STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079103	A. BUILDING: _____ B. WING _____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S ASSISTED LIVING	5767 HWY 135 STONEVILLE, NC 27048

(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 Rockingham County Department of Social Services conducted an annual survey on October 3-4, 2017.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 4 residents (Resident #1 and #4) observed during medication pass including errors in medications of Linzess, Vitamin D3, Tramadol, Trazadone, and 1 of 4 sampled residents (Resident #4) for record review with a physician's order for Potassium Chloride. The findings are: The medication error rate was 10% as evidenced by the observation of 4 errors out of 30 opportunities during the 8:00 a.m. medication pass on 10/04/17.	D 358		

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A. Review of Resident #1's current FL2 dated 02/04/17 revealed diagnoses of adult failure to thrive, chronic obstructive pulmonary disease, heart failure, muscle weakness, unspecified severe protein calorie malnutrition, major depressive disorder, difficulty in walking, and unspecified cirrhosis of the liver.

Observation on 10/04/17 from 7:55 am to 8:00 am of medication administration for Resident #1 revealed:
-Resident #1 was sitting in her room; on the side of her bed.
-The Medication Aide (MA) reviewed Resident #1's Medication Administration Record (MAR) for medications due for administration.
-The MA then sanitized his hands; prepared 10 oral medications and 1 inhaler for Resident #1 and administered them with a 4 ounce cup of water.
-The MA documented administration of the 8 am medications on the October 2017 MAR.
-Linzess was not in the medications prepared for administration.
-The MA sanitized his hands and continued to the next resident.

Review of Resident #1's record revealed a physician's order dated 02/18/17 for Linzess (a medication used to manage irritable bowel syndrome) 72 mcg daily.

Review of Resident #1's October 2017 MAR revealed:
-An entry for Linzess 72 mcg daily at 8:00 am.
-Linzess 72 mcg was documented as administered for dates from 10/01/2017 through 10/04/2017 once daily at 8:00 am.

Review of medications on hand available for

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administration for Resident #1 on 10/04/17 at 11:50 am revealed a bottle of Linzess dispensed on 09/14/17 for a 30 day supply.

Interview on 10/04/17 at 1:45 pm with the first shift MA/Supervisor revealed:
-He was unsure if he administered the Linzess on 10/04/17 at 8:00 am.
-He felt the error was caused by not having a system or set order for reviewing the MARs and administering medications to residents.
-He would pull the stack of medications and compare the stack of medications in their order to the MAR.
-He did not pull medications in the order the medications were listed on the MAR and scheduled times of administration.

Interview on 10/04/17 at 1:25 pm with Resident #1 revealed:
-The staff administered all her medications.
-She was aware she was taking Linzess but was unaware if she received the medication on 10/04/17 at 8:00 am.

Telephone interview on 10/04/17 at 10:55 am, with a representative from the contracted pharmacy provider revealed:
-The pharmacy received an order for Linzess on 02/18/17 and was last dispensed on 09/14/17 for a thirty day supply.
-The facility faxed over new or changed orders to the pharmacy.
-The pharmacy added new or changed orders to the MAR and printed MAR's for the facility monthly.

Interview on 10/04/17 at 11:15 am with the Administrator revealed she was not aware Resident #1 did not receive Linzess on 10/04/17

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D 358	Continued From page 3 at 8:00 am. Attempted interview with Resident #1's prescribing physician on 10/04/17 at 11:49 am was unsuccessful. B. Review of Resident #4's current FL2 dated 09/22/17 revealed: -Diagnoses included hypertension, depressive psychosis, paralysis, obesity, general muscle weakness, anxiety disorder, Parkinson's disease, and chronic pain. -A physician's order for vitamin D3 (an essential vitamin) 1,000 iu daily, tramadol-acetaminophen (a medication used to treat pain) 37.5/325 mg twice daily, and trazadone (a medication used to treat depression or anxiety) 50 mg at bedtime. Observation on 10/04/17 from 8:05 am to 8:10 am of medication administration for Resident #4 revealed: -Resident #4 was standing in hallway. -The MA reviewed Resident #4's MAR for medications due for administration. -The MA then sanitized his hands; prepared 9 oral medications for Resident #4 and administered them with a 4 ounce cup of water. -The MA documented administration of the am medications on the October 2017 MAR. -The vitamin D3 1,000 iu and tramadol 37.5/325 mg was not in the medications prepared for administration. -The trazadone 50 mg was administered with the 8:00 am medication pass. -The MA sanitized his hands. Review of Resident #4's October 2017 MAR revealed: -An entry for vitamin D3 1,000 iu daily at 8:00 am. -An entry for tramadol/acetaminophen 37.5/325	D 358		

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mg twice daily at 8:00 am and 8:00 pm.
-An entry for trazadone 50 mg at 8:00 pm.
-The vitamin D3 1,000 iu was documented as administered on 10/04/2017 at 8:00 am.
-The tramadol/acetaminophen 37.5/325 mg was documented as administered 10/01/17-10/04/17 at 8:00 am.
-The trazadone 50 mg was not documented as administered on 10/04/17 at 8:00 am.

Review of medications on hand available for administration for Resident #4 on 10/04/17 at 11:55 am revealed:
-A bubble pack of vitamin D3 1,000 iu was available for administration.
-A bubble pack of tramadol/acetaminophen 37.5/325 mg was not available for administration.
-A bubble pack of trazadone 50 mg was available for administration.

Interview on 10/04/17 at 1:45 pm with the first MA/shift Supervisor revealed:
-He thought he had administered the vitamin D3 on 10/04/17 at 8:00 am to Resident #4.
-He thought the trazadone was the tramadol when he administered 8:00 am medications to Resident #4.
-He felt the error was caused by not having a system or set order for reviewing the MAR and administering medications to residents.
-He would pull the stack of medications and compare the stack of medications in their order to the MAR.
-He did not pull medications in the order the medications were listed on the MAR and scheduled times of administration.

Interview on 10/04/17 at 1:50 pm with Resident #4 revealed:
-The staff administered all his medications.

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D 358	Continued From page 5 -He was unaware of all his scheduled morning medications. -Resident #4 was aware he usually received trazadone at bedtime. Telephone interview on 10/04/17 at 10:55 am, with a representative from the contracted pharmacy provider revealed: -The pharmacy received an order for vitamin D3 1,000 iu once daily on 09/25/17 from the FL2 dated 09/22/17 for a 25 day supply. -The pharmacy received an order for tramadol/acetaminophen 37.5/325 mg twice daily on 9/25/17 from the FL2 dated 09/22/17. The pharmacy had not filled the medication because they were waiting on a written prescription. -It was the facility's responsibility to obtain a new written prescription and fax it to the pharmacy. -The facility faxed over new or changed orders to the pharmacy. -The pharmacy added new or changed orders to the MAR and printed MAR's for the facility monthly. Interview on 10/04/17 at 11:15 am with the Administrator revealed: -She was not aware Resident #4 did not receive vitamin D3 or tramadol/acetaminophen on 10/04/17 at 8:00 am. -She was not aware tramadol/acetaminophen 37.5/325 mg was not available for administration. -She was not aware Resident #4 received trazadone 50 mg on 10/04/17 at 8:00 am and was ordered to be administered at 8:00 pm. -She called the contracted pharmacy on 10/04/17 and was made aware they were waiting on a written prescription for Resident #4's tramadol. -The pharmacy had not made her aware that they were waiting on a written prescription for Tramadol prior to her calling on 10/04/17.	D 358		

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-She had called and made the prescribing physician aware of the medication error on 10/04/17.

Attempted telephone interview with prescribing physician on 10/04/17 at 11:07 am was unsuccessful.
C. Review of Resident #3's current FL2 dated 11/30/2016 revealed diagnoses of major depressive disorder, schizophrenia, and diabetes.

Review of Resident #3's record revealed:
-A signed physician's encounter sheet dated 08/16/17 with physician's orders for furosemide 20 mg (used to treat fluid retention), one tablet daily and potassium chloride 10 milliequivalents (meq) (used to treat leg cramps), one tablet daily, for bilateral lower leg pitting edema.
-A physician's order dated 9/06/17 increasing the dosage for furosemide to 40 mg, one tablet daily, and potassium chloride 20 meq, one tablet daily.

Review of Resident #3's August 2017 Medication Administration Record (MAR) revealed:
-An entry for furosemide 20 mg and potassium chloride 10 meq were transcribed onto the MAR by hand for 8 AM
-An entry for furosemide 20 mg and potassium chloride 10 meq was documented as administered from 08/17/2017 through 08/31/2017 at 8 AM.

Review of Resident #3's September 2017 Medication Administration Record (MAR) revealed:
-Entries for furosemide 40 mg and potassium chloride 20 meq were transcribed onto the MAR by hand for the month of September.
-Entries for furosemide 20 mg and potassium chloride 10 meq were documented as

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administered from 09/01/17 through 09/07/17.
-The furosemide 20 mg and potassium chloride 10 meq were marked "Order Changed" and highlighted as discontinued on the September MAR.
-There was no documentation of medication administration for the furosemide 20 mg or potassium chloride 10 meq after 09/07/17.
-potassium chloride 20 meq was documented as administered from 09/08/2017 through 09/30/2017.
-furosemide 40 mg was documented as administered from 09/08/2017 through 09/30/2017.
-The order dated 09/06/17 for furosemide 40 mg and potassium chloride 20 meq was marked as held on 09/07/2017, and a note was added on the back of the MAR stating "med not given, not in," also dated 09/07/17.

Review of medications on hand for administration for Resident #3 on 10/04/17 revealed a bubble pack of furosemide 40 mg dispensed on 09/16/17 for a thirty day supply and a bubble pack of potassium chloride 20 meq dispensed on 09/14/17 for a thirty day supply.

Telephone interview on 10/04/17 at 09:29 am, with a representative from the contracted pharmacy provider revealed:
-The pharmacy received an order for an increase in the potassium chloride dose from 10 meq to 20 meq on 09/06/2017.
-They also received an order to increase furosemide from 20 mg to 40 mg on 09/06/2017.
-The order for furosemide 40 mg was processed and filled on 09/06/17 for a partial order. It was filled again on 09/16/17 for a full month (30 day supply) and dispensed to the facility.
-The order for potassium chloride 20 meq was

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D 358	Continued From page 8 profiled to begin on 09/14/17 and was not filled and sent to the facility until 9/15/17 for one month supply. The pharmacy staff could not give a reason as to why the medication was not filled immediately. -The pharmacy entered all the orders from the FL2, office visits, faxes or physician telephone orders onto the MAR. Orders could be received from either the facility by fax, the provider's office by fax or telephone, or by eScript electronically. -They had no record of facility staff contacting them regarding the change in dosage for the potassium chloride to request the potassium chloride 20 meq be filled before the profile date of 09/14/17, or to request to administer two potassium chloride 10 meq tablets in lieu of the potassium chloride 20 meq until the potassium chloride 20 meq was received from the pharmacy. Interview on 10/04/17 at 10:05 am with the Administrator revealed: -The staff was aware of the increase in dosage for both the furosemide and the potassium chloride. -The facility received the furosemide 40 mg from the pharmacy on 09/07/2017, sometime after the morning medications were given. -The facility did not receive any potassium chloride 20 meq from the pharmacy on 09/07/2017 when they received the furosemide. -The staff continued to give potassium chloride 10 meq from 09/07/17 to 09/15/17 when the new dosage of potassium chloride 20 meq arrived. -The staff documented on the MAR they administered potassium chloride 20 meq, one tablet daily in the AM, as ordered on 09/07/2017 through 09/14/2017, when the medication had not been received from the pharmacy until 09/15/2017.	D 358		

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D 358	Continued From page 9 -She and other staff only administered one 10 meq potassium chloride tablet daily in the AM to Resident #3 from 09/08/2017 through 09/14/2017, while documenting on the MAR they had administered 20 meq of potassium chloride. -"I don't know why we didn't give 2 tabs of 10 meq (potassium chloride) to equal 20 meq. I guess we just missed it." Second interview on 10/04/17 at 11:15 am with the Administrator revealed: -No staff person has been designated to review the MAR for accuracy compared to the physician orders. -Multiple staff have reviewed resident MARs, but not regularly or on a schedule. -The medication aide (MA) on duty at the time an order was received was responsible for transcribing the new order onto the MAR. -There was no quality assurance program in place to assure residents were receiving the correct medications or the MAR was accurate. -She now planned to implement a verification tracking system to ensure accuracy of medication administration. Telephone interview on 10/04/17 at 11:44 am with a representative for Resident #3's primary care physician revealed: -She had seen Resident #3 for an assessment on 09/25/17. -Resident #3 reported no leg cramps to her at her assessment. -Although her expectation was that ordered medications be given as prescribed, she did not feel the resident had been harmed by receiving the lower dose of potassium chloride than ordered on the dates 09/08/17 through 09/15/17. Interview on 10/04/17 at 01:40 pm with Resident	D 358		

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D 358	Continued From page 10 #3 revealed: -She had been taking furosemide and potassium chloride since August for "swelling in her legs, and leg cramps." -She had not had any leg cramps since starting the potassium chloride in August 2017. -She was not aware she had received the wrong dosage for seven days after her potassium chloride dosage was increased. Interview on 10/04/17 at 1:45 pm with a MA/Supervisor revealed: -The MA/Supervisor was aware he and other staff had incorrectly administered Resident #3's potassium chloride by giving a lower dose than ordered from 09/08/17 through 09/14/17 while documenting on the MAR that potassium chloride 20 meq was administered. -He was also aware both the furosemide 40 mg and potassium chloride 20 meq had been incorrectly documented as administered on 09/02/17, 09/03/17, 09/04/17 and 09/05/17 when they were not administered. -He was aware the order to increase the dosage to furosemide 40 mg and potassium chloride 20 meq was not received or transcribed onto the MAR until 09/06/17. -When administering medications, he would pull the stack of medications and compare the stack of medications in their order on the MAR. -He did not pull medications in the order the medications were listed on the MAR and scheduled times of administration.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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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 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 assure the Medication Administration Records (MARs) were accurate for 1 of 4 sampled residents (Resident # 3) regarding furosemide and potassium chloride.

The findings are:

Review of Resident #3's current FL2 dated 11/30/2016 revealed diagnoses included major depressive disorder, schizophrenia, and diabetes.

Review of Resident #3's record revealed:
-Signed physician's encounter sheet dated 08/16/17 starting furosemide 20 mg (for fluid retention), one tablet daily and potassium chloride 10 milliequivalents (meq) (for leg cramps), one tablet daily, for bilateral lower leg pitting edema.

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D 367	Continued From page 12 -A physician's order dated 9/06/17 increasing the dosage for furosemide to 40 mg, one tablet daily, and potassium chloride 20 meq, one tablet daily. Review of Resident #3's printed Medication Administration Record (MAR) for September 2017 revealed: -Entries for furosemide 40 mg and potassium chloride 20 meq were transcribed onto the MAR by hand, scheduled for administration at 8 AM. -Entries for furosemide 20 mg and potassium chloride 10 meq were documented as administered from 09/01/17 through 09/07/17. -The furosemide 20 mg and potassium chloride 10 meq were marked "Order Changed" and highlighted as discontinued on the September MAR. -There was no documentation of medication administration for the furosemide 20 mg or potassium chloride 10 meq after 09/07/17. -There was documentation of administration of furosemide 40 mg and potassium chloride 20 meq on the MAR on 09/02/17 to 09/05/17 at 8 AM, and every day from 09/08/17 to 09/30/17 at 8 AM. -The order dated 09/07/17 for furosemide 40 mg and Potassium 20 meq was documented on the MAR as held, with a handwritten note on the back of the MAR documenting the medications were "not given, not in." Review of medications on hand for administration for Resident #3 on 10/04/17 revealed a bubble pack of furosemide 40 mg dispensed 09/16/17 and a bubble pack of potassium chloride 20 meq dispensed on 09/14/17. Telephone interview on 10/04/17 at 09:29 am, with a representative from the contracted pharmacy provider revealed:	D 367		

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	HAL079103	A. BUILDING: _____ B. WING _____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S ASSISTED LIVING	5767 HWY 135 STONEVILLE, NC 27048

(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 13 -The pharmacy received an order for an increase in the potassium chloride dose from 10 meq to 20 meq on 09/06/2017. -They also received an order to increase furosemide from 20 mg to 40 mg on 09/06/2017. -The order for furosemide 40 mg was processed and filled on 09/06/2017 for a partial order. It was filled again on 09/16/17 for a full month supply and dispensed to the facility. -The order for potassium chloride 20 meq was profiled to begin on 09/14/17 and was not filled and sent to the facility until 9/15/17 for one month supply. The pharmacy staff could not give a reason as to why the medication was not filled immediately. -They had no record of facility staff contacting them requesting the increase in dosage. Interview on 10/04/17 at 10:05 am with the Administrator revealed: -The staff were aware of the increase in dosage for both the furosemide and the potassium chloride. -The staff received the furosemide 40 mg from the pharmacy on 09/07/2017, sometime after the morning medications were given. -The staff did not receive any potassium chloride 20 meq from the pharmacy on 09/07/2017 when they received the furosemide. -The staff continued to administer potassium chloride 10 meq from 09/07/17 to 09/15/17 when the new dosage of potassium chloride 20 meq arrived. -The staff documented on the MAR that they administered potassium chloride 20 meq, one tablet daily at 8 AM, as ordered from 09/07/2017 through 09/14/2017, when the medication had not been received from the pharmacy until 09/15/2017. -She and other staff only administered one 10	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 14	D 367		

meq potassium chloride tablet daily in the AM to Resident #3 from 09/08/2017 through 09/14/2017, while documenting on the MAR that they administered 20 meq of potassium chloride.
-She was also aware both the furosemide 40 mg and potassium chloride 20 meq had been incorrectly documented as administered on 09/02/17, 09/03/17, 09/04/17 and 09/05/17 when these dosages were not given, as the order was not written until 09/06/17.
-"I don't know why we didn't give 2 tabs of 10 meq (potassium chloride) to equal 20 meq. I guess we just missed it."

Second interview on 10/04/17 at 11:15 am with the Administrator revealed:
-No staff person had been designated to review the MARs for accuracy compared to the physician orders.
-Multiple staff had reviewed resident MARs, but not regularly or on a schedule.
-The medication aide (MA) on duty at the time an order was received was responsible for transcribing the new order onto the MAR.
-There was no quality assurance program in place to assure residents were receiving the correct medications or the MAR was accurate.
-She now planned to implement a verification tracking system to ensure accuracy of medication administration and MAR.

Telephone interview on 10/04/17 at 11:44 am with a representative from Resident #3's primary care physician revealed:
-The provider had seen Resident #3 for an assessment on 09/25/17.
-Resident #3 reported no leg cramps to her at her assessment.
-Although her expectation was that ordered medications be given as prescribed, she did not

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D 367	Continued From page 15	D 367		

feel the resident had been harmed by receiving the lower dose of potassium chloride than ordered on the dates 09/08/17 through 09/15/17.
-She was unaware the medication had not been administered correctly until contacted by the survey team member for interview on 10/04/17.

Interview on 10/0417 at 01:40 pm with Resident #3 revealed:
-She had been taking furosemide and potassium chloride since August for "swelling in her legs, and leg cramps."
-She had not had any leg cramps since starting the potassium chloride in August 2017.
-She was not aware that she had received the wrong dosage for seven days after her potassium chloride dosage was increased.

Interview on 10/04/17 at 1:45 pm with a MA/Supervisor revealed:
-The MA/Supervisor was aware he and other staff had incorrectly administered Resident #3's potassium chloride by giving a lower dose than ordered from 09/08/17 through 09/14/17 while documenting on the MAR that potassium chloride 20 meq was administered.
-He was also aware both the furosemide 40 mg and potassium chloride 20 meq had been incorrectly documented as administered on 09/02/17, 09/03/17, 09/04/17 and 09/05/17 when they were not administered.
-He was aware the order to increase the dosage to furosemide 40 mg and potassium chloride 20 meq was not received or transcribed onto the MAR until 09/06/17.
-He felt the error was caused by not having a system or set order for reviewing the MAR and administering medications to residents.