276	follow lab reveiw to ensure FNP reviews all labs after monthly lab draw. The follow up appointment will be entered into EMAR system on same day as initial visit and schedule with be reviewed by FNP and RCC/SCC. Completion Date 8/1/17 Signature/Title [signature]	

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D 368	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medication was administered as ordered by a licensed prescribing practitioner for 1 of 5 residents (#3) sampled. (Potassium Chloride.) The findings are: Review of Resident #3's current FL2 dated 3/29/17 revealed diagnoses included Alzheimer's dementia, cognitive muscle weakness, angina, generalized pain, and hypertension. Review of Resident #3's medication orders revealed an order dated 5/31/17 for KCl (potassium chloride) 20meq, 1 tablet daily; 1 every 4 hours for 5 doses. (KCL is a supplement used to treat low serum potassium levels.) Review of Resident #3's electronic Medication Administration Record (eMAR) for June 2017 revealed: -An entry for KCl 20meq, 1 tablet by mouth daily; 1 every 4 hours for 5 doses with a start date	D 358	D 358 The Hermitage (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescriptions, 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. 1. Facility began chart reviews for all residents on 7-14-2017 and completed all reveiws on 8-2-2017. 2. Facility provided mandatory Med Administration training for all Medication Aides on 7-14-2017 3. RCC/SCC received a training review on reviewing and approving medication orders in QuickMar on 7-15-2017. 4. Facility will complete a weekly medication cart audit to assure medications are available for administration, along with being given appropriately. Completion Date 8/14/17 Signature/Title [illegible]	

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D 358	Continued From page 3 6/1/17 and a stop date of 6/5/17. -The KCl 20meq had scheduled administration times of 12am, 4am, 8am, 12pm, 4pm, and 8pm. -The KCl 20meq was documented as administered from 4am on 6/1/17 through 8pm on 6/5/17 with 5 doses documented as administered on 6/1/17, and 6 doses documented as administered on 6/2/17, 6/3/17, 6/4/17, and 6/5/17 for a total of 29 doses. -A second entry for KCl 20meq, 1 tablet daily, with a scheduled administration time of 8am, and a start date of 6/2/17. -This KCl 20meq entry was documented as administered daily at 8am from 6/2/17 through 6/30/17. Review of Resident #3's eMAR for July 2017 revealed: -An entry for KCl 20meq, 1 tablet daily, with a scheduled administration time of 8am. -The KCl 20meq was documented as administered daily from 7/1/17 through 7/13/17. Review of the Nurse Practitioner's (NP) progress note dated 6/7/17 revealed: -This was a follow-up visit for laboratory studies completed for Resident #3 showing a potassium level of 3.0mmol/L. (The normal range for potassium for this lab is 3.6 to 5.0 mmol/L.) -"Starting on June 1, the resident was started on 20meq every 4 hours for 5 doses followed by daily potassium chloride doses." -"This has been completed, and resident is currently on a chronic daily dose of potassium chloride 20meq." Interview with staff from the provider pharmacy on 7/13/17 at 11:10am revealed: -They dispensed 30 tablets of KCl 20meq for Resident #3 on 5/31/17 and it was labeled 1	D 358		

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D 358	Continued From page 4 tablet by mouth daily. -They dispensed 30 tablets of KCl 20meq for Resident #3 on 6/27/17 and it was labeled 1 tablet by mouth daily, and 1 tablet every 4 hours for 5 doses. -No KCl tablets were obtained from the back-up pharmacy provider. -The procedure for order entry in the eMAR system involved the facility faxing the order to the pharmacy, the pharmacy entering the order, and facility staff approving the entry. Review of packing slips from shipments from the pharmacy provider revealed: -Five tablets of KCl 20meq with an order number of 76073155 for Resident #3 were shipped on 5/31/17 at 7:46pm. -Thirty tablets of KCl 20meq with an order number of 76073156 for Resident #3 were shipped on 5/31/17 at 7:46pm. -Thirty tablets of KCl 20meq with an order number of 8375944 for Resident #3 were shipped on 6/27/17 at 4:03pm. Review of Resident #3's medications on hand on 7/13/17 at 12:45pm revealed: -A bubble pack of KCl 20meq tablets dated 6/27/17 labeled, "1 tablet by mouth daily; 1 tablet every 4 hours for 5 doses." -Only 2 tablets of KCl 20meq had been used from the original package of 30 tablets, leaving 28 tablets. Review of Resident #3's medications on hand and KCl 20meq documented as administered on the June and July 2017 eMARs revealed: -Seventy-one tablets of KCl 20meq were documented as administered on the June and July 2017 eMARs. -Thirty-seven tablets of KCl 20meq were used	D 358		

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D 358	Continued From page 5 from Resident #3's original supply of 65 KCl tablets. -If the KCl 20meq had been administered as ordered, 47 tablets would have been used from Resident #3's supply. Interview with the facility Administrator on 7/13/17 at 10:40am revealed: -The facility coordinators (Resident Care Coordinator and Special Care Coordinator) can add medication orders to the eMAR. -The facility's pharmacy provider would know if KCl had been obtained from the back-up pharmacy. -The Special Care Coordinator (SCC) in charge at that time (the first of June) no longer worked at the facility. Interview with the facility Administrator on 7/13/17 at 12:15pm revealed: -The current SCC had signed off on the order entry for Resident #3's KCl 20meq, 1 every 4 hours for 5 days, instead of 5 doses. -At the time of this occurrence, the former SCC was training with the current SCC, and may have been logged in under her name in the computer system. -"We aren't sure who approved this eMAR order entry for Resident #3's KCl." Interview with the facility Administrator on 7/13/17 at 2:45pm revealed: -She believed the pharmacy provider had actually sent 95 tablets of KCl 20meq and not 65 as the pharmacy claimed. -She believed there was an extra bubble pack of 30 KCl 20meq tablets sent from the pharmacy because there were 4 different order numbers for the KCl 20meq for Resident #3. -She believed her MAs had actually given the	D 358		

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D 358	Continued From page 6	D 358		

extra doses of KCl 20meq at the first of June, and in doing so, the current count of 28 tablets of KCl found in the med cart for Resident #3 would be correct.
-She did not believe the MAs that signed the eMAR at the first of June 2017 for the administration of KCl 20meq for Resident #3 had falsified the eMAR records.

Review of the results of the lab draw on 7/13/17 at 12:13pm revealed:
-All values on the BMP were within normal limits.
-The resident's potassium level was 4.8mmol, reference range 3.6 to 5.0mmol/L.

Interview with a medication aide (MA) on 7/13/17 at 12:50pm revealed:
-She had only worked on the special care unit (where Resident #3 resided) once.
-She remembered administering medications to Resident #3 but did not specifically recall administering her KCl.

Telephone interview with a second MA who routinely works the 7pm to 7am shift on 7/13/17 at 3:15pm revealed:
-She remembered she had administered KCl to Resident #3 starting 6/2/17 "and I remember giving it every 4 hours" at 8pm, 12 midnight, and 4am as it was scheduled.
-"I had to wake her up in the middle of the night."
-The resident had "not been very happy" about being awakened to take the medication.
-Resident #3 had never refused any scheduled doses of the KCl when she had taken them in to the resident.
-"She sleeps deep and it's hard to wake her up."
-She did not remember Resident #3 complaining.

Interview with the NP on 7/13/17 on 3:30pm

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D 358	Continued From page 7 revealed: -She believed Resident #3 had received the KCl 20 meq as she had ordered it, 1 every 4 hours for 5 doses, then 1 daily. -When she examined Resident #3 on 6/7/17, (just after the extra doses of KCl were documented as given), there was "no change in the resident's status." -"There was no change in her (Resident #3) blood pressure or cardiac status." Review of information from the National Institute of Health revealed: -Signs of hypokalemia (low potassium levels) are cramping, weakness, muscle pain, and malaise (a general feeling of discomfort, uneasiness, or depression.) -Signs of hyperkalemia (high potassium levels) are tiredness, numbness or tingling, nausea, chest pain, and irregular heart rhythm.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367	D 367 The Hermitage (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the	

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D 367	Continued From page 8 medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to accurately document the administration of 1 medication, (potassium chloride) for 1 of 5 sampled residents (#3) on the electronic Medication Administration Record (eMAR.) The findings are: Review of Resident #3's current FL2 dated 3/29/17 revealed diagnoses included Alzheimer's dementia, cognitive muscle weakness, angina, generalized pain, and hypertension. Review of Resident #3's medication orders revealed an order dated 5/31/17 for KCl (potassium chloride) 20meq, 1 tablet daily; 1 every 4 hours for 5 doses. (KCL is a supplement used to treat low serum potassium levels.) Review of Resident #3's electronic Medication Administration Record (eMAR) for June 2017 revealed: -An entry for KCl 20meq, 1 tablet by mouth daily; 1 every 4 hours for 5 doses with a start date 6/1/17 and a stop date of 6/5/17. -The KCl 20meq had scheduled administration times of 12am, 4am, 8am, 12pm, 4pm, and 8pm. -The KCl 20meq was documented as administered from 4am on 6/1/17 through 8pm on 6/5/17 with 5 doses documented as administered	D 367	resident; (6) date and time of administration; (7) documentation of any omissions medications or treatments and the reason for the omission, including refusals; and, (8) name and initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR) 1. A mandatory Medication Aide training was completed on 7-14-17 on proper documentation and medication administration. 2. All resident MARs and Chart reviews were started on 7-14-17 and completed on 8-2-2017. 3. RCC/SCC to review MARs of any resident receiving a new order to assure accuracy. Completion Date 8/1/17 Signature/Title [signature] RN	

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D 367	Continued From page 9 on 6/1/17, and 6 doses documented as administered on 6/2/17, 6/3/17, 6/4/17, and 6/5/17 for a total of 29 doses. -A second entry for KCl 20meq, 1 tablet daily, with a scheduled administration time of 8am, and a start date of 6/2/17. -This KCl 20meq entry was documented as administered daily at 8am from 6/2/17 through 6/30/17. Review of Resident #3's eMAR for July 2017 revealed: -An entry for KCl 20meq, 1 tablet daily, with a scheduled administration time of 8am. -The KCl 20meq was documented as administered daily from 7/1/17 through 7/13/17 for a total of 13 doses. Review of the Nurse Practitioner's (NP) progress note dated 6/7/17 revealed: -"Starting on June 1, the resident was started on 20meq every 4 hours for 5 doses followed by daily potassium chloride doses." -"This has been completed, and resident is currently on a chronic daily dose of potassium chloride 20meq." Review of Resident #3's medications on hand on 7/13/17 at 12:45pm revealed: -A bubble pack of KCl 20meq tablets dated 6/27/17 labeled, "1 tablet by mouth daily; 1 tablet every 4 hours for 5 doses." -Only 2 tablets of KCl 20meq had been used from the package, leaving 28 tablets. Interview with the facility Administrator on 7/13/17 at 10:40am revealed: -The facility coordinators (Resident Care Coordinator and Special Care Coordinator) can add medication orders to the eMAR.	D 367		

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D 367	Continued From page 10 -The facility's pharmacy provider would know if KCl had been obtained from the back-up pharmacy. -The Special Care Coordinator (SCC) in charge at that time (the first of June) no longer worked at the facility. Interview with staff from the provider pharmacy on 7/13/17 at 11:10am revealed: -They dispensed 30 tablets of KCl 20meq for Resident #3 on 5/31/17 and it was labeled 1 tablet by mouth daily. -They dispensed 30 tablets of KCl 20meq for Resident #3 on 6/27/17 and it was labeled 1 tablet by mouth daily, and 1 tablet every 4 hours for 5 doses. -No KCl tablets were obtained from the back-up pharmacy provider. -The procedure for order entry in the eMAR system involved the facility faxing the order to the pharmacy, the pharmacy entering the order, and facility staff approving the entry on the eMAR. Review of packing slips from shipments from the pharmacy provider revealed: -Five tablets of KCl 20meq with an order number of 76073155 for Resident #3 were shipped on 5/31/17 at 7:46pm. -Thirty tablets of KCl 20meq with an order number of 76073156 for Resident #3 were shipped on 5/31/17 at 7:46pm. -Thirty tablets of KCl 20meq with an order number of 8375944 for Resident #3 were shipped on 6/27/17 at 4:03pm. Review of the packing slip from the provider pharmacy dated 6/28/17 revealed: -An entry for Resident #3's KCl 20meq with an order number of 8375945. -The order had not been filled due to a denial	D 367		

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D 367	Continued From page 11 from the Insurer. -A notation stating "not due to be refilled until 7/23/17." Review of Resident #3's medications on hand and KCl 20meq documented as administered on the June and July 2017 eMARs revealed: -Seventy-one tablets of KCl 20meq were documented as administered on the June and July 2017 eMARs. -Thirty-seven tablets of KCl 20meq were used from Resident #3's supply of KCl, leaving a discrepancy of 34 tablets. -Facility staff documented administering more KCl on the June and July 2017 eMARs than they had available to administer. Interview with the facility Administrator on 7/13/17 at 12:15pm revealed: -The current SCC had signed off on the order entry for Resident #3's KCl 20meq, 1 every 4 hours for 5 days, instead of 5 doses. -At the time of this occurrence, the former SCC was training with the current SCC, and may have been logged in under her name in the computer system. -"We aren't sure who approved this eMAR order entry for Resident #3's KCl." Interview with the current SCC on 7/13/17 at 12:25pm revealed she did not recall approving the order entry for Resident #3's KCl. Interview with a medication aide (MA) on 7/13/17 at 12:50pm revealed: -She had only worked on the special care unit (where Resident #3 resided) once. -She remembered administering medications to Resident #3 but did not specifically recall administering her KCl.	D 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERMITAGE	165 BRICKFARM ROAD DILLSBORO, NC 28725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 12 Interview with the facility Administrator on 7/13/17 at 2:45pm revealed: -She believed the pharmacy provider had actually sent 95 tablets of KCl 20meq and not 65 as the pharmacy claimed. -She believed there was an extra bubble pack of 30 KCl 20meq tablets sent from the pharmacy because there were 4 different order numbers for the KCl 20meq for Resident #3. -She believed her MAs had actually given the extra doses of KCl 20meq at the first of June, and in doing so, the current count of 28 tablets of KCl found in the med cart for Resident #3 would be correct. -She did not believe the MAs that signed the eMAR at the first of June 2017 for the administration of KCl 20meq for Resident #3 had falsified the eMAR records. Telephone interview with a second MA who routinely works the 7pm to 7am shift on 7/13/17 at 3:15pm revealed: -She remembered she had administered KCl to Resident #3 starting 6/2/17 "and I remember giving it every 4 hours" at 8pm, 12 midnight, and 4am as it was scheduled. -She did not remember how many days multiple doses of potassium chloride were administered. -The resident had never refused any scheduled doses of the potassium chloride when she had taken them in to the resident. An attempt to contact a 3rd MA who signed the eMAR for Resident #3's KCl at the first of June 2017 at 3:10pm on 7/13/17 was unsuccessful. Interview with the NP on 7/13/17 on 3:30pm revealed: -She believed Resident #3 had received the KCl	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050017	A. BUILDING: _____ B. WING _____	R 07/13/2017

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D 367	Continued From page 13 20 meq as she had ordered it, 1 every 4 hours for 5 doses, then 1 daily thereafter. -When she examined Resident #3 on 6/7/17, (just after the extra doses of KCl were documented as given), there was "no change in the resident's status." -"There was no change in her (Resident #3) blood pressure or cardiac status."	D 367		