STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023042	A. BUILDING: _____ B. WING _____	C 11/09/2017

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SUMMIT PLACE OF KINGS MOUNTAIN	1001 PHIFER ROAD KINGS MOUNTAIN, NC 28086

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D 000	Initial Comments The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted an annual survey on November 7-9, 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, interviews, and record reviews, the facility failed to administer clonidine, vitamin D3, and lovastatin as ordered for 2 of 4 residents (Resident #7 and #8) observed during the 8am medication pass on 11/8/17. The findings are: A. Review of Resident #8's current FL2 dated 6/6/17 revealed: -Diagnoses included high blood pressure and hypothyroidism. -A physician's order for clonidine (used to control blood pressure) 0.1mg 24 hr. patch apply 1 patch topically weekly on Tuesday remove old patch. -A physician's order for vitamin D3 (used to supplement vitamin D levels) 4000 units daily.	D 358		

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D 358	Continued From page 1 1. Review of Resident #8's signed physician order sheet dated 7/25/17 revealed a physician's order for clonidine 0.1mg 24 hr. patch apply 1 patch topically weekly on Tuesday remove old patch. Review of Resident #8's physician order dated 7/25/17 revealed check blood pressure weekly, call physician if blood pressure is greater than 140/90 for two consecutive weeks. Review of Resident #8's Facility Concern/Physician Response form dated 10/31/17 revealed: -In reference to clonidine 0.1mg 24hr. patch "Resident needs new script. No more refills." -Resident #8's physician wrote in response "I will send electronic script" to Resident #8's pharmacy. Observation of Resident #8 on 11/8/17 at 8:15am revealed the resident was administered nine oral medications by Staff A, Medication Aide (MA). Interview with Resident #8 on 11/8/17 at 8:15am revealed: -"Have my patches come in yet?" -"The other patch is coming off. It's kinda itchy." Interview with Staff A, MA, on 11/8/17 at 8:21am revealed: -The clonidine 0.1mg patch was supposed to be administered on 11/7/17 at 8am according to Resident #8's Medication Administration Record (MAR). -According to the MAR, the patch was not administered, because there were no patches available for the resident. -"I will have to call and check on it." -Resident #8 did not use the facility pharmacy. -Staff A was not aware that Resident #8 had	D 358		

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missed her weekly dose of clonidine until the resident had told her that morning during the medication pass.

Review of Resident #8's November MAR revealed:
-An entry for clonidine 0.1mg 24 hr. patch scheduled weekly on Tuesdays at 8am.
-The clonidine was documented administered 0 occurences for 1 opportunity at 8am on 11/7/17.
-On the back of the MAR the reason documented the 11/7/17 was not given was "clonidine patch not here."

Observation of Resident #8's medications on hand on 11/8/17 at 8:21am revealed there were no clonidine 0.1mg 24 hr. patches available for the resident.

Interview with the Resident Care Coordinator (RCC) on 11/8/17 at 8:36am revealed he would "go get" the clonidine patches from Resident #8's pharmacy.

Interview with the Administrator on 11/8/17 at 10:30am revealed the RCC was getting the clonidine patches for Resident #8 and "it will be here today."

Review of Resident #8's August, September, and October 2017 MARs revealed:
-Entries for clonidine 0.1 mg 24 hr. patch scheduled weekly on Tuesdays at 8am.
-The clonidine 0.1mg 24 hr. patch was documented administered 14 occurrences out of 14 opportunities as scheduled.
-The blood pressure range was 122/76 to 165/69.

Interview with the RCC on 11/8/17 at 12:50pm revealed:

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D 358	Continued From page 3 -On 11/7/17, the Medication Aide that had done the 8am medication pass for Resident #8 had told the Lead Medication Aide that "we were out of clonidine patches" for Resident #8. -The Lead Medication Aide had told that MA "to come talk to me about it." -"It didn't get passed on, but we will have it." Telephone interview with Resident #8's pharmacy on 11/8/17 at 2:50pm revealed: -The clonidine 0.1mg 24 hr. patches were dispensed on 7/5/17 4 patches, 8/4/17 4 patches, 8/29/17 4 patches, and 9/26/17 4 patches. -The resident would receive a refill "this afternoon" of 4 patches. Interview with Staff A, MA, on 11/9/17 at 8:35am revealed: -Resident #8's clonidine patches had come in "the afternoon sometime" on 11/8/17. -The patch was applied on 11/8/17. -Resident #8's blood pressure that morning had been 132/76. Observation of Resident #8's medications available on the cart on 11/9/17 at 9:30am revealed there were 3 clonidine 0.1mg 24 hr. patches available for use. Interview with the Lead MA on 11/9/17 at 10:30am revealed: -When a MA realized a resident was out of a medication, the MA "should fax a reorder request to the pharmacy." -If the MA could not find a medication in "overstock and they can't get the med here, they are supposed to let me or [RCC's name] know and we will take care of it." -"But they have to let us know."	D 358		

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D 358	Continued From page 4 Interview with Resident #8 on 11/9/17 at 11:01am revealed: -"I got it yesterday" referring to her weekly clonidine patch. -"There was a mix up with the doctor's office change, but the script was with the old doctor." -"All my other meds are fine." Telephone interview with Resident #8's physician's nurse on 11/9/17 at 11:45am revealed: -She had spoken with Resident #8's physician concerning the clonidine patch. -There was "no harm" for Resident #8 having been delayed in having a new clonidine patch applied. -"The other patch would have provided some coverage." Refer to interview with Staff B, MA, on 11/9/17 at 9:45am. 2. Review of Resident #8's signed physician order sheet dated 7/25/17 revealed a physician's order for vitamin D3 400 units daily. Observation of Resident #8 on 11/8/17 at 8:15am revealed Resident #8 was administered nine oral medications including 1 vitamin D3 2000 unit gel capsule by Staff A, MA. Observation of Resident #8's medications on hand on 11/8/17 at 8:21am revealed: -There were no vitamin D3 400 unit capsules available for the resident. -There was one bottle of vitamin D3 2000 unit capsules available for the resident. Review of Resident #8's August, September, and October 2017 MARs revealed:	D 358		

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-Entries for vitamin D3 400 units daily at 8am.
-Vitamin D3 400 units daily was documented as administered 92 occurrences out of 92 opportunities.

Review of Resident #8's November MAR revealed:
-An entry for vitamin D3 400 units daily at 8am.
-Vitamin D3 400 units was documented as administered 8 occurrences out of 8 opportunities from 11/1/7 to 11/8/17.

Interview with the RCC on 11/8/17 at 12:50pm revealed:
-He had just started working at the facility in August 2017.
-Resident #8's family provided the vitamin D3 supplement for the resident.
-The family had provided a bottle of vitamin D3 (2,000 unit dosage caps) that did not match the order written by Resident #8's physician.
-He spoke frequently with families to explain that what they supplied had to match the physician's order.
-He was going through each residents medications and orders that did not use the two facility pharmacies to check and make sure the medications on hand matched the physician's orders.
-One of the the facility pharmacies had last audited the facility medication carts in September 2017.
-He and the Lead MA had then went back through the medication carts and follow through with all of the pharmacies recommendations.

Interview with the Lead MA on 11/9/17 at 10:30am revealed:
-When a MA realized a resident was out of a medication, the MA "should fax a reorder request

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to the pharmacy."
-If the MA could not find a medication in "overstock and they can't get the med here, they are supposed to let me or [RCC's name] know and we will take care of it."
-"But they have to let us know."

Telephone interview with Resident #8's physician's nurse on 11/9/17 at 11:45am revealed:
-She had spoken with Resident #8's physician concerning the resident having received vitamin D3 2,000 units daily instead of 400 units a day as ordered.
-"The increased dose may have been helpful" to the resident.
-"She would draw a vitamin D level and check it though."
-The physician was not "alarmed" at the amount of Vitamin D3 the resident had been taking.

Refer to interview with Staff B, MA, on 11/9/17 at 9:45am.

B. Review of Resident #7's current FL2 dated 8/1/17 revealed:
-Diagnoses included hyperlipidemia and diabetes mellitus type 2.
-A physician's order for lovastatin (used to lower cholesterol) 40mg daily.

Review of Resident #7's physician order dated 8/10/17 revealed increase lovastatin to 40mg twice a day.

Interview with Staff A, MA, on 11/8/17 at 8:33am revealed Resident #7 was supposed to get a lovastatin 40mg at 8am, however there was no lovastatin available for the resident on the cart.

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D 358	Continued From page 7 Interview with the RCC on 11/8/17 at 8:36am revealed he would "go get" a supply of lovastatin from Resident #7's pharmacy. Observation of Resident #7 on 11/8/17 at 8:43am revealed the resident was administered seven oral medications which did not include lovastatin by Staff A, Medication Aide (MA). Review of Resident #7's August 2017 MAR revealed: -An entry for lovastatin 40mg 2 tablets once daily at 8pm from 8/1/17 to 8/9/17. -An entry for lovastatin 40mg 1 tablet two times a day at 8am and 8pm from 8/10/17 to 8/31/17. -The lovastatin was documented as administered 51 occurrences out of 51 opportunities from 8/1/17 to 8/31/17. Review of Resident #7's September 2017 MAR revealed: -An entry for lovastatin 40mg 1 tablet two times daily at 8am and 8pm. -The lovastatin was documented as administered 60 occurrences out of 60 opportunities. Review of Resident #7 October 2017 MAR revealed: -An entry for lovastatin 40mg 1 tablet two times daily at 8am and 8pm. -The lovastatin was documented as administered 57 occurrences out of 62 opportunities. -The initials on the front of the MAR were circled indicating the medication was not given on 10/19/17 at 8pm, 10/21/17 at 8am and 8pm, on 10/22/17 at 8pm, and 10/24/17 at 8am. -On the back of the MAR there was an entry on 10/21/17 at 8pm for lovastatin "no meds in cart ordered 10/21/17."	D 358		

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Review of Resident #7's November 2017 MAR revealed:
-An entry for lovastatin 40mg 1 tablet two times daily at 8am and 8pm.
-The lovastatin was documented as administered 15 occurrences out of 17 opportunities from 11/1/17 to 11/9/17 at 8am.
-The initials on the front of the MAR were circled indicating the medication was not given on 11/7/17 at 8am and 8pm.
-On the back of the MAR there was no documentation as to the reason the lovastatin was not administered on 11/7/17.

Interview with Staff A, MA, on 11/9/17 at 8:35am revealed Resident #7's lovastatin "came in yesterday about 9:30am" so she got her morning dose on 11/8/17.

Observation of Resident #7's lovastatin 40mg tablets available on the medication cart on 11/9/17 at 9:30am revealed there were 13 tablets available.

Telephone interview with Resident #7's pharmacy on 11/9/17at 10:21am revealed:
-"They brought her lovastatin to me to repackage it."
-"We do that as a courtesy."
-According to their records, some lovastatin was repackaged for Resident #7 on 10/21/17, however there was no record as to how many tablets were sent.
-"We sent more yesterday (11/8/17), 14 more pills."

Attempted interview with Resident #7 on 11/9/17 at 10:55am revealed the resident was sleeping.

Refer to interview with Staff B, MA, on 11/9/17 at

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D 358	Continued From page 9 9:45am. _____ Interview with Staff B, MA, on 11/9/17 at 9:45am revealed: -If she went to administer a medication to a resident and the medication was not available "I check overstock and make sure its not in there." -"If not in there, I fax a reorder to the pharmacy or call and see if they have already got it coming out." -Circled initials on the front of the MAR meant a medication was not administered. -She would write a corresponding entry for that date and time on the back of the MAR explaining why the medication was not administered. -"If the med is a critical med, I'll call the doctor to see if the doctor still wants us to give it that day when it comes in." -"I give the phone to the nurse to write the verbal doctor order then fax it to the doctor so he can sign the order."	D 358		