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LEGACY HEIGHTS SENIOR LIVING COMMUNITY	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on November 14-15 with a telephone exit on November 16, 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (Resident #8) observed during the medication passes including errors with medications for blood pressure; and 3 of 7 residents (Residents #2, #3, and #7) sampled including errors with sliding scale insulin (#2); a thyroid supplement and medication for anxiety (#7); and a medication for fluid retention (#3). The findings are: A. The medication error rate was 6% as evidenced by the observation of 2 errors out of 29	D 358		

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opportunities during the 11:00 am and 8:00 am medication passes on 11/14/17 and 11/15/17.

Review of Resident #8's current FL-2 dated 10/17/17 revealed diagnoses included hypertension NOS (negative of symptoms), anxiety, and osteoarthritis.

1. Review of Resident #8's current FL-2 dated 10/17/17 revealed an order for "furosemide 20 mg one daily, hold for SBP (systolic blood pressure) < (sp. less than) 100. (Furosemide is a diuretic used to treat hypertension/swelling that can deplete potassium from the body).

Observation during the 11:00 am medication pass on 11/14/17 revealed:
-Resident #8 was administered medication while sitting in her wheelchair at a table in her room.
-At 10:45 am, the medication aide (MA) prepared 8 oral medications for administration to Resident #8.
-The MA said she needed to take Resident #8's blood pressure to determine if furosemide 20 mg should be held or administered.
-The MA obtained a blood pressure for Resident #8 at 10:49 am with a value of 144/80.
-The MA administered Resident #8's oral medications at 10:56 am.
-The MA returned to the medication cart and said she would not administer furosemide because of instructions for holding furosemide preprinted on Resident #2's November 2017 MAR.
-The MA said she had administered all Resident #8's scheduled oral medications and was ready to proceed to the next resident.

Review of Resident #8's November 2017 medication administration record (MAR) from 11/01/17 to 11/13/17 revealed;

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-Furosemide 20 mg one by mouth every day routinely for HTN (hypertension) hold for SBP (systemic blood pressure) < (sp. less than) 100 was preprinted on the MAR.
-The medication was scheduled for administration at 9:00 am.
-Blood pressure values were documented daily with a systolic range of 116 to 151.
-Furosemide 20 mg was documented for held on 11/13/17 for blood pressure value of 140/70 (documented by the current MA).

Interview on 11/14/17 at 11:00 am with the MA revealed:
-She consulted Resident #8's MAR order for furosemide 20 mg and read aloud "furosemide 20 mg one tablet every day ... hold for top blood pressure (sp. SBP) greater than 100.
-She would not administer furosemide 20 mg because of instruction in the order said to hold furosemide for blood pressure "greater than" 100.
-She would document furosemide 20 mg was held due to blood pressure parameters.
-She was not clear what the symbol "<" meant and interpreted the symbol to be "greater than".
-After calling her attention to the symbol (<), she would check with the Resident Care Coordinator (RCC) for the meaning of the symbol.

Interview on 11/14/17 at 11:20 am with the RCC revealed:
-The RCC was responsible for reviewing physician orders compared to the contract pharmacy's entries on the residents' MARs.
-She was not aware the MA was confused with the meaning of the symbol "<" for less than until she came to the medication cart, at 11:10 am, and was asked by the MA if furosemide 20 mg should have been administered to Resident #8 based on the order on the MAR and blood

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pressure reading of 144/80.
-The RCC instructed the MA to administer furosemide 20 mg to Resident #8, and the symbol meant if SBP was greater than 100 not to hold the furosemide.
-The RCC would call the contract pharmacy about typing the words for the symbol "greater than" on Resident #8's MAR to avoid further confusion.

Interview on 11/14/17 at 1:20 pm with the Resident Services Director (RSD) revealed the RCC would be responsible to assure medications were administered as ordered, including assuring MA staff understood the instructions on the residents' MARs.

Interview on 11/15/17 at 3:45 pm with Resident #8 revealed;
-She did not know all the medications she was taking.
-Medication staff brought her medications to her room, took her blood pressure, and administered her medications.
-She did not count the medications she received; she depended on the staff to administer the medications she was supposed to receive according to the physician.

Based on observation and record review, furosemide 20 mg was not administered to Resident #8, as ordered, when the systemic blood pressure was greater than 100 (144/80) during 11:00 am the medication pass on 11/14/17.

2. Review of Resident #8's current FL-2 dated 10/17/17 revealed an order for K-DUR (Potassium Chloride delayed release) 10 meq one tablet daily with Lasix (furosemide). Hold if

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Lasix not given. (K-DUR is a supplement used to replace potassium.)

Observation during the 11:00 am medication pass on 11/14/17 revealed:
-Resident #8 was administered medication while sitting in her wheelchair at a table in her room.
-At 10:45 am, the medication aide (MA) prepared 8 oral medications for administration to Resident #8, including one potassium chloride extended release 10 meq (generic for K-DUR) tablet.
-The MA said she needed to take Resident #8's blood pressure to determine if furosemide 20 mg should be held or administered
-The MA did not hold potassium chloride extended release 10 meq until furosemide was administered as ordered on the FL-2 dated 10/17/17.

Review of Resident #8's November 2017 medication administration record (MAR) from 11/01/17 to 11/13/17 revealed:
-K-DUR 10 meq one tablet every day routinely for HTN (hypertension) Give when Lasix given and hold if Lasix not given was preprinted on the MAR.
-The medication was scheduled for administration at 9:00 am.
-Blood pressure values were documented daily with a systolic range of 116 to 151.
-Potassium chloride 10 meq was documented as administered daily from 11/01/17 to 11/14/17.

Interview on 11/14/17 at 11:20 am with the RCC revealed:
-The RCC was responsible for reviewing physician orders compared to the contract pharmacy's entries on the residents' MARs.
-The MA would be responsible to not administer Resident #8's potassium chloride 10 meq until the

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resident's blood pressure was taken and furosemide 20 mg administered.

Interview on 11/14/17 at 1:20 pm with the Resident Services Director (RSD) revealed the RCC would be responsible to assure medications were administered as ordered, including assuring MA staff understood the instructions on the residents' MARs.

Interview on 11/14/17 at 1:40 pm with the MA administering Resident #8's 11:00 am medications revealed:
-She was aware Resident #8 had instructions regarding administering furosemide 20 mg but overlooked the instructions to not administer potassium chloride 10 meq if furosemide was not administered.
-"She should not have administered potassium chloride 10 meq until Resident #8's blood pressure was taken and furosemide 20 mg was administered".
-She overlooked the parameters for administering potassium chloride 10 meq printed on the resident's MAR and potassium 10 meq medication bubble pak.

Interview on 11/15/17 at 3:45 pm with Resident #8 revealed;
-She did not know all the medications she was taking.
-Medication staff brought her medications to her room, took her blood pressure, and administered her medications.
-She did not count the medications she received; she depended on the staff to administer the medications she was supposed to receive according to the physician.

Review of Resident #8's record revealed a

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potassium value of 4.0 (normal values are between 3.5 to 5.0) documented on the Pharmacy Quarterly Drug Review dated 4/15/17. No additional laboratory values for potassium were available for review.

Based on observation and record review, Resident #8 was administered potassium chloride 10 meq, hold if Lasix (furosemide) not given, when furosemide 20 mg was not administered during 11:00 am the medication pass on 11/14/17.

B. Review of Resident #3's current FL-2 dated 6/26/17 revealed:
-Diagnoses included hypertension, chronic obstructive pulmonary disease (COPD) and history of falls.
-There was an order for furosemide 40 mg one tablet in the morning. (Furosemide is used to treat swelling and high blood pressure).

Review of Resident #3's record revealed a subsequent physician's order dated 7/19/17 to administer furosemide 40 mg in the am (morning) and 40 mg at 2:00 pm.

Continued review of Resident #3's record revealed furosemide 40 mg was discontinued on 11/13/17; Bumex 1.5 mg every morning and at 2:00 pm daily was ordered. (Bumex is used to treat swelling and high blood pressure).

Review of Resident #3's July 2017 medication administration record (MAR) revealed:
-Furosemide 40 mg every morning and at 2:00 pm was handwritten on the MAR.
-Furosemide 40 mg was scheduled for 8:00 am and 2:00 pm.
-Furosemide was documented for administration

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D 358	Continued From page 7 7/20/17 to 7/31/17. Review of Resident #3's August 2017 MAR revealed: -Furosemide 40 mg twice daily (morning and at 2:00 pm) was preprinted on the MAR. -Furosemide 40 mg was scheduled for 8:00 am and 8:00 pm on the preprinted MAR. -The 8:00 pm scheduled time had been struck through and 2:00 pm handwritten on the MAR. -Furosemide was documented for administration at 8:00 am and 2:00 pm from 08/01/17 to 08/31/17. Review of Resident #3's September 2017 and October 2017 MARs revealed: -Furosemide 40 mg every morning and at 2:00 pm was preprinted on the MAR. -Furosemide 40 mg was scheduled for 8:00 am and 8:00 pm on the preprinted MAR. -There was no adjustment to the scheduled time of administration on the September or October MAR. -Furosemide was documented for administration at 8:00 am and 8:00 pm from 09/01/17 to 10/31/17. Review of Resident #3's November 2017 MAR revealed: -Furosemide 40 mg every morning and at 2:00 pm was preprinted on the MAR. -Furosemide 40 mg was scheduled for 8:00 am and 8:00 pm on the preprinted MAR. -There was no adjustment to the scheduled time of administration on the November MAR. -Furosemide 40 mg was documented for administration at 8:00 am and 8:00 pm from 11/01/17 to 11/13/17 at 8:00 am. -Furosemide 40 mg was documented for discontinued on 11/13/17.	D 358		

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-Bumex 1.5 mg every morning and at 2:00 pm was handwritten on the MAR and scheduled for administration at 8:00 am and 2:00 pm daily beginning 11/14/17.

Review of Resident #3's September 2017, October 2017, and November (11/01/17 to 11/13/17) 2017 MAR revealed furosemide 40 mg was documented as administered at 8:00 am and 8:00 pm as scheduled on the MARs.

Interview on 11/25/17 at 12:18 pm with the Resident Care Coordinator (RCC) revealed:
-The RCC, along with a lead Medication Aide (MA) (2 people reviewing the MARs) were responsible to check the MAR from month to month for accuracy.
-Medication orders were sent to the contract pharmacy provider for entry onto the MAR.
-The RCC made any corrections to the MAR for instructions or administration time and documented corrections on a tissue copy of the MAR, which was sent back to the contract pharmacy provider.
-Corrections made to the MAR and sent to the pharmacy should begin to appear on the following month's MAR.
-She reviewed Resident #3's monthly MAR's for furosemide 40 mg from July 2017 to November 2017 and said July 2017 was handwritten; change from 8:00 pm to 2:00 pm was made on August 2017 MAR and was sent to the pharmacy.
-She said September, October and November 2017 MARs for Resident #3 did not reflect furosemide 40 mg scheduled at 2:00 pm (still had 8:00 pm scheduled) and were not identified as incorrect when the month to month MAR reviews were done.

Telephone interview on 11/15/17 at 12:33 pm with

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D 358	Continued From page 9 Resident #3's primary care physician revealed: -She was not aware Resident #3 had received furosemide 40 mg at 8:00 am and 8:00 pm since 10/01/17. -She ordered the furosemide 40 mg to be given at 2:00 pm due to increased risk of falls when residents got up to use the bathroom at night. -Resident #3 took the furosemide for chronic swelling in his legs. -She was not aware of any falls for Resident #3 that might be related to getting up at night to use the bathroom. -She changed the resident's medication to a different diuretic on 11/13/17 and the facility should be giving the new medication at 2:00 pm also. Interview on 11/15/17 at 1:50 pm with Resident #3 revealed: -He was aware he was taking furosemide 40 mg in the afternoon for a while but most recently had been receiving the medication at night. -He had not noticed any difference in his urine output and had not been getting up at night to urinate routinely. -He had not mentioned the change in the time he received his furosemide since he was not aware of any problems related to taking furosemide at 8:00 pm. -He had a new medication for swelling now. Interview on 11/15/17 at 4:00 pm with an evening shift MA revealed: -She routinely administered medications by the time scheduled on the MAR. -The RCC was responsible to review the MAR for accuracy prior to putting the MAR on the medication cart for the MAs. -MAs did not make changes to the MAR, only the RCC.	D 358		

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D 358	Continued From page 10 -She focused on the medication and the time of administration when she passed medications. -She overlooked Resident #3's furosemide 40 mg instructions printed on the MAR for administration at 2:00 pm daily due to the medication appeared on the MAR with a time of administration scheduled at 8:00 pm. Interview on 11/15/17 at 5:45 pm with the Resident Services Director (RSD) and Executive Director (ED) revealed: -The RCC was responsible for ensuring medications were administered as ordered. -The RSD said the facility did not currently have a system in place to routinely audit resident's MARs compared to physician's orders other than the month to month MAR audit. Based on interview and record review, the facility failed to assure failed to assure Resiedent #3 received furosemide 20 mg at 2:00 pm (instead of 8:00 pm) daily as ordered. C. Review of Resident #2's current FL-2 dated 10/24/17 revealed: -Diagnoses included chronic systolic/diastolic heart failure, acute respiratory failure, type 2 diabetes, persistent atrial fibrillation, kidney disease stage 4. -Humalog mix 75-25 12 units to be given each morning. -Humalog mix 75-25 10 units to be given each evening. -There was an order for Humalog insulin use per sliding scale as follows: 60-150= 0 units; 151-200= 1 units; 201-250= 2 units; 251-300= 3 units; 301-350= 4 units; 351-400=5 units; 401-450= 6 units; 451-500= 7 units; above 500 call MD (physician). (Humalog is an insulin used to treat elevated blood sugar).	D 358		

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D 358	Continued From page 11 Review of Resident #2's signed physician's orders dated 08/11/17 revealed there was an order to check blood sugars three times per day before meals. Review of Resident #2's physician's orders dated 8/28/17 revealed an order for Humalog sliding scale insulin (SSI) to be given as needed for the FSBS checked daily before each meal as follows: Below 70, follow hypoglycemia orders, 70- 140 =0 units; 141-170= 1 units; 171-200= 2 units; 201-230= 3 units; 231-260= 4 units; 261-290= 5 units; 291-320= 6 units, 321-350= 7 units, 351-380= 8 units; If over 380= 10 units. Review of glucometer blood sugar review sheet revealed FSBS checks for September 2017 three times daily before meals at 6:30 am, 11:30 am, and 4:30 pm. Review of Resident #2's Medication Administration Record (MAR) for September 2017 revealed: -Insulin per SSI was not documented as administered correctly for 2 out of 87 opportunities. Examples were as follows: -On 9/10/17 at 6:30 am, blood sugar result was 156, initials were listed on the MAR, the amount of units were not listed, and should have been administered 1 unit. -On 9/20/17 at 11:30 am, blood sugar result was 209, initials were listed on the MAR, no amount of SSI was documented as administered, and should have been administered 3 units. Review of Resident #2's MAR for October 2017 revealed: -Check FSBS three times daily was transcribed	D 358		

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onto the MAR at 6:30 am, 11:30 am, and 4:30 pm, from 10/27/17 through 10/31/17.
-Insulin per SSI was not documented as administered correctly for 3 out of 16 opportunities. Examples are as follows:
-On 10/27/17 at 4:30 pm, blood sugar result was 197, initials were listed on the MAR, no amount of SSI was documented as administered, and should have been administered 1 unit.
-On 10/30/17 at 4:30 pm, blood sugar result was 216, initials were listed on the MAR, no amount of SSI was documented as administered, and should have been administered 2 units.
-On 10/31/17 at 4:30 pm, blood sugar result was 163, initials were listed on the MAR, no amount of SSI was documented as administered, and should have been administered 1 unit.

Review of Resident #2's MAR for November 2017 revealed:
-Check FSBS three times daily was transcribed onto the MAR at 6:30 am, 11:30 am, and 4:30 pm, from 10/27/17 through 10/31/17.
-Insulin per SSI was not documented as administered for 3 out of 41 opportunities. Examples are as follows:
-On 11/5/17 at 6:30 am, blood sugar result was 151, initials were listed on the MAR, 0 units of SSI was documented as administered, and should have been administered 1 unit.
-On 11/14/17 at 6:30 am, blood sugar result was 164, initials were listed on the MAR, 0 units of SSI was documented as administered, and should have been administered 1 unit.
-On 11/3/17 at 11:30 am, blood sugar result was 202, initals were listed on the MAR, 1 unit of SSI was documented as administered, and should have been administered 2 units.
-On 11/6/17 at 11:30 am, blood sugar result was 187, initals were listed on the MAR, 0 units of SSI

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LEGACY HEIGHTS SENIOR LIVING COMMUNITY	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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
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was documented as administered, and should have been administered 1 unit.
-On 11/6/17 at 4:30 pm, blood sugar result was 238, initials were listed on the MAR, 3 units of SSI was documented as administered, and should have been administered 2 units.
-On 11/9/17 at 4:30 pm, blood sugar result was 224, initials were listed on the MAR, 3 units of SSI was documented as administered, and should have been administered 2 units.

Interview on 11/15/17 at 12:40 pm with a Medication Aide (MA) revealed:
-She was knowledgeable about sliding scale insulin and how to administer insulin according to the sliding scale.
-She administered insulin according to Resident #2's sliding scale order, but was not sure why she did not document the insulin.
-She thought she may had been distracted and had not realized that it was not recorded on the MAR.
-There was not specific instructions that she received for how the SSI should be recorded on the MAR.
-She had not noticed that she did not record the units.
-She thought the Resident Care Coordinator (RCC) was responsible for reviewing the MAR for accuracy.

Interview on 11/15/17 at 4:00 pm with another MA revealed:
-She had worked at the facility for 3 years, she had been a MA for 15 years.
-She knew about sliding scale insulin and how to administer insulin according to the sliding scale.
-She administered insulin according to the sliding scale ordered for Resident #2.
-She recorded the incorrect unit of insulin given

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as she always follows the sliding scale as listed.
-She was unsure why she would have recorded the insulin incorrectly.
-She had not noticed that she recorded the incorrect units.
-She thought the RCC/Resident Care Director (RCD) was responsible for reviewing the MAR for accuracy.

Interview on 11/15/17 at 11:05 am with Resident #2 revealed:
-The MAs took her blood sugar daily before meals.
-She was aware that she was supposed to received insulin, but was unsure of amounts.
-The MAs took her blood sugar and gave the resident insulin if she needed it.
-She relied on the staff to check her blood sugar and give insulin as ordered.
-She felt like she got the insulin she needed.

Telephone interview on 11/15/17 at 1:22 pm with Resident #2's primary care physician revealed:
-She had not been notified that insulin had not been administered or was administered incorrectly.
-She expected staff to follow orders and if there were any errors, she was to be notified.
-If medication was administered incorrectly, Resident #2 would be at risk for hypoglycemia and staff would be expected to follow hypoglycemia protocol.

Interview on 11/15/17 at 4:20 pm with the Resident Care Coordinator (RCC) revealed:
-She completed initial training with staff as well as annual training on diabetes.
-She had no written policy for insulin administration per sliding scale.
-The contract pharmacy did all of MAR entries for

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the facility.
-Any new orders were received and transcribed on the MAR by the MAs.
-She was not aware that staff were not documenting how much insulin they were administering.
-She reviewed the MAR monthly to collect blood sugars to share with physician.
-There are no reviews of the MAR for accuracy or new orders.
-There are no reviews of the MARs at the end of the month for accuracy or documentation.

Interview on 11/15/17 at 4:45 pm with the Resident Care Director (RCD) revealed:
-She supervised all resident care staff.
-She expected MAs to follow physician's orders and record administration of medication on the MAR.
-MAs are trained by the RCC or RCD and informed that blood sugars and insulin administered are to be recorded on the MAR before working as a MA.
-She thought it was an oversight on the MAs that insulin administered was not documented on the MAR.
-She expected the RCC to review the MAR monthly for accuracy and address inaccuracy with the MAs.
-She was not aware that insulin was not documented as given for Resident #2.

Interview on 11/15/17 at 4:45 pm with the Administrator revealed:
-She expected the facility to follow the doctors' orders and document appropriately to show the work was done.
-The MAs should have let the RCC/RCD know about the missing documentation for (SSI).
D. Review of Resident #7's current FL-2 dated

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D 358	Continued From page 16 04/03/2017 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease, hypothyroidism, agitation, arthritis, atrial fibrillation, shortness of breath, and diverticulosis. -A physician's order for levothyroxine 150 mcg (used to treat hypothyroidism) once a day. -A physician's order for fluoxetine 20 mg (used to treat agitation) once a day. Review of Resident #7's July 2017 Medication Administration Record (MAR) revealed: -An entry for levothyroxine 150 mcg, 1 tablet once a day, scheduled for administration at 7:00 am. -Levothyroxine 150 mcg was documented as administered at 7:00 am from 07/01/2017 to 07/17/2017, no documentation for the day of 07/18/2017, and documented as administered from 07/19/2017 until 07/31/2017. -An entry for fluoxetine 20 mg, 1 capsule once a day, scheduled for administration at 9:00 am. -Fluoxetine 20 mg was documented as administered at 9:00 am from 07/01/2017 to 07/31/2017. Review of Resident #7's August 2017 Medication Administration Record (MAR) revealed: -An entry for levothyroxine 150 mcg, 1 tablet once a day, scheduled for administration at 7:00 am. -Levothyroxine 150 mcg was documented as administered at 7:00 am from 08/01/2017 to 08/19/2017, no documentation for the day of 08/20/2017, and documented as administered from 08/21/2017 until 08/31/2017. -An entry for fluoxetine 20 mg, 1 capsule once a day, scheduled for administration at 9:00 am. -Fluoxetine 20 mg was documented as administered at 9:00 am from 08/01/2017 to	D 358		

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D 358	Continued From page 17 08/31/2017. Review of Resident #7's September 2017 Medication Administration Record (MAR) revealed: -An entry for levothyroxine 150 mcg, 1 tablet once a day, scheduled for administration at 7:00 am. -Levothyroxine 150 mcg was documented as administered at 7:00 am from 09/01/2017 to 09/30/2017. -An entry for fluoxetine 20 mg, 1 capsule once a day, scheduled for administration at 9:00 am. -Fluoxetine 20 mg was documented as administered at 9:00 am from 09/01/2017 to 09/30/2017. Review of Resident #7's October 2017 Medication Administration Record (MAR) revealed: -An entry for levothyroxine 150 mcg, 1 tablet once a day, scheduled for administration at 7:00 am. -Levothyroxine 150 mcg was documented as administered at 7:00 am from 10/01/2017 to 10/31/2017. -An entry for fluoxetine 20 mg, 1 capsule once a day, scheduled for administration at 9:00 am. -Fluoxetine 20 mg was documented as administered at 9:00 am from 10/01/2017 to 10/31/2017. Review of Resident #7's November 2017 Medication Administration Record (MAR) revealed: -An entry for levothyroxine 150 mcg, 1 tablet once a day, scheduled for administration at 7:00 am. -Levothyroxine 150 mcg was documented as administered at 7:00 am from 11/01/2017 to 11/15/2017.	D 358		

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D 358	Continued From page 18 -An entry for fluoxetine 20 mg, 1 capsule once a day, scheduled for administration at 9:00 am. -Fluoxetine 20 mg was documented as administered at 9:00 am from 11/01/2017 to 11/15/2017. Observation on 11/15/17 at 12:15 pm of Resident #7's medications on hand revealed: -A prescription bottle of fluoxetine 20 mg to be administered once a day, with a fill date of 9/11/17 for a quantity of 30 capsules. -There were 7 capsules of the 30 capsules remaining. - Another prescription bottle of fluoxetine 20 mg to be administered once a day, with a fill date of 10/8//17 for a quantity of 30 capsules. -There were 22 capsules of the 30 capsules remaining. - Another prescription bottle of fluoxetine 20 mg to be administered once a day, with a fill date of 11/7/17 for a quantity of 30 capsules. -There were 28 capsules of the 30 capsules remaining. -There was a total amount of 57 capsules of fluoxetine 20 mg on hand. Observation on 11/15/17 at 12:22 pm of Resident #7's medications on hand revealed: -A prescription bottle of levothyroxine 150 mcg to be administered once a day, with a fill date of 10/20/17 for a quantity of 30 tablets. -There were 33 tablets in the bottle labeled to only contain 30 tablets. - Another prescription bottle of levothyroxine 150 mcg to be administered once a day, with a fill date of 9/20/17 for a quantity of 30 tablets. -There were 17 tablets of the 30 tablets remaining in that bottle. -There was a total amount of 50 tablets of	D 358		

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D 358	Continued From page 19 levothyroxine 150 mcg on hand. Based on observations, records reviews, and interviews, it was determined Resident #7 was non-interviewable. Telephone interview on 11/16/17 at 9:00 am with the pharmacy revealed: -A prescription was filled for Resident #7 on 06/20/17 for 30 tablets of levothyroxine 150 mcg to be given once a day. -A prescription was filled for Resident #7 on 7/20/17 for 30 tablets of levothyroxine 150 mcg to be given once a day. - A prescription was filled for Resident #7 on 8/20/17 for 30 tablets of levothyroxine 150 mcg to be given once a day. - A prescription was filled for Resident #7 on 9/20/17 for 30 tablets of levothyroxine 150 mcg to be given once a day. - A prescription was filled for Resident #7 on 10/20/17 for 30 tablets of levothyroxine 150 mcg to be given once a day. -The prescription for levothyroxine was on automatic refill and another bottle was due to be filled on 11/20/17 for 30 tablets. -A total of 150 levothyroxine 150 mcg tablets had been dispensed to the facility between 06/20/17 and 10/20/17. -A prescription was filled for Resident #7 on 06/08/17 for 30 capsules of fluoxetine 20 mg to be given once a day. -A prescription was filled for Resident #7 on 07/08/17 for 30 capsules of fluoxetine 20 mg to be given once a day. -A prescription was filled for Resident #7 on 08/15/17 for 30 capsules of fluoxetine 20 mg to be given once a day. -A prescription was filled for Resident #7 on	D 358		

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09/11/17 for 30 capsules of fluoxetine 20 mg to be given once a day.
-A prescription was filled for Resident #7 on 10/08/17 for 30 capsules of fluoxetine 20 mg to be given once a day.
-A prescription was filled for Resident #7 on 11/07/17 for 30 capsules of fluoxetine 20 mg to be given once a day.
-A total of 180 fluoxetine 20 mg capsules had been dispensed to the facility between 06/08/17 and 11/07/17.

Observation on 11/15/17 at 12:15 pm of Resident #7's fluoxetine prescription bottles revealed:
-A prescription bottle filled date of 09/11/17 with 7 out of the 30 capsules remaining.
-A prescription bottle filled date of 10/08/17 with 22 out of the 30 capsules remaining.
-A prescription bottle filled date of 11/07/17 with 28 out of the 30 capsules remaining.
-According to the dispense dates, quantity dispensed (180 capsules) and amounts documented as administered (138 capsules from 07/01/17 to 11/15/17), there would have been enough fluoxetine 20 mg capsules to have been administered between 07/01/17 to 11/15/17.
-There should have been 21 capsules on hand and available to be administered, but were 57 of the 180 tablets of fluoxetine 20 mg on hand and available for administration.

Observation on 11/15/17 at 12:22 pm of Resident #7's levothyroxine prescription bottles revealed:
-A prescription bottle filled date of 09/20/17 marked for 30 tablets, with 33 tablets remaining in the bottle.
-A prescription bottle filled date of 10/20/17 with 17 out of the 30 tablets remaining in the bottle.
-According to the dispense dates, quantity dispensed (150 tablets) and amounts

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D 358	Continued From page 21 documented as administered (136 tablets from 07/01/17 to 11/15/17), there would have been enough levothyroxine 150 mcg tablets to have been administered between 07/01/17 to 11/15/17. -There should have been 4 tablets on hand and available to be administered, but were 50 of the 150 tablets of levothyroxine 150 mcg on hand and available for administration. Interview on 11/15/17 at 12:12 pm with a Medication Aide (MA) revealed: -She works both "ABC" and "DEF" sides in the special care unit on a rotating basis. -She had worked on the opposite side of the building from Resident #7 for the past week so she could not state whether Resident #7 had received her medications every day during that time. -When administering medications to Resident #7, she would read the MAR first for changes. -She then pulled the medications from the cart and prepared them by crushing them and mixing with pudding. -She crushed and mixed with pudding because Resident #7 needed thickened liquids and pureed foods. -She opened the fluoxetine capsules and emptied them into the pudding and then threw the empty capsules in the trash. -She would place a dot in each box on the MAR as she prepared the medicine, and then initial at each dot after the resident took the medication. -Resident #7 always took her medications and never refused. -She had never missed administering Resident #7 her fluoxetine. -She did not know why there were so many capsules of fluoxetine on hand. -She did not know why there were so many tablets of levothyroxine on hand.	D 358		

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D 358	Continued From page 22 Observation on 11/15/17 at 12:20 pm of the trash can attached to the medication cart showed an empty blue and green capsule, matching the fluoxetine capsules in Resident #7's bottle dated 11/07/17. Interview on 11/15/17 at 1:20 pm with a Medication Aide (MA) revealed: -She had been giving the medications out of the newest bottles since Resident #7 received those bottles. -The family brought in the resident's medications each month. -The medication aides would tell the family when the resident had seven pills left to order more medicine. -She gave the medication every day she was assigned to Resident #7's hall. -The medication aides would rotate each week between "ABC" and "DEF" halls. -Resident #7 had never refused any of her medications and she had never missed a dose. -The Memory Care Director was responsible for checking the MARs against the orders for accuracy, and for performing weekly medication cart audits. Telephone interview on 11/15/17 at 1:45 pm with Resident #7's family member revealed: -She picked up medications the day they were filled by the pharmacy and delivered them to the facility. -She had Resident#7's medications on automatic refill at the pharmacy based on a 30 day supply. -She brought the medications when filled because they were "due" according to the pharmacy. -The facility did not tell her when to refill prescription medication.	D 358		

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D 358	Continued From page 23 -The facility did tell her when to refill Resident #7's over the counter medications. -She had been making the facility MAs sign for the medications when she delivered them because she had noticed "a lot of meds left" and was worried "that medications were not being given correctly." -She discussed this concern with the MAs when she would deliver medications to the facility. -She previously made the facility sign regarding number of medications on hand because of excess medications left over, but stopped when resident came off of hospice. -She planned to make facility MAs begin signing regarding medications on hand again when she delivered medications because she was noticing an increased number of medications on hand again. -She felt that during resident's time on hospice the facility kept better records and gave medications as ordered because she was keeping track. -"This is not right. This could hurt her." Interview on 11/15/17 at 4:48 pm with the Memory Care Director revealed: -She was not aware Resident #7 was not getting all of her medications. -She performed audits weekly to look for "holes on the MAR" and to make sure medications were available on the cart. -Resident #7 received medications from hospice until hospice care was ended in April 2017, then family brought medications. -She stated, "I did not count hospice medications" and "maybe they are overflow from hospice". -She was responsible for checking all orders against the MARs. Telephone interview on 11/15/17 at 6:49 pm with	D 358		

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D 358	Continued From page 24 Resident #7's primary care provider revealed: -She had taken over care for Resident #7 after hospice care ended on 4/25/17. Resident was now on palliative care. -The fluoxetine was given for agitation and the levothyroxine was prescribed for hypothyroidism. -There was no documentation of the facility notifying her of missed doses of fluoxetine or levothyroxine. -She expected the facility to administer the medications as ordered by her and notify the health provider if doses were missed. -She considered the missed doses of levothyroxine to be the biggest concern due to risk of hypothyroidism, with symptoms such as: slow heart rate, constipation, weight gain, high cholesterol, enlarged thyroid, and irritability. -Missing doses of fluoxetine would increase agitation. -Resident #7's TSH level was within normal range (3.42 uIU/ml) on 10/23/17, which was the only time she had checked the resident's labs. -She "did not have any concerns for the resident's care" and felt that "the facility was caring for her well." -She had not noticed an increase in agitation or any other symptoms when she assessed the resident on 10/25/17. Telephone interview on 11/16/17 at 11:07 am with hospice contracted pharmacy revealed: -They had last filled the fluoxetine 20 mg once daily on 4/6/17 for a 15 day supply (15 capsules dispensed). -They had last filled the levothyroxine 150 mcg once daily on 4/6/17 for a 15 day supply (15 tablets dispensed). -They had not dispensed any medications for resident #7 after her hospice care ended on 4/25/17.	D 358		

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D 358	Continued From page 25 The facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents (Resident #8) observed during the medication passes and 3 of 7 residents (Residents #2, #3, and #7). This failure put Resident #8 at risk because of not receiving an anti-hypertensive medication, furosemide, put the resident at risk for increased blood pressure, stroke and receiving a potassium supplement, put the resident at risk for hyperkalemia which includes an adverse effect on the heart; Resident #2 at risk for a hypoglycemic reaction because of not taking a SSI as ordered; Resident #3 was put at an increased risk of falls when the resident got up to use the bathroom at night because of taking furosemide 40 mg at night when should have been given at 2:00 pm; Resident #7 at risk for increased agitation; hypothyroid symptoms such as slow heart rate, constipation, weight gain, high cholesterol, enlarged thyroid, and irritability because of the failure to receive the fluoxetine and the levothyroxine. This was detrimental to the health and safety of Resident #8, #2, #3, and #7 and constitutes a Type B Violation. A Plan of Protection was provided by the facility on 11/15/17 as follows: -The facility will audit for accuracy of documentation, transcription, matching physician orders, correct dispensing per physicians orders. -All medication aides will be inserviced prior to shift over the next 5 days to assure a thorough understanding of all aspects of medication administration, documentation and medication storage. -The RSD, RCC and ED will monitor medication administration and documentation weekly for accuracy and compliance for 4 weeks and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	11/16/2017

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D 358	Continued From page 26 monthly there after. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 31, 2017.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of 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, interviews and record reviews, the facility failed to assure medication administration records were accurate for 1 of 7 sampled residents regarding documentation for administration of sliding scale insulin (SSI) for Resident #2.	D 367		

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D 367	Continued From page 27 The findings are: Review of Resident #2's current FL2 dated 10/24/17 revealed: -Diagnoses included chronic systolic/diastolic heart failure, acute respiratory failure, type 2 diabetes, persistent atrial fibrillation, kidney disease stage 4. -Humalog mix 75-25 12 units to be given each morning. (Humalog is an insulin used to treat elevated blood sugar). -Humalog mix 75-25 10 units to be given each evening. -There was an order for Humalog insulin use per sliding scale as follows: 60-150= 0 units; 151-200= 1 units; 201-250= 2 units; 251-300= 3 units; 301-350= 4 units; 351-400=5 units; 401-450= 6 units; 451-500= 7 units; above 500 call MD (physician). Review of Resident #2's signed physician's orders dated 08/11/17 revealed there was an order to check finger stick blood sugars (FSBS) three times per day before meals. Review of Resident #2's physician's orders dated 8/28/17 revealed an order for Humalog sliding scale insulin (SSI) to be given as needed for the FSBS checked daily before each meal as follows: Below 70, follow hypoglycemia orders, 70- 140 =0 units; 141-170= 1 units; 171-200= 2 units; 201-230= 3 units; 231-260= 4 units; 261-290= 5 units; 291-320= 6 units, 321-350= 7 units, 351-380= 8 units; If over 380= 10 units. Review of Resident #2's Medication Administration Record (MAR) for September 2017 revealed:	D 367		

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-Blood sugars were not documented correctly on the MAR for 57 out of 87 opportunities. Examples were as follows:
-On 9/12/17 at 6:30 am, no blood sugar result was recorded, initials were listed on the MAR, 1 unit of insulin was documented as administered, no injection site recorded.
-On 9/16/17 at 11:30 am, no blood sugar result was recorded, no units of insulin was documented as administered, no were initials listed on the MAR, no reason documented indicating if the dosage was missed or refused.
-Insulin per SSI was not documented as administered for 2 out of 87 opportunities. Examples were as follows:
-On 9/10/17 at 6:30 am, blood sugar result was 156, no SSI was documented as administered, and should have been administered 1 units.
-On 9/20/17 at 11:30 am, blood sugar result was 209, no SSI was documented as administered, and should have been administered 3 units.

Review of glucometer blood sugar review sheet revealed FSBS checks for September 2017 three times daily before meals at 6:30 am, 11:30 am, and 4:30 pm.

Review of Resident #2's MAR for October 2017 revealed:
-Resident #2 was hospitalized October 1-October 26, 2017 for a medical condition not related to the diagnosis of diabetes.
-Check FSBS three times daily was transcribed onto the MAR at 6:30 am, 11:30 am, and 4:30 pm, from 10/27/17 through 10/31/17.
-Insulin per SSI was not documented as administered for 3 out of 16 opportunities. Examples are as follows:
-On 10/27/17 at 4:30 pm, blood sugar result was 197, no SSI was documented as administered,

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D 367	Continued From page 29	D 367		

and should have been administered 1 unit.
-On 10/30/17 at 4:30 pm, blood sugar result was 216, no SSI was documented as administered, and should have been administered 2 units.
-On 10/31/17 at 4:30 pm, blood sugar result was 163, no SSI was documented as administered, and should have been administered 1 unit.

Review of Resident #2's MAR for November 2017 revealed:
-Check FSBS three times daily was transcribed onto the MAR at 6:30 am, 11:30 am, and 4:30 pm, from 10/27/17 through 10/31/17.
-Insulin per SSI was not documented as administered for 3 out of 41 opportunities. Examples are as follows:
-On 11/5/17 at 6:30 am, blood sugar result was 151, no SSI was documented as administered, and should have been administered 1 unit.
-On 11/14/17 at 6:30 am, blood sugar result was 164, no SSI was documented as administered, and should have been administered 1 unit.
-On 11/6/17 at 11:30 am, blood sugar result was 187, no SSI was documented as administered, and should have been administered 1 unit.

Interview on 11/15/17 at 12:40 pm with a Medication Aide (MA) revealed:
-She was knowledgeable about sliding scale insulin and how to administer insulin according to the sliding scale.
-She administered insulin according to Resident #2's sliding scale order, but was not sure why she did not document the insulin.
-She thought she may had been distracted and had not realized that it was not recorded on the MAR.
-There was not specific instructions that she received for how the SSI should be recorded on the MAR.

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D 367	Continued From page 30 -She had not noticed that she did not record the units. -She thought the Resident Care Coordinator (RCC) was responsible for reviewing the MAR for accuracy. Interview on 11/15/17 at 11:05 am with Resident #2 revealed: -The MAs took her blood sugar daily before meals. -She was aware that she was supposed to received insulin, but was unsure of amounts. -The MAs took her blood sugar and gave the resident insulin if she needed it. -She relied on the staff to check her blood sugar and give insulin as ordered. -She felt like she got the insulin she needed. Telephone interview on 11/15/17 at 1:22 pm with Resident #2's primary care physician revealed: -She had not been notified that insulin had not been administered or was administered incorrectly. -She expected staff to follow orders and if there were any errors, she was to be notified. -If medication was administered incorrectly, Resident #2 would be at risk for hypoglycemia and staff would be expected to follow hypoglycemia protocol. Interview on 11/15/17 at 4:20 pm with the Resident Care Coordinator (RCC) revealed: -She completed initial training with staff as well as annual training on diabetes. -She had no written policy for insulin administration per sliding scale. -The contract pharmacy did all of MAR entries for the facility. -Any new orders were received and transcribed on the MAR by the MAs.	D 367		

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D 367	Continued From page 31 -She was not aware that staff were not documenting how much insulin they were administering. -She reviewed the MAR monthly to collect blood sugars to share with physician. -There are no reviews of the MAR for accuracy or new orders. -There are no reviews of the MARs at the end of the month for accuracy or documentation. Interview on 11/15/17 at 4:45 pm with the Resident Care Director (RCD) revealed: -She supervised all resident care staff. -She expected MAs to follow physician's orders and record administration of medication on the MAR. -MAs are trained by the RCC or RCD and informed that blood sugars and insulin administered are to be recorded on the MAR before working as a MA. -She thought it was an oversight on the MAs that insulin administered was not documented on the MAR. -She expected the RCC to review the MAR monthly for accuracy and address inaccuracy with the MAs. -She was not aware that insulin was not documented as given for Resident #2. Interview on 11/15/17 at 4:45 pm with the Administrator revealed: -She expected the facility to follow the doctors' orders and document appropriately to show the work was done. -The MAs should have let the RCC/RCD know about the missing documentation for (SSI).	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 32 G.S. 131D-21 Declaration of Residents' 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 record review 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 relevant federal and state laws and rules and regulations related to medication administration. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (Resident #8) observed during the medication passes including errors with medications for blood pressure; and 3 of 7 residents (Residents #2, #3, and #7) sampled including errors with sliding scale insulin (#2); a thyroid supplement and medication for anxiety (#7); and a medication for fluid retention (#3). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		