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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
C 000	Initial Comments The Adult Care Licensure Section and Wake County Human Services conducted an annual survey on 08/16/17 with an exit conference via telephone on 08/22/17.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not meet the health care needs of 1 of 3 residents sampled (#1) by failing to notify the physician of the resident's refusal to wear compression stockings for swelling in her legs and feet. The findings are: Review of Resident #1's current FL-2 dated 06/01/17 revealed the resident's diagnoses included end stage renal disease with dialysis 3 times a week, recurring small bowel obstruction, chronic constipation with overflow diarrhea, minor neuro-cognitive deficits, anxiety, lower extremity and wrist edema, cluster B personality disorder, insomnia, generalized abdominal pain, allergic rhinitis, essential hypertension, dry eyes, chronic pain, Sjogren's syndrome, complication of hemodialysis catheter pocket infected, and alcohol abuse. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 06/02/17.	C 246		

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C 246	Continued From page 1 Review of Resident #1's assessment and care plan dated 06/03/17 revealed: -The resident required limited assistance with bathing, dressing, and grooming. -The resident had lower extremity edema (swelling). Review of an order from an urgent care provider dated 06/07/17 for Resident #1 revealed there was an order for support knee high stockings with Velcro closure. (Velcro support stockings are compression stockings used to treat swelling in the legs.) Review of Resident #1's June 2017 medication administration record (MAR) revealed the order for compression stocking was not included on the MAR Review of Resident #1's July 2017 MAR revealed: -There was a computer printed entry for TED hose (thromboembolic deterrent hose) use as directed with "FYI" printed where the times usually print. (TED hose are compression stockings used to help with swelling and to prevent blood clots.) -Documentation was blank for the entire month with no reasons for the omissions. Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for TED hose (thromboembolic deterrent hose) use as directed with "FYI" printed in the time slots. -Documentation was blank from 08/01/17 - 08/16/17 with no reasons for the omissions. Observation of Resident #1 on 08/16/17 at 5:25	C 246		

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C 246	Continued From page 2 p.m. revealed: -The resident was sitting in a chair in the living room watching television. -The resident's ankles were slightly swollen. -The resident was wearing crew socks. -The resident was not wearing compression stockings. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -The urgent care provider ordered compression hose because her legs and feet were swollen. -The swelling in her legs and feet were "a lot better". -She had compression stockings but she did not want to wear them. -The swelling in her legs was better. -She did not know if her physician was aware she was not wearing the compression stockings. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 6:00 p.m. revealed: -Resident #1 wore the compression stockings about 3 times to her knowledge. -She advised the resident to talk with her primary care provider (PCP) about the compression stockings and her not wearing them. -Staff were supposed to document the resident's refusal to wear the compression stockings on the MARs. -She did not think about documenting the refusals and she did not notify the resident's PCP or any other provider about the resident's refusal to wear the compression stockings. -The resident's legs were very swollen when she was admitted to the facility a couple of months ago. -The swelling in the resident's legs was "a lot better" now and the swelling had gone down.	C 246		

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C 246	Continued From page 3 Telephone interview with the Administrator on 08/16/17 at 6:20 p.m. revealed: -Resident #1 had an order for compression stockings and she had a pair but she refused to wear them. -The refusals should be documented on the MARs. -She had told the resident to get a discontinue order for the compression stocking since she was not wearing them. -The SIC should have notified the physician that Resident #1 was refusing to wear the compression stockings. -She had told the SIC to notify the physician of any refusal for any resident. Telephone interview with a registered nurse (RN) at the urgent care center on 08/22/17 at 9:56 a.m. revealed: -The Nurse Practitioner (NP) who saw Resident #1 as a patient on 06/07/17 was not available. -According to their documentation, Resident #1 had end stage renal disease and a history of bilateral foot edema (swelling). -Resident #1 was seen at their office on 06/07/17 for "painful bilateral edema of the dorsal foot". -There was no documentation in their records that anyone from the facility had contacted them about the resident's order for compression stockings or whether the resident was wearing them. Telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. revealed the nurse and PCP were unavailable for interview.	C 246		
C 315	10A NCAC 13G .1002(a) Medication Orders	C 315		

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C 315	Continued From page 4 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure clarification of medication orders for 1 of 3 residents sampled (#1) including two medications used to control phosphorus levels in dialysis / end stage renal disease, two medications used to lower blood pressure, an antipsychotic, a medication used to treat rheumatoid arthritis, a topical medication for pain and inflammation, two medications for constipation, an antianxiety medication, and lubricant eye drops for dry eyes. The findings are: Review of Resident #1's current FL-2 dated 06/01/17 revealed the resident's diagnoses included end stage renal disease with dialysis 3 times a week, recurring small bowel obstruction, chronic constipation with overflow diarrhea, minor neuro-cognitive deficits, anxiety, lower extremity	C 315		

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and wrist edema, cluster B personality disorder, insomnia, generalized abdominal pain, allergic rhinitis, essential hypertension, dry eyes, chronic pain, Sjogren's syndrome, complication of hemodialysis catheter pocket infected, and alcohol abuse.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 06/02/17.

A. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Hydralazine 25mg 1 tablet every 8 hours. (Hydralazine is used to treat high blood pressure.)

Review of Resident #1's June 2017 medication administration record (MAR) revealed:
-There was a handwritten entry for Hydralazine 25mg 1 tablet every 8 hours.
-Hydralazine 25mg was documented as administered at 8:00 a.m., 3:00 p.m., and 11:00 p.m. from 06/02/17 - 06/30/17.

Review of a physician's visit summary with the primary care provider (PCP) dated 07/14/17 for Resident #1 revealed:
-The form was not signed by the physician.
-The updated active medications list included Hydralazine 50mg 3 times a day and Hydralazine 25mg every 8 hours.
-The resident's blood pressure was 168/90.

Review of a physician's order dated 07/20/17 for Resident #1 revealed an order to discontinue Hydralazine 25mg every 8 hours.

Review of Resident #1's July 2017 MAR revealed:
-There was a computer printed entry for Hydralazine 25mg 1 tablet every 8 hours and it

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C 315	Continued From page 6 was documented as administered at 8:00 a.m., 3:00 p.m., and 11:00 p.m. from 07/01/17 - 07/20/17 (8:00 a.m.) and then handwritten documentation it was discontinued on 07/20/17. -Hydralazine 50mg 3 times a day was not transcribed onto the MAR and none was documented as administered. -The resident did not receive any Hydralazine from 07/21/17 - 07/31/17. Review of Resident #1's physician's orders and progress notes revealed no documentation the PCP was contacted to clarify the order for Hydralazine. Review of hospital admission forms dated 08/02/17 for Resident #1 revealed: -She as admitted for altered mental status, chronic end stage renal disease on dialysis, and hypertensive urgency. -The resident's systolic blood pressures ranged from 160 - 190 since presenting to the hospital. -There was no documentation regarding Hydralazine on the hospital forms. Review of a prescription dated 08/11/17 for Resident #1 revealed an order for Hydralazine 25mg 3 times a day. Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed: -Hydralazine was not included on the active medications list. -Hydralazine 25mg every 8 hours as directed was stopped on 07/06/17. Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17.	C 315		

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C 315	Continued From page 7 -There was a handwritten entry for Hydralazine 25mg 1 tablet 3 times a day and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 08/11/17 - 08/16/17 (8:00 a.m.). Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed: -The most current FL-2 the pharmacy had on file for Resident #1 was dated 06/01/17. -The most current order they had on file for Hydralazine was dated 08/11/17 for 25mg 3 times a day. -They never received an order dated 07/14/17 for Hydralazine 50mg. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -She had high blood pressure and felt agitated. -She was getting 50mg of Hydralazine at one time but then it changed to 25mg 3 times a day. -She did not know why the Hydralazine order changed because her blood pressure had been running high. -The facility did not check her blood pressure but it was checked during physician visits and sometimes at dialysis. Observation of medications on hand for Resident #1 revealed there was a supply of Hydralazine 25mg tablets dispensed on 08/11/17. Refer to interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m.	C 315		

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C 315	Continued From page 8 Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. B. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Losartan 100mg at bedtime. (Losartan is used to treat high blood pressure.) Review of Resident #1's June 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Losartan 100mg 1 tablet at bedtime. -Losartan was documented as administered at 8:00 p.m. from 06/02/17 - 06/30/17. Review of a physician's order dated 07/20/17 revealed there was an order to change Losartan 100mg at bedtime to 50mg at bedtime. Review of Resident #1's July 2017 MAR revealed: -There was a computer printed entry for Losartan 100mg 1 tablet at bedtime and it was documented as administered at 8:00 p.m. from 07/01/17 - 07/19/17 then handwritten documentation the order changed to 50mg on 07/20/17. -There was a handwritten entry for Losartan 50mg 1 tablet at bedtime and it was documented as administered at 8:00 p.m. from 07/20/17 - 07/31/17. Review of a visit summary with the primary care provider (PCP) dated 08/11/17 for Resident #1 revealed: -The visit summary was not signed by the PCP.	C 315		

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C 315	Continued From page 9 -There was a note on page 4 to take Losartan 100mg nightly. Review of physician's orders for Resident #1 revealed: -There was no signed order for Losartan 100mg on 08/11/17. -There was no documentation the PCP was contacted to verify or obtain a signed order. Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed: -Losartan was not included on the list of active medications. -Losartan 50mg once daily was stopped on 08/07/17. Review of physician's orders for Resident #1 revealed there was no documentation the facility clarified with the dialysis center or the PCP regarding the Losartan. Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Losartan 50mg 1 tablet at bedtime and it was documented as administered at 8:00 p.m. from 08/05/17 - 08/15/17. Observation of medications on hand for Resident #1 revealed there was a supply of Losartan 50mg tablets 1 tablet at bedtime dispensed on 07/20/17. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -She had not noticed the visit form dated 08/11/17 had Losartan 100mg instead of 50mg.	C 315		

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C 315	Continued From page 10 -She continued to administer the 50mg tablets. -She had not contacted the PCP about the Losartan because she did not notice it. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -She had high blood pressure and felt agitated. -The facility did not check her blood pressure but it was checked during physician visits and sometimes at dialysis. -The Losartan was decreased from 100mg to 50mg but she was not sure why it was decreased because her blood pressure was running high. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. C. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Renvela 2.4gm packet 1 packet 3 times a day with meals. (Renvela lowers phosphate levels in kidney disease requiring dialysis. Renvela should be taken with meals so it can bind to phosphorus in the foods.) Review of a hospital discharge report dated 08/05/17 for Resident #1 revealed there was an order for Renvela 2.4gm packet 3 times a day	C 315		

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with meals.

Review of a visit summary with the primary care provider (PCP) dated 08/11/17 for Resident #1 revealed:
-The visit summary was not signed by the PCP.
-There was a note on page 4 to stop taking Renvela.

Review of physician's orders for Resident #1 revealed:
-There was no signed order to discontinue the Renvela.
-There was no documentation the PCP was contacted to verify or obtain a discontinue order.

Telephone interview with a nurse at Resident #1's dialysis center on 08/16/17 at 4:15 p.m. revealed:
-Resident #1 refused to go to dialysis yesterday on 08/15/17.
-The facility made them aware of the refusal.
-They had a medication list from a hospital discharge summary dated 08/05/17 that Resident #1 should be receiving.
-She would fax the medication list.
-The resident's most recent lab work at dialysis was done on 08/10/17.
-The resident's phosphorus level was high at 5.7 (reference range 2.5 - 4.5) on 08/10/17.

Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed:
-Renvela 2.4gm packet 3 times a day with meals was included as an active medication.
-Renvela 2.4gm packet dissolved in water 3 times a day with meals was stopped on 07/06/17.

Review of physician's orders for Resident #1 revealed there was no documentation the facility clarified with the dialysis center or the PCP

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regarding whether the Renvela should be discontinued.

Review of Resident #1's June 2017 - August 2017 medication administration records (MARs) revealed:
-There was a handwritten entry for Renvela 2.4gm mix 1 packet as directed and take by mouth 3 times a day with meal and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 06/02/17 - 06/30/17.
-There was a computer printed entry for Renvela 2.4gm powder mix 1 packet as directed and take by mouth 3 times daily with meals and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 07/01/17 - 07/31/17.
-The resident was in the hospital from 08/02/17 - 08/05/17.
-There was a computer printed entry for Renvela 2.4gm powder mix 1 packet as directed and take by mouth 3 times daily with meals and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 08/05/17 - 08/11/17 and then noted to be discontinued on 08/11/17.

Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed:
-The most current FL-2 the pharmacy had on file for Resident #1 was dated 06/01/17.
-The pharmacy had been having trouble receiving discontinue orders from the facility.
-She did not have a discontinue order on file for Renvela.

Observation of medications on hand for Resident #1 revealed there was a supply of Renvela dispensed on 07/03/17.

Interview with the Supervisor-in-Charge (SIC) on

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C 315	Continued From page 13 08/16/17 at 3:10 p.m. revealed: -The Renvela had been discontinued and it needed to be sent back. -She did not have a signed physician's order to discontinue it but she went by the instructions from the PCP visit form dated 08/11/17. -She had not contacted the PCP to get an order or to verify if the Renvela should be discontinued. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -When she went to physician's appointments or to the hospital, she gave copies of paperwork to the facility staff. -She went to dialysis 3 times a week. -The Renvela was switched to Velphoro because the nutritionist at dialysis thought it would be better for her phosphorus levels. -She could not recall when it was switched. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. D. Review of a physician's orders for Resident #1 revealed there was an order dated 07/06/17 for Velphoro 500mg take 2 tablets 3 times daily with meals. (Velphoro lowers phosphate levels in kidney disease requiring dialysis. Velphoro	C 315		

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C 315	Continued From page 14 should be taken with meals so it can bind to phosphorus in the foods.) Review of Resident #1's July 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Velphoro 500mg chew 2 tablets 3 times daily with meals. -Velphoro was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 07/07/17 - 07/31/17. Review of a hospital discharge summary dated 08/05/17 revealed Velphoro was not included in the list of medications. Review of Resident #1's physician's orders revealed no documentation the facility tried to obtain clarification of the Velphoro order. Telephone interview with a nurse at Resident #1's dialysis center on 08/16/17 at 4:15 p.m. revealed: -Resident #1 refused to go to dialysis yesterday on 08/15/17. -The facility made them aware of the refusal. -They had a medication list from a hospital discharge summary dated 08/05/17 that Resident #1 should be receiving. -She would fax the medication list. -The resident's most recent lab work at dialysis was done on 08/10/17. -The resident's phosphorus level was high at 5.7 (reference range 2.5 - 4.5) on 08/10/17. Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed: -Velphoro 500mg was not included on the list of active medications. -Velphoro 500mg 2 tablets 3 times a day with meals for phosphorus was stopped on 08/07/17.	C 315		

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C 315	Continued From page 15 Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Velphoro 500mg chew 2 tablets 3 times daily with meals for phosphorus and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 08/05/17 - 08/16/17. Observation of medications on hand for Resident #1 revealed there was a supply of Velphoro 500mg dispensed on 07/07/17 with instructions to take 2 tablets 3 times a day. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 6:00 p.m. revealed she had not contacted the primary care provider (PCP) or dialysis to clarify the order for Velphoro. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed the Renvela was switched to Velphoro because the nutritionist at dialysis thought it would be better for her phosphorus levels. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m.	C 315		

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C 315	Continued From page 16 E. Review of Resident #1's current FL-2 dated 06/01/17 revealed medication orders included: -Seroquel 25mg ½ tablet prior to dialysis. (Seroquel is an antipsychotic.) -Seroquel 25mg 1 tablet at bedtime. Review of Resident #1's June 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Seroquel 25mg take 1 tablet at bedtime and it was documented as administered at 8:00 p.m. from 06/02/17 - 06/30/17. -There was a handwritten entry for Seroquel 25mg take ½ tablet (12.5mg) 3 times weekly on Tuesdays, Thursdays, and Saturdays and it was documented as administered on those days from 06/03/17 - 06/29/17. (No time was documented.) Review of Resident #1's July 2017 MAR revealed: -There was a computer printed entry for Seroquel 25mg take 1 tablet at bedtime and it was documented as administered at 8:00 p.m. from 07/01/17 - 07/31/17. -There was a computer printed entry for Seroquel 25mg take ½ tablet (12.5mg) 3 times weekly on Tuesdays, Thursdays, and Saturdays prior to dialysis and it was documented as administered on those days from 07/01/17 - 07/29/17. (No time was documented.) Review of a hospital discharge report dated 08/05/17 for Resident #1 revealed: -There was an order for Seroquel 25mg at bedtime. -There was no order for Seroquel to be taken prior to dialysis. Review of a visit summary with the primary care provider (PCP) dated 08/11/17 for Resident #1	C 315		

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revealed:
-The visit summary was not signed by the PCP.
-There was a note on page 4 to stop Seroquel 25mg.

Review of physician's orders for Resident #1 revealed:
-There was no signed order to stop Seroquel 25mg.
-There was no documentation the PCP was contacted to verify or obtain a signed order.

Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed Seroquel 25mg ½ tablet at bedtime and ½ tablet prior to dialysis were active medications.

Review of physician's orders for Resident #1 revealed there was no documentation the facility clarified with the dialysis center or the PCP regarding either of the Seroquel orders.

Review of Resident #1's August 2017 MAR revealed:
-The resident was in the hospital from 08/02/17 - 08/05/17.
-There was a computer printed entry for Seroquel 25mg take 1 tablet at bedtime and it was documented as refused at 8:00 p.m. from 08/06/17 - 08/10/17 then it was noted to be discontinued by the PCP on 08/11/17.
-There was a computer printed entry for Seroquel 25mg take ½ tablet (12.5mg) 3 times weekly on Tuesdays, Thursdays, and Saturdays prior to dialysis and it was documented as administered on those days from 08/08/17 - 08/12/17. (No time was documented.)

Observation of medications on hand for Resident #1 revealed there was a supply of Seroquel 25mg

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C 315	Continued From page 18 dispensed on 07/27/17 to take ½ tablet prior to dialysis on Tuesday, Thursday, and Saturday. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -She did not have a signed physician's order to discontinue Seroquel 25mg but she went by the instructions from the PCP visit form dated 08/11/17 to stop Seroquel 25mg. -She thought the instructions only applied to the dosage at bedtime and not the dosage prior to dialysis since it was a half tablet. -She had not contacted the PCP to clarify the Seroquel orders. Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed: -The most current FL-2 the pharmacy had on file for Resident #1 was dated 06/01/17. -She did not have a discontinue order on file for Seroquel. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed she stopped taking Seroquel because it caused her to have dry mouth. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at	C 315		

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C 315	Continued From page 19 4:04 p.m. F. Review of a physician's order dated 07/12/17 from Resident #1's rheumatologist revealed there was an order for Plaquenil 200mg once a day. (Plaquenil is used to treat auto-immune disorders like rheumatoid arthritis.) Review of a visit summary with the primary care provider (PCP) dated 07/14/17 for Resident #1 revealed: -The visit summary was not signed by the PCP. -There were instructions on page 4 to stop Plaquenil and contact the rheumatologist. Review of physician's orders and progress notes revealed: -There was no signed physician's order to discontinue the Plaquenil. -There was no documentation the rheumatologist was contacted regarding the order for Plaquenil. -There was no documentation the PCP was contacted regarding the Plaquenil. Review of Resident #1's July 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Plaquenil 200mg 1 tablet daily. -Plaquenil was documented as administered (no time) daily from 07/13/17 - 07/18/17. -There was a handwritten note dated 07/20/17 to hold Plaquenil until further instructions from PCP. Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -There was no entry for Plaquenil 200mg on the August 2017 MAR.	C 315		

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C 315	Continued From page 20 Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed she did not remember receiving Plaquenil and she was not sure what the medication was used to treat. Attempts to contact Resident #1's rheumatologist on 08/16/17 and 08/21/17 were unsuccessful. Telephone interview with a medical assistant for Resident #1's primary care provider's (PCP) on 08/16/17 at 4:05 p.m. revealed the nurse and PCP were unavailable for interview. Refer to interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. G. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Voltaren 1% gel apply 2gms 4 times a day as needed for swollen wrists. (Voltaren gel is used to treat pain and inflammation.) Review of a physician's order dated 07/07/17 for Resident #1 revealed an order for Voltaren 1% gel apply 2 grams topically once a day. Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed:	C 315		

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C 315	Continued From page 21 -Voltaren 1% gel was not included on the active list of medications. -Voltaren 1% gel apply liberally to affected area twice daily as needed was stopped on 08/07/17. Review of Resident #1's physician's orders revealed no documentation of the facility obtaining clarification of the Voltaren orders. Review of Resident #1's June 2017 medication administration record (MAR) revealed Voltaren 1% gel was not included on the MAR. Review of Resident #1's July 2017 MAR revealed: -There was a computer printed entry for Voltaren 1% gel apply 2 grams topically to swollen wrists 4 times a day as needed. -No Voltaren gel was documented as administered in July 2017. Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Voltaren 1% gel apply 2 grams topically to swollen wrists 4 times a day as needed. -No Voltaren gel was documented as administered in August 2017. Observation of medications on hand for Resident #1 revealed there was a Voltaren 1% gel box that was empty with no tube of gel inside and the box did not have a prescription label. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -She did not know where the tube of Voltaren gel was located. -She usually put the gel on the resident's hands	C 315		

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or wrists if needed.
-She had not contacted the primary care provider (PCP) to clarify the Voltaren gel orders.

Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed she was supposed to use the Voltaren gel because she had knots on both wrists but the gel did not work for her.

Refer to interview with the SIC on 08/16/17 at 2:02 p.m.

Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m.

Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m.

Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m.

H. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Lactulose 20gm packet 1 packet twice daily. (Lactulose is a laxative for constipation.)

Review of a hospital discharge report dated 08/05/17 for Resident #1 revealed there was an order for Lactulose 30ml twice a day.

Review of a visit summary with the primary care provider (PCP) dated 08/11/17 for Resident #1 revealed:
-The visit summary was not signed by the PCP.
-There was a note on page 4 to stop taking Lactulose.

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C 315	Continued From page 23 Review of physician's orders for Resident #1 revealed: -There was no signed order to discontinue the Lactulose. -There was no documentation the PCP was contacted to verify or obtain a discontinue order. Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed Lactulose 10gm/15ml take 30ml twice a day was included as an active medication. Review of physician's orders for Resident #1 revealed there was no documentation the facility clarified with the dialysis center or the PCP regarding whether the Lactulose should be discontinued. Review of Resident #1's June 2017 - August 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Lactulose 10gm/15ml take 30ml twice daily and it was documented as administered at 8:00 a.m. and 8:00 p.m. from 06/02/17 - 06/30/17. -There was a computer printed entry for Lactulose 10gm/15ml take 30ml twice daily and it was documented as administered at 8:00 a.m. and 8:00 p.m. from 07/01/17 - 07/31/17. -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Lactulose 10gm/15ml take 30ml twice daily and it was documented as refused at 8:00 a.m. and 8:00 p.m. from 08/06/17 - 08/11/17 then noted to be discontinued on 08/11/17. Observation of medications on hand for Resident #1 revealed there were 2 bottles of Lactulose dispensed on 06/20/17, one unopened and the	C 315		

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C 315	Continued From page 24 other about half full. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -The Lactulose had be discontinued and it needed to be sent back. -She did not have a signed physician's order to discontinue but she went by the instruction from the PCP visit form dated 08/11/17. -She had not contacted the PCP to get an order or to verify if the Lactulose should be discontinued. Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed: -The most current FL-2 the pharmacy had on file for Resident #1 was dated 06/01/17. -They never received a copy of a hospital discharge report dated 08/05/17 for Resident #1. -The pharmacy had been having trouble receiving discontinue orders from the facility. -She did not have a discontinue order on file for Lactulose. -The facility had not contacted the pharmacy about clarifying orders for Resident #1. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -When she went to physician's appointments or to the hospital, she gave copies of paperwork to the facility staff. -She went to dialysis 3 times a week. -She had been in the hospital for over 5 months for a bowel obstruction prior to being admitted to the facility. -She stopped taking Lactulose because she had loose stools. Refer to interview with the SIC on 08/16/17 at	C 315		

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C 315	Continued From page 25 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. I. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Psyllium 3.4gm packet 1 packet once daily. (Psyllium is a fiber laxative and may be used to treat constipation or diarrhea.) Review of a hospital discharge report dated 08/05/17 for Resident #1 revealed there was an order for Psyllium 3.4gm packet 1 packet once daily. Review of a visit summary with the primary care provider (PCP) dated 08/11/17 for Resident #1 revealed: -The visit summary was not signed by the PCP. -There was a note on page 4 to change Psyllium to 1 packet 3 times a day. Review of physician's orders for Resident #1 revealed: -There was no signed order to change the Psyllium from once a day to 3 times a day. -There was no documentation the PCP was contacted to verify or obtain a signed order. Review of a list of medications for Resident #1	C 315		

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faxed by the dialysis center on 08/16/17 revealed:
-Psyllium was not listed as an active medication.
-Psyllium 1 teaspoon once a day as needed was stopped on 06/27/17.

Review of physician's orders for Resident #1 revealed there was no documentation the facility clarified with the dialysis center or the PCP regarding the dosage of Psyllium to be administered.

Review of Resident #1's June 2017 - August 2017 medication administration record (MAR) revealed:
-There was a handwritten entry for Psyllium mix 1 packet as directed and take once daily and it was documented as administered at 8:00 a.m. from 06/03/17 - 06/30/17.
-There was a computer printed entry for Psyllium mix 1 packet as directed and take once daily and it was documented as administered at 8:00 a.m. from 07/01/17 - 07/31/17.
-The resident was in the hospital from 08/02/17 - 08/05/17.
-There was a computer printed entry for Psyllium mix 1 packet as directed and take once daily and it was documented as refused on 08/01/17 and as administered at 8:00 a.m. from 08/06/17 - 08/11/17 and then a handwritten note the order was changed to 3 times a day on 08/11/17.
-There was a handwritten entry for Psyllium take 1 packet 3 times daily and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 08/12/17 - 08/16/17.

Observation of medications on hand for Resident #1 revealed there was a supply of Psyllium dispensed on 08/09/17 with instructions to take 1 packet once daily.

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C 315	Continued From page 27 Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -She did not have a signed physician's order to change the frequency of Psyllium but she went by the instructions from the PCP visit form dated 08/11/17. -She had not contacted the PCP to get an order to change the frequency of Psyllium. Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed the most current order they had on file for Psyllium was for 1 packet once daily dated 06/01/17. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed she thought she stopped taking Psyllium because she had loose stools. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. J. Review of a physician's order dated 08/11/17 for Resident #1 revealed: -There was an order for Buspar 10mg 3 times a day as needed. (Buspar is used to treat anxiety disorders.) -There was no indication for the use of the of	C 315		

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C 315	Continued From page 28 "prn" (as needed) medication. Review of Resident #1's physician's orders revealed no documentation the physician was contacted to clarify the Buspar order. Review of Resident #1's August 2017 medication administration record (MAR) revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a handwritten entry for Buspar 10mg 1 tablet 3 times a day as needed and it was documented as "prn" in the time slots. -Staff documented Buspar as administered 3 times a day from 08/11/17 - 08/17/17 with times of administration documented on 4 occasions only. Observation of medications on hand for Resident #1 revealed there was a supply of Buspar 10mg 1 tablet 3 times a day as needed that was dispensed on 08/11/17. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 6:00 p.m. revealed: -She had noticed the "prn" (as needed) order for Buspar did not have an indication. -She had not contacted the primary care provider (PCP) to clarify the order. -She looked up Buspar on the internet and found it was used for anxiety. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed she was taking Buspar for anxiety but it did not help her symptoms. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical	C 315		

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C 315	Continued From page 29	C 315		

assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m.

Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m.

Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m.

K. Review of a physician's order dated 06/07/17 for Resident #1 revealed there was an order for Refresh Plus eye drops per over-the-counter (OTC) directions. (Refresh Plus is a lubricant eye drop for dry eyes.)

Review of a physician's order dated 08/05/17 revealed an order for Refresh eye drops or Artificial Tears as needed for dry eyes.

Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed the following:
-Refresh Plus eye drops was not on the list of active medications.
-Refresh Plus instill 1 drop in both eyes as needed was stopped on 08/07/17.

Review of physician's orders for Resident #1 revealed there was no documentation the facility clarified the orders for Refresh Plus eye drops.

Review of Resident #1's June 2017 - August 2017 medication administration records (MARs) revealed:
-There was a handwritten entry for Refresh Plus lubricant eye drops use as directed per OTC, instill 1 or 2 drops in the affected eye(s) as needed and it was documented as administered

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C 315	Continued From page 30 as a "prn" on 8 occasions from 06/14/17 - 06/25/17. -There was a computer printed entry for Refresh Plus 0.5% eye drops use as directed per OTC directions and there was handwritten documentation for "prn" and "self-administer". -Refresh Plus was documented as administered by staff on 8 occasions from 07/01/17 - 07/23/17. -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Refresh Plus 0.5% eye drops use as directed per OTC directions and "FYI" was printed in the time slots. -Refresh Plus was documented as administered on 2 occasions, 08/07/17 (8:00 p.m.) and 08/11/17 (4:00 p.m.) Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -She kept Refresh Plus eye drops in her room and she was supposed to use them 3 times a day. -She could not specify how often she used the Refresh Plus eye drops. Refer to interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's primary care provider's (PCP) on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m.	C 315		

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C 315	Continued From page 31 Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 2:02 p.m. revealed: -Resident #1 usually chose to obtain her own transportation to physician's appointments. -She had a difficult time getting copies of paperwork from physician's visits and hospital stays from Resident #1 because the resident like to keep it herself. -She used the paperwork from physician's visits and hospital visits to make changes to Resident #1's orders. -Sometimes the list of medications were not signed by the physician and sometimes the orders did not match. -She had called Resident #1's primary care provider (PCP) to clarify the resident's medication orders but she could not recall when she called and she did not document it. Telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. revealed the nurse and PCP were unavailable for interview. Telephone interview with the Administrator on 08/16/17 at 6:20 p.m. revealed: -They had been having some issues with Resident #1's medications at the facility. -Resident #1 went to physicians' appointments a lot to get her medications changed and she saw different physicians. -They usually tried to get clarification but sometimes the resident would not give the facility paperwork from appointments. -She was trying to work with the physicians' offices to get copies of Resident #1's orders. -The SIC usually transcribed orders onto the MARs when the orders were received. -She had told the SIC she needed to call the	C 315		

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C 315	Continued From page 32 physicians' offices or the hospital to get any copies of orders after appointments or hospitalizations. -She had told the SIC not to use medication lists if they were not signed by a physician. -She was going to get a new FL-2 signed for Resident #1 so her orders would be clear and current. Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed: -They usually received medication orders from the facility. -If a resident went a physician's appointment and came back with orders the facility would fax the orders to the pharmacy. -The pharmacy occasionally received electronic prescriptions from providers so the pharmacy would fax a copy of those orders to the facility. -The facility sometimes sent hospital discharge records to the pharmacy but they would have a medication list that was not signed by a physician. -She had spoken to the facility's Administrator in the past and told her the pharmacy needed medication orders signed by the physician. -In response, the Administrator would send a signed FL-2 form with medications listed on it. -The pharmacy staff printed MARs for the facility 3 business days prior to the first of each month. -The facility was supposed to transcribe any new orders or orders changes onto the MARs once the new monthly MARs were received. -The pharmacy had triplicate forms for the MARs so the facility could document any new orders or order changes on one copy of the MARs and send it back to the pharmacy. -The pharmacy would in turn update any new orders or order changes on the next month's MARs.	C 315		

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C 315	Continued From page 33 -The facility had not contacted the pharmacy about clarifying orders for Resident #1. Telephone interview with the Administrator on 08/21/17 at 12:43 p.m. revealed: -She received a medication list from Resident #1's PCP on Friday (08/18/17) but it was not signed by the PCP. -She called the PCP's office again this morning to get signed clarification of Resident #1's medication orders. -She had not received the signed documentation back from the PCP. No further documentation was received by the exit of the survey on 08/22/17. --- The facility failed to clarify medication orders for Resident #1 who had multiple diagnoses including end stage renal disease requiring hemodialysis 3 times a week. The facility did not clarify or verify orders from multiple providers and / or hospital stays including medications used to control phosphorus levels, medications used to lower blood pressure, an antipsychotic, a medication used to treat rheumatoid arthritis, a topical medication for pain and inflammation, two medications for constipation, an antianxiety medication, and lubricant eye drops for dry eyes. The failure of the facility to clarify medication orders was detrimental to the health, safety, and welfare of Resident #1 and constitutes a Type B Violation. --- Review of the facility's plan of protection dated 08/22/17 revealed: -The facility is currently reviewing all residents' medication orders and MARs to ensure all	C 315		

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C 315	Continued From page 34 medication orders and medications are reconciled and administered according to doctor's orders. -The facility is also currently working on clarifying orders for Resident #1 from the primary doctor. -A new medication list reconciled by all prescribing doctors is awaiting the primary doctor's signature. -The Administrator is currently auditing all residents' charts for medication clarifications that requires notifying doctors for clarification. -The facility plans to implement rules that would indicate to all staff that they should check all traveling charts that residents take to doctor's visits for any summary sheets or med lists that residents will bring back from the visits for any medication clarification from the doctors. -Staff will be educated on doctor's orders and medication clarification including medication orders have to be signed by a doctor and not from visit summary notes that are printed out. -Medication orders that are not signed by the doctor would need written signed clarification from the doctor before implementation. -The facility will notify all doctors' offices to send all medication orders with a signature and dated to accompany the orders or call it to the pharmacy directly. -All residents' charts will be checked by staff weekly for medication discrepancies and clarification and staff will get immediate clarification from doctors. -The Administrator will check all charts bi-weekly and coordinate with the pharmacy for medication reconciliation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 6, 2017.	C 315		

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C 330	Continued From page 35	C 330		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents sampled (#1) including a medication for controlling phosphorus levels in dialysis / end stage renal disease, a medication for prevention of heart disease, a medication for mild to moderate pain, an antacid / calcium supplement, and a lubricant eye drop. The findings are: Review of Resident #1's current FL-2 dated 06/01/17 revealed the resident's diagnoses included end stage renal disease with dialysis 3 times a week, recurring small bowel obstruction, chronic constipation with overflow diarrhea, minor neuro-cognitive deficits, anxiety, lower extremity and wrist edema, cluster B personality disorder, insomnia, generalized abdominal pain, allergic rhinitis, essential hypertension, dry eyes, chronic pain, Sjogren's syndrome, complication of hemodialysis catheter pocket infected, and	C 330		

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C 330	Continued From page 36 alcohol abuse. Review of Resident #1's Resident Register revealed the resident as admitted to the facility on 06/02/17. A. Review of physician's orders dated 07/07/17, 07/14/17, and 08/05/17 for Resident #1 revealed there was an order for Aspirin 81mg once daily. (Aspirin is used in the prevention of heart disease.) Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed Aspirin 81mg EC 1 tablet once daily was included on the active list of medications. Review of Resident #1's July 2017 and August 2017 medication administration records (MARs) revealed Aspirin 81mg EC was not included on either MAR. Observation of medications on hand for Resident #1 revealed there was no Aspirin 81mg EC on hand. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 6:00 p.m. revealed: -She had not noticed the order for Aspirin. -She did not know why the order for Aspirin was not transcribed onto the MARs. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed she thought she was receiving an Aspirin every day from facility staff. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical	C 330		

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C 330	Continued From page 37 assistant for Resident #1's primary care provider's (PCP) on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. B. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Renvela 2.4gm packet 1 packet 3 times a day with meals. (Renvela lowers phosphate levels in kidney disease requiring dialysis. Renvela should be taken with meals so it can bind to phosphorus in the foods.) Telephone interview with a nurse at Resident #1's dialysis center on 08/16/17 at 4:15 p.m. revealed: -The resident's most recent lab work at dialysis was done on 08/10/17. -The resident's phosphorus level was high at 5.7 (reference range 2.5 - 4.5) on 08/10/17. Review of a list of active medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed Renvela 2.4gm packet 3 times a day with meals was included on the list. Review of Resident #1's June 2017 - August 2017 medication administration records (MARs) revealed: -There was a handwritten entry for Renvela 2.4gm mix 1 packet as directed and take by mouth 3 times a day with meals. -Renvela was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 06/02/17 - 06/30/17 instead of with meals.	C 330		

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C 330	Continued From page 38 -There was a computer printed entry for Renvela 2.4gm powder mix 1 packet as directed and take by mouth 3 times daily with meals. -Renvela was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 07/01/17 - 07/31/17 instead of with meals. -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Renvela 2.4gm powder mix 1 packet as directed and take by mouth 3 times daily with meals. -Renvela was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 08/05/17 - 08/11/17 instead of with meals and then it was noted to be discontinued on 08/11/17. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -The facility's meal times were usually around 8:00 a.m., 12:00 noon, and 5:00 p.m. but it varied at times. -She had not noticed the Renvela was ordered with meals so she gave the medication according to the times listed on the MARs. -The 2:00 p.m. and 8:00 p.m. doses were not in accordance with the facility's meal times. -She would adjust the administration times for the Renvela to be given with meals. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -She could not recall if she received Renvela with meals. -The Renvela was switched to Velphoro because the nutritionist at dialysis thought it would be better for her phosphorus levels. -She could not recall when it was switched. Refer to interview with the SIC on 08/16/17 at 2:02 p.m.	C 330		

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C 330	Continued From page 39 Refer to telephone interview with a medical assistant for Resident #1's primary care provider's (PCP) on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. C. Review of physician's orders dated 07/07/17, 07/14/17, and 08/05/17 for Resident #1 revealed: -There was an order for Tylenol 650mg every 6 hours as needed. (Tylenol is a pain reliever / fever reducer.) -There was no indication for the use of the of "prn" (as needed) medication. Review of Resident #1's physician's orders revealed no documentation the physician was contacted to clarify the Tylenol order. Review of a list of medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed Tylenol 325mg 2 tablets every 3 hours as needed was included on the active list of medications. Review of Resident #1's July 2017 medication administration record (MAR) revealed Tylenol 325mg was not included on the MAR. Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -Tylenol 325mg was not included on the MAR.	C 330		

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C 330	Continued From page 40 Observation of medications on hand for Resident #1 revealed there was no Tylenol 650mg tablets on hand. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 6:00 p.m. revealed: -She had not noticed the order for Tylenol. -She did not know why the order for Tylenol was not transcribed onto the MAR. -The resident complained of back pain some days. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -She kept some Tylenol 500mg tablets in her room and took some every day. -She needed to buy some more Tylenol because she took it 3 times a day for back pain when she needed it. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's primary care provider's (PCP) on 08/16/17 at 4:05 p.m. Refer to telephone interview with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. D. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Calcium Carbonate 500mg chew 1 tablet 3 times a day before meals. (Calcium Carbonate is an antacid, calcium supplement, and it may be used to treat	C 330		

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C 330	Continued From page 41 high phosphate levels in kidney disease.) Review of Resident #1's June 2017 - August 2017 medication administration records (MARs) revealed: -There was a handwritten entry for Calcium Carbonate Antacid chew and swallow 1 tablet 3 times daily and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 06/02/17 - 06/30/17 instead of before meals. -There was a computer printed entry for Calcium Carbonate Antacid chew and swallow 1 tablet 3 times daily and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 07/01/17 - 07/31/17 instead of before meals. -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Calcium Antacid chew and swallow 1 tablet 3 times daily and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. from 08/05/17 - 08/16/17 instead of before meals. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -The facility's meal times were usually around 8:00 a.m., 12:00 noon, and 5:00 p.m. but it varied at times. -She had not noticed the Calcium Carbonate was ordered before meals so she gave the medication according to the times listed on the MARs. -The 2:00 p.m. and 8:00 p.m. doses were administered after the meals instead of before the meals. -She would adjust the administration times for the Calcium Carbonate to be given before meals. Interview with Resident #1 on 08/16/17 at 5:25	C 330		

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C 330	Continued From page 42 p.m. revealed: -She typically received Calcium Carbonate tablets after her meals -She preferred to get them before her meals. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's primary care provider's (PCP) on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. E. Review of Resident #1's current FL-2 dated 06/01/17 revealed there was an order for Thera Tears 0.25% 1 drop in each eye twice daily. (Thera Tears are lubricant eye drops for dry eyes.) Review of Resident #1's June 2017 medication administration record (MAR) revealed Thera Tears was not included on the handwritten MAR. Review of a list of active medications for Resident #1 faxed by the dialysis center on 08/16/17 revealed Thera Tears was not included on the list. Review of Resident #1's physician's orders revealed there was no order to discontinue Thera Tears. Review of Resident #1's July 2017 MAR revealed: -There was a computer printed entry for Thera	C 330		

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C 330	Continued From page 43 Tears 0.25% eye drops place 1 drop in each eye twice daily and it was scheduled for 8:00 a.m. and 8:00 p.m. -No doses were documented as administered with no reasons for the omissions. Review of Resident #1's August 2017 MAR revealed: -The resident was in the hospital from 08/02/17 - 08/05/17. -There was a computer printed entry for Thera Tears 0.25% eye drops place 1 drop in each eye twice daily and it was scheduled for 8:00 a.m. and 8:00 p.m. -No doses were documented as administered with no reasons for the omissions. Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed: -The pharmacy had been having trouble receiving discontinue orders from the facility. -She did not have a discontinue order on file for Thera Tears. Observation of medications on hand for Resident #1 revealed there was no Thera Tears on hand. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 3:10 p.m. revealed: -Resident #1 did not have any Thera Tears. -Resident #1 had Refresh Plus eye drops the resident used in her room. -She could not explain the omissions on the MARs. -She did not know why the resident was not receiving Thera Tears. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed she was not aware of an order for	C 330		

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C 330	Continued From page 44 Thera Tears and she did not receive any Thera Tears eye drops. Refer to interview with the SIC on 08/16/17 at 2:02 p.m. Refer to telephone interview with a medical assistant for Resident #1's primary care provider's (PCP) on 08/16/17 at 4:05 p.m. Refer to telephone interviews with the Administrator on 08/16/17 at 6:20 p.m. and 08/21/17 at 12:43 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. _____ Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 2:02 p.m. revealed: -Resident #1 usually chose to obtain her own transportation to physician's appointments. -She had a difficult time getting copies of paperwork from physician's visits and hospital stays from Resident #1 because the resident like to keep it herself. -She used the paperwork from physician's visits and hospital visits to make changes to Resident #1's orders. -Sometimes the list of medications were not signed by the physician and sometimes the orders did not match. -She had called Resident #1's primary care provider (PCP) to clarify the resident's medication orders but she could not recall when she called and she did not document it. -She had copies of page 4 and 5 of hospital discharge papers that had a list of medications to stop.	C 330		

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C 330	Continued From page 45 Telephone interview with a medical assistant for Resident #1's PCP on 08/16/17 at 4:05 p.m. revealed the nurse and PCP were unavailable for interview. Telephone interview with the Administrator on 08/16/17 at 6:20 p.m. revealed: -They had been having some issues with Resident #1's medications at the facility. -Resident #1 went to physicians' appointments a lot to get her medications changed and she saw different physicians. -She was trying to work with the physicians' offices to get copies of Resident #1's orders. -The SIC usually transcribed orders onto the MARs when the orders were received. -The SIC was supposed to transcribe all new orders and order changes onto the MARs. -She had told the SIC she needed to call the physicians' offices or the hospital to get any copies of orders after appointments or hospitalizations. -She had told the SIC not to use medication lists if they were not signed by a physician. -She was going to get a new FL-2 signed for Resident #1 so her orders would be current. Telephone interview with a pharmacist at the facility's primary pharmacy on 08/21/17 at 4:04 p.m. revealed: -They usually received medication orders from the facility. -If a resident went to a physician's appointment and came back with orders the facility would fax the orders to the pharmacy. -The pharmacy occasionally received electronic prescriptions from providers so the pharmacy would fax a copy of those orders to the facility. -The facility sometimes sent hospital discharge	C 330		

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C 330	Continued From page 46	C 330		

records to the pharmacy but they would have a medication list that was not signed by a physician.
-She had spoken to the facility's Administrator in the past and told her the pharmacy needed medication orders signed by the physician.
-In response, the Administrator would send a signed FL-2 form with medications listed on it.
-The pharmacy staff printed MARs for the facility 3 business days prior to the first of each month.
-The facility was supposed to transcribe any new orders or orders changes onto the MARs once the new monthly MARs were received.
-The pharmacy had triplicate forms for the MARs so the facility could document any new orders or order changes on one copy of the MARs and send it back to the pharmacy.
-The pharmacy would in turn update any new orders or order changes on the next month's MARs.
-The most current FL-2 the pharmacy had on file for Resident #1 was dated 06/01/17.

Telephone interview with the Administrator on 08/21/17 at 12:43 p.m. revealed:
-She received a medication list from Resident #1's PCP on Friday (08/18/17) but it was not signed by the PCP.
-She called the PCP's office again this morning to get signed clarification of Resident #1's medication orders.
-She had not received the signed documentation back from the PCP.

No further documentation was received by the exit of the survey on 08/22/17.

The facility failed to assure that Resident #1 who had a diagnosis of end stage renal disease with hemodialysis 3 times a week received a

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C 330	Continued From page 47 phosphate binding medication as ordered and the resident had high phosphorus levels on 08/10/17. The facility failed to administer Tylenol for back pain and Aspirin to prevent heart disease for Resident #1 who had diagnoses of chronic pain and essential hypertension. The failure of the facility to administer medications as ordered was detrimental to the health and safety of Resident #1 and constitutes a Type B Violation. _____ Review of the facility's plan of protection dated 08/22/17 revealed: -The facility will make sure that all medications are administered correctly as ordered by currently reviewing all medications and MARs for all residents. -The facility will coordinate with the pharmacy to make sure all time frames indicated on the medication orders match what is written on MARs. -The facility will educate staff on time frames to give medications as ordered by the doctors. -All medication time frames on the MARs have been corrected by the Administrator and staff with direct correspondence with the pharmacy. -The Administrator conducted an audit of the MARs for all current residents and educated staff on time frames for all current medications on the MARs. -The Administrator will check MARs monthly when new MARs are printed by the pharmacy prior to the beginning of a new month. -The Administrator will check the MARs monthly to make sure all time frames indicated on the MARs matches doctor's orders and to make sure staff follows orders and administers medications according to the time frame indicated. -Facility staff will notify the Administrator of all new medication orders prior to transcribing them	C 330		

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C 330	Continued From page 48 on the MARs to ensure the time frames of administration are understood by staff. -The Administrator will observe staff monthly on medication administration to monitor staff's pattern on administering medications and time frames. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 6, 2017.	C 330		
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.	C 350		

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C 350	Continued From page 49 This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 1 of 2 residents sampled (#1) who self-administered medications had orders to self-administer a prescription medication and 3 over-the-counter medications that were kept in the resident's room. The findings are: Review of Resident #1's current FL-2 dated 06/01/17 revealed the resident's diagnoses included end stage renal disease with dialysis 3 times a week, recurring small bowel obstruction, chronic constipation with overflow diarrhea, minor neuro-cognitive deficits, anxiety, lower extremity and wrist edema, cluster B personality disorder, insomnia, generalized abdominal pain, allergic rhinitis, essential hypertension, dry eyes, chronic pain, Sjogren's syndrome, complication of hemodialysis catheter pocket infected, and alcohol abuse. Review of Resident #1's Resident Register revealed the resident as admitted to the facility on 06/02/17. Interview with Resident #1 on 08/16/17 at 5:25 p.m. revealed: -She kept the Atrovent Nasal Spray in her room. -She used 4 sprays in each nostril 3 times a day. -She did not want to show the surveyor the medications in her room. -She kept Refresh Plus eye drops in her room and she was supposed to use them 3 times a day. -She could not specify how often she used the Refresh Plus eye drops. -She did not use Biotene mouthwash but she had some Biotene mouth spray in her room.	C 350		

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C 350	Continued From page 50 -She used the Biotene mouth spray as needed but she could not remember how often she used it. -She kept some Tylenol 500mg tablets in her room and took some every day. -She needed to buy some more Tylenol because she took it 3 times a day for back pain when she needed it. -She had been having trouble with her memory. -She could not recall if her primary care provider (PCP) was aware she was self-administering some of her medications. Review of a physician's order dated 06/07/17 for Resident #1 revealed: -There was an order for Refresh Plus eye drops per over-the-counter directions. (Refresh Plus is a lubricant eye drop for dry eyes.) -There was no order to self-administer the Refresh Plus eye drops. Review of Resident #1's June 2017 - August 2017 medication administration records (MARs) revealed: -There was a handwritten entry for Refresh Plus lubricant eye drops use as directed per over-the-counter (OTC) instill 1 or 2 drops in the affected eye(s) as needed -Refresh Plus was documented as administered as a "prn" on 8 occasions from 06/14/17 - 06/25/17. -There was a computer printed entry for Refresh Plus 0.5% eye drops use as directed per OTC directions and there was handwritten documentation for "prn" and "self-administer". -Refresh Plus was documented as administered by staff on 8 occasions from 07/01/17 - 07/23/17. -There was a computer printed entry for Refresh Plus 0.5% eye drops use as directed per OTC directions and "FYI" was printed in the time slots.	C 350		

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C 350	Continued From page 51 -Refresh Plus was documented as administered on 2 occasions, 08/07/17 (8:00 p.m.) and 08/11/17 (4:00 p.m.) Review of a physician's orders dated 08/05/17 for Resident #1 revealed: -There was an order for Biotene Mouthwash use as directed as needed for dry mouth. (Biotene mouthwash is used to manage the symptoms of dry mouth.) -There was an order for Biotene Moisturizing Mouth Spray 1 spray into mouth 3 times a day as needed. (Biotene mouth spray is used to manage the symptoms of dry mouth.) -There was no order to self-administer either formulation of Biotene. Review of Resident #1's August 2017 MAR revealed there was no entry for Biotene Mouthwash or Biotene Mouth Spray. Review of a physician's order dated 07/25/17 for Resident #1 revealed: -There was an order for Atrovent 0.03% nasal spray, use 2 sprays in each nostril 3 times a day. (Atrovent nasal spray is used to treat runny nose caused by allergies.) -There was no order for the resident to self-administer the Atrovent nasal spray. Review of Resident #1's July 2017 and August 2017 MARs revealed: -There was a handwritten entry for Atrovent 0.03% Nasal Spray 2 sprays in each nostril 3 times daily and the word "self-administers" was handwritten across the MAR and none was documented as administered by staff. -There was a computer printed entry for Atrovent 0.03% Nasal Spray place 2 sprays in each nostril 3 times daily and it was documented as	C 350		

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C 350	Continued From page 52 administered at 8:00 a.m., 4:00 p.m., and 8:00 p.m. from 08/05/17 - 08/16/17. Review of physician's orders dated 07/07/17, 07/14/17, and 08/05/17 for Resident #1 revealed: -There was an order for Tylenol 650mg every 6 hours as needed. (Tylenol is a pain reliever / fever reducer.) -There was no order for Tylenol 500mg. -There was no order for the Tylenol to be self-administered. Review of Resident #1's July 2017 and August 2017 MARs revealed Tylenol 325mg was not included on either of the MARs. Interview with the Supervisor-in-Charge (SIC) on 08/16/17 at 6:00 p.m. revealed: -She was aware Resident #1 had the Atrovent nasal spray in her room. -She kept the box with the prescription label in the medication room. -She thought she had told Resident #1's PCP that the resident was self-administering the Atrovent nasal spray but she did not get an order from the PCP. -She also thought Resident #1 had some Biotene Mouth spray in her room. -The resident did not have any Biotene Mouthwash to her knowledge. -The facility's policy required a physician's order for a resident to self-administer medications. -Resident #1 did not have an order to self-administer any medications. -She was not aware Resident #1 was self-administering any other medications or that the resident had other medications in her room. -She could not explain why some of the medications had self-administers written beside them on the MARs.	C 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092153	A. BUILDING: _____ B. WING _____	08/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 350	Continued From page 53 Telephone interview with the Administrator on 08/16/17 at 6:20 p.m. revealed: -The SIC usually transcribed orders onto the MARs when the orders were received. -She talked with the SIC last week about not letting Resident #1 keep medications in her room and self-administer. -She told the SIC they would have to get self-administration orders from the physician for any resident to self-administer. -Resident #1 had memory issues and was not capable of self-administering her medications. -She found Tylenol and a cough syrup in Resident #1's room about 2 weeks ago. -She removed the medications about 2 weeks ago and told the SIC to keep a check on Resident #1's room for medications. Review of an office visit report dated 08/11/17 faxed from Resident #1's PCP's office on 08/22/17 revealed: -The resident was seen by the PCP on 08/11/17 for a follow-up to a hospital visit on 08/02/17 for altered mental status. -The resident had a history of anxiety, depression, end stage renal disease, and hypertension. -The resident was having difficulty with loss of independence and was having anxiety, depression, and insomnia. -The resident had been taking Atrovent Nasal Spray more than prescribed (3 sprays) because she felt it was not working well as prescribed. -The medication list included Tylenol 325mg 2 tablets every 3 hours as needed for pain. -There was no orders for the resident to self-administer any medications. Telephone interview with a medical assistant for	C 350		

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C 350	Continued From page 54 Resident #1's PCP on 08/16/17 at 4:05 p.m. revealed the nurse and PCP were unavailable for interview.	C 350		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication orders and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure clarification of medication orders for 1 of 3 residents sampled (#1) including two medications used to control phosphorus levels in dialysis / end stage renal disease, two medications used to lower blood pressure, an antipsychotic, a medication used to treat rheumatoid arthritis, a topical medication for pain and inflammation, two medications for constipation, an antianxiety medication, and lubricant eye drops for dry eyes. [Refer to Tag C315 10A NCAC 13G .1002(a) Medication Orders (Type B Violation).]	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 912	Continued From page 55 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents sampled (#1) including a medication for controlling phosphorus levels in dialysis / end stage renal disease, a medication for prevention of heart disease, a medication for mild to moderate pain, an antacid / calcium supplement, and a lubricant eye drop. [Refer to Tag C330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation).]	C 912		