Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060147	A. BUILDING: _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANSON RIDGE AT THE VILLAGES OF MECKLENBU	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 Mecklenburg County Department of Social Services conducted an annual survey on 1/30/18 - 1/31/18 with a telephone exit on 2/2/18.	D 000	RANSON RIDGE'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIEES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult 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: Based on observations, record reviews, and interviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 5 sampled residents (Resident #2) regarding tramadol (a medication used to treat moderate to severe pain), ferrous sulfate (a medication used to treat low blood levels of iron), Zyrtec (a medication used to treat allergies), ranitidine (a medication used to treat gastroesophageal reflux disease) and omeprazole (a medication used to treat gastroesphageal reflux disease). The findings are:	D 344	D 344 10A NCAC13F .1002(a) Medication Orders WHAT MEASURES WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: All current residents' medical chart (all orders and MAR/TAR) will be audited to ensure that physician orders are correct and Residents are receiving medications as ordered by the licensed prescribing practitioner. If discrepancies are identified, the licensed prescribing practitioner will be contacted for clarification. The facility will continue with the policy that the Resident Care Coordinator, the Monday-Friday LPN Nurse Manager, and the newly hired weekend LPN Nurse Manager will be the only staff that will receive and process orders from any licensed prescribing practitioner. The Resident Care Coordinator and the Monday-Friday LPN Nurse Manager have received additional training on receiving, reconciling, clarifying, transcribing and processing orders by the Corporate Registered Nurse. They have demonstrated competency to the Corporate RN. The newly hired (Date of Hire: 02-20-18) weekend LPN Nurse Manager will receive training and education on receiving, processing, reconciling, clarifying and transcribing orders by the consultant RN and must demonstrate competency. A new policy that all orders received from a licensed prescribing practitioner, by either the Resident Service Supervisor, the M-F Nurse Manager, or the weekend Nurse Manager and reconciled, clarified (if needed) processed and transcribed by one of these nurses must be check for accuracy by one of the other nurses within 24 hours (M-F) and 48 hours (Saturday & Sunday) for accuracy in processing. A print out of new orders for the past 48 hours will be printed on Monday morning and checked by the M-F Nurse Manager or RSD for accuracy; M-F a report each morning will be printed for the past 24 hours and each order check for accuracy by the M-F Nurse Manager (if processed by the RSD) or the RSD (if the order was processed by the M-F Nurse Manager) for accuracy. The licensed prescribing practitioner will be notified immediately of any discrepancies found for further direction. Admission orders and readmission orders will be reconciled (especially if multiple admission forms – orders are received), verified or clarified within 24 hours following admission with the licensed prescribing practitioner or physician. Residents' orders and medication regime will be reviewed and reconciled every three months to verify that medications being administered are as prescribed.	3-15-18

A new policy/system of printing all new orders received the past 24 hours from the computer and verified with the actual order received to ensure that medications (medication, dosage, and length of administration) have been transcribed to the eMAR correctly. A stop date will be entered in the eMAR for all medications ordered with a specific administration stop date.

WHAT MEASURES WILL BE PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURING AGAIN:

Following completion of the medical record audit for all current residents, four (4) medical records for four (4) residents receiving new orders during the week will be audited by the Consultant RN for receiving, reconciling, and clarifying, processing and accurate transcribing of orders for the next four (4) weeks. If errors are found, the individual responsible for the error will be re-educated for one additional time; thereafter, disciplinary action will be taken up to and including termination. Following four (4) weeks of auditing new orders, the Consultant RN will review a total of six (6) per month as an ongoing quality assurance measure.

Admission orders and readmission orders will be reconciled (especially if multiple admission forms – orders are received), verified or clarified within 24 hours following admission with the licensed prescribing practitioner or physician.

Residents' orders and medication regime will be reviewed and reconciled every three months to verify that medications being administered are as prescribed.

A new policy/system of printing all new orders received the past 24 hours from the computer and verified with the actual order received to ensure that medications (medication, dosage, and length of administration) have been transcribed to the eMAR correctly. A stop date will be entered in the eMAR for all medications ordered with a specific administration stop date.

WHO WILL MONITOR THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN:

The Consultant RN will monitor the situation to ensure it does not occur again. She will audit four (4) charts of residents' receiving new orders during the week for four (4) weeks; then six (6) per month ongoing.

HOW OFTEN THE MONITORING WILL TAKE PLACE:

The Consultant RN will monitor the situation to ensure it does not occur again. She will audit four (4) charts of residents' receiving new orders during the week for four (4) weeks; then six (6) per month ongoing.

COMPLETION DATES BY WHICH THE PLAN OF CORRECTION WILL BE COMPLETED:

The POC will be completed by 3-15-18.

Revied and accepted by
Diana Spalding RN, BSN on
3/14/18.

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D 344	Continued From page 1 Review of Resident #2's current FL 2 dated 01/15/18 revealed: -Diagnoses included chronic obstructive pulmonary disease, gastroesophageal reflux disease, neuropathy, history of seasonal allergies, numbness and tingling of the right leg and history of bilateral shoulder fracture. -A physician's order for omeprazole 40 mg daily. -A physician's order for Zyrtec 10 mg daily. -No physician's orders for tramadol, ferrous sulfate, or ranitidine. Review of Resident #2's Resident Register revealed an admission date of 03/01/16. 1. Review of Resident #2's signed physician order sheet dated 09/26/17 revealed: -An order for tramadol HCL 50 mg take 1 tablet twice daily as needed. -An order for ferrous sulfate 325 mg take 1 tablet daily. -An order for ranitidine 150 mg take 1 tablet by mouth twice daily. -An order for omeprazole 20 mg take 1 capsule daily. Review of Resident #2's previous FL 2 dated 09/13/17 revealed: -A physician's order for omeprazole 40 mg daily. -A physician's order for Zyrtec 5 mg daily. -A physician's order to discontinue ferrous sulfate 325 mg daily. -No physician's orders for tramadol or ranitidine. Review of Resident #2's electronic Medication Administration Records (eMAR) for October, November, and December 2017 and January 2018 revealed: -There were no entries during all 4 months for	D 344		

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D 344	Continued From page 2 tramadol HCL 50 mg 1 tablet twice daily as needed, ferrous sulfate 325 mg 1 tablet daily or ranitidine 150 mg 1 tablet twice daily. -There was documentation omeprazole 40 mg 1 capsule daily was administered rather than omeprazole 20 mg 1 capsule daily from 10/01/17 to 01/12/18 except for on 01/06/18 when the medication was not administered due to resident being in the hospital. Review of Resident #2's quarterly Consultant Pharmacist's Medication Review dated 12/28/17 revealed: -There was documentation staff needed to locate discontinued orders for ferrous sulfate 325 mg and ranitidine 150 mg because they were on the most recent physician order sheet but not on the eMAR. -There was documentation staff needed to locate the order for the increase of omeprazole to 40 mg daily that was on the eMAR because the most recent physician order sheet had an order for omeprazole 20 mg daily. Observation on 01/31/18 of Resident #2's medications available for administration at 3:00 pm revealed: -There was Zyrtec 5 mg, tramadol 50 mg, ferrous sulfate 325 mg, and omeprazole 40 mg available to administer. -There was no ranitidine available to administer. Interview on 01/31/18 with Resident #2's Physician Assistant (PA) at 10:13 am revealed: -She did not know Resident #2 was not receiving tramadol HCL 50 mg 1 tablet twice daily as needed, ferrous sulfate 325 mg daily, and ranitidine 150 mg twice daily as indicated in the physician orders. -She did not know the facility was administering	D 344		

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D 344	Continued From page 3 40 mg of omeprazole rather than 20 mg as listed in the physician's orders. Interviews on 01/31/18 at 12:02 pm and 2:27 pm with the Resident Care Coordinator (RCC) revealed: -The former Nurse Manager (NM) was responsible for printing physician order sheets from their computer system every 6 months and getting the physician to sign them. -The former NM had printed Resident #2's medication list early in the month of September 2017 and then the resident was hospitalized and sent to a skilled nursing facility (SNF) for rehabilitation until 09/14/17. -Resident #2's medication orders for tramadol, ferrous sulfate, ranitidine, and omeprazole were changed while the resident was in the SNF. -The former NM did not reprint an updated medication list prior to having the physician sign the physician order sheet on 09/26/17. -The former NM did not review the signed physician order sheet to verify its accuracy and did not contact the physician to clarify the orders. -She was responsible for reviewing recommendations made by the consultant Pharmacist during the quarterly medication reviews. -She was responsible for ensuring follow up of the recommendations made. -She had not reviewed the Pharmacist's recommendations from December 2017. -If she had reviewed the recommendations, she would have been aware of the discrepancy between Resident #2's signed physician orders and medications actually being administered and could have gotten clarification at that time. Interview on 01/31/18 with the Administrator at 6:00 pm revealed:	D 344		

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-The RCC and the NM were responsible for reviewing recommendations made by the Pharmacist during their medication reviews.
-Had they reviewed these recommendations they would have noticed the discrepancies in Resident #2's eMAR compared to the physician orders.

Interview on 02/01/18 with the RCC at 10:55 am revealed:
-She had obtained clarification orders from Resident #2's Nurse Practitioner (NP) on 02/01/18.
-The NP ordered to discontinue tramadol 50 mg, discontinue ferrous sulfate 325 mg, discontinue ranitidine, and continue giving omeprazole 40 mg daily.

Interview on 01/31/18 with Resident #2 at 2:50 pm revealed:
-She thought she had been on tramadol at one time due to chronic shoulder pain from previous fractures.
-She had not experienced any significant pain recently but her shoulder "constantly felt uncomfortable."
-She had not had any recent issues with allergies or indigestion.

Refer to interview on 01/31/18 with the Administrator at 5:15 pm.

2. Review of Resident #2's eMAR for January 2018 revealed there was documentation Zyrtec 5 mg daily was administered rather than 10 mg daily from 01/15/18 to 01/29/18.

Interview on 01/31/18 with Resident #2's PA at 10:13 am revealed she was unaware the facility was administering a different dose of Zyrtec compared to what was listed in the physician's

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D 344	Continued From page 5 orders. Interviews on 01/31/18 with the Resident Care Coordinator (RCC) at 4:56 pm revealed: -She had reviewed Resident #2's FL 2 that came back with her from her hospitalization dated 01/15/18. -She only reviewed the section of the FL 2 titled "new medications" and "changed medications." -She did not review the section of the FL 2 titled "continued medications" so she did not notice the order for Zyrtec was different than the order they currently had and therefore did not obtain clarification from the physician. Interview on 02/01/18 with the RCC at 10:55 am revealed: -She had obtained clarification orders from Resident #2's Nurse Practitioner (NP) on 02/01/18. -The NP ordered to continue giving Zyrtec 5 mg daily. Interview on 01/31/18 with Resident #2 at 2:50 pm revealed she had not had any recent issues with allergies or indigestion. Interview on 01/31/18 with Resident #2's PA at 10:13 am revealed she expected the facility to follow physician orders. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. Interview on 01/31/18 with the Administrator at 5:15 pm revealed: -The RCC and the NM were responsible for reviewing orders that came into the facility and comparing them to the current eMAR and then entering the correct doses of medications into the	D 344		

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D 344	Continued From page 6 eMAR system. -She would expect them to contact the physician to clarify if new orders were different from the current orders they had.	D 344		
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 ensure medications were administered as ordered by a licensed prescribing practitioner for 4 of 6 sampled residents related to carvedilol [(a medication used for treating high blood pressure and congestive heart failure) #4], gabapentin [(a medication used to treat nerve pain) #2], Coumadin [(a medication to prevent harmful blood clots and help reduce the risk of stroke or heart attack) #5, #6]. The findings are: 1. Review of Resident #4's current FL2 dated 12/08/17 revealed: -Diagnoses included hypertension, coronary	D 358	D 358 10A NCAC13F .1004(a) Medication Administration WHAT MEASURES WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: All current residents' medical chart (all orders and MAR/TAR) will be audited to ensure that medications are being administered as ordered by the licensed prescribing practitioner. If discrepancies are identified, the physician and/or licensed prescribing practitioner will be notified for clarification. The facility will continue with the policy that the Resident Care Coordinator, the Monday-Friday LPN Nurse Manager and the newly hired weekend LPN Nurse Manager will be the only staff that will receive and process physician and/or prescribing practitioner orders. The Resident Care Coordinator and the Monday-Friday LPN Nurse Manager have received additional training on receiving, processing, reconciling, clarifying and transcribing orders by the Corporate Registered Nurse. They have demonstrated competency to the Corporate RN. The newly hired (Date of Hire: 02-20-18) week end LPN Nurse Manager will receive training and education on receiving, processing, reconciling, clarifying and transcribing orders by the consultant RN and must demonstrate competency. A new policy that all orders received from a licensed prescribing practitioner once received, reconciled, clarified (if needed) processed and transcribed by one nurse must be check for accuracy by one of the other nurses that did not receive and process the order within 24 hours for accuracy in processing M-F and 48 hours for Saturday & Sunday. A new system/policy to use a PT/INR lab draw log will be implemented whereby all physician orders for PT/INR draws will be noted on the log and timely followed up until draw has occurred, report has been received, and licensed prescribing practitioner has been notified of the results. The M-F Nurse Manager will be responsible for using the log to ensure PT/INRs are drawn timely, results are received timely, and receiving prescribing practitioner notified timely.	3-15-18

			Medication Aides will receive education on the correct procedure for administering medications by following the licensed prescribing practitioner's orders and that the medication administered is correct and accurate. The Medication Aides will receive education on what to do if there is an omission or error in the medication administration process. WHAT MEASURES WILL BE PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURING AGAIN: Following completion of the medical record audit for all current residents, four (4) medical records for four (4) residents receiving new orders during the week will be audited by the Consultant RN for receiving, reconciling, clarifying, processing, and accurate transcribing of orders for the next four (4) weeks. If errors are found, the individual responsible for the error will be re-educated for one additional time; thereafter, disciplinary action will be taken up to and including termination. Following four (4) weeks of auditing new orders, the Consultant RN will review a total of six (6) per month as an ongoing quality assurance measure. WHO WILL MONITOR THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN: The Consultant RN will monitor the situation to ensure it does not occur again. She will audit four (4) charts of residents' receiving new orders during the week for four (4) weeks; then six (6) per month ongoing. HOW OFTEN THE MONITORING WILL TAKE PLACE: The Consultant RN will monitor the situation to ensure it does not occur again. She will audit four (4) charts of residents' receiving new orders during the week for four (4) weeks; then six (6) per month ongoing. COMPLETION DATES BY WHICH THE PLAN OF CORRECTION WILL BE COMPLETED: The POC will be completed by 3-15-18.	

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D 358	Continued From page 7 artery disease, chronic pain, diabetes, an ejection fraction of 10% - 15%, atrial fibrillation, and congestive heart failure (CHF). -An order for carvedilol 3.125 mg twice daily. Review of Resident #4's Resident Register revealed he was admitted to the facility on 12/11/17. Review of Resident #4's clarification orders dated 12/11/17 revealed an order for carvedilol 3.125 mg tablets twice daily. Review of Resident #4's pharmacy review dated 12/28/17 revealed: -A documentation the carvedilol 3.125 mg twice daily was transcribed onto the December 2017 electronic Medication Administration Record (eMAR). -A recommendation to get a clarification for carvedilol 3.125 mg twice daily. Review of Resident #4's December 2017 eMAR revealed: -Carvedilol 3.125 mg twice daily was not documented as administered 12/08/17 at 8:00 am and 8:00 pm through 12/28/17. -Carvedilol 3.125 mg twice daily was documented as administered 12/29/17 at 8:00 am and 8:00 pm through 12/31/17 at 8:00 am and 8:00pm. Review on 1/31/18 of medications on hand for Resident #4 revealed a bubble pack containing carvedilol 3.125 mg to be dispensed twice daily, filled on 1/25/18 with 59 doses remaining out of 60. Telephone interview on 1/31/18 with a pharmacy representative at 9:16 am revealed: -Documentation of an order on the FL2 for	D 358		

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D 358	Continued From page 8 carvedilol 3.125 mg twice daily dated 12/11/17. -Carvedilol 3.125 mg twice daily was filled initially on 12/12/17 for a quantity of 60. -Carvedilol 3.125 mg twice daily was filled a second time on 1/25/18 for a quantity of 60. -"We cannot see the MAR and the orders as they are entered, they only can see the resident profiles". -We only fill the orders they receive. Interview on 1/31/18 with a medication aide (MA) at 7:00 am revealed: -She was hired in November 2017. -She did not give Resident #4 the carvedilol 3.125 mg twice daily before 12/29/17 because it was not on the eMAR. -She only gives medications on the MAR. -She did not know if the carvedilol was in the drawer for Resident #4 December 12, 2017. -The Resident Care Coordinator (RCC) or the Nurse Manager (NM) were the only two staff capable of entering or modifying orders in the eMAR. Interview on 1/31/18 with Resident #4's physician at 10:01 am revealed: -She did not know the Carvedilol 3.125 mg twice daily had not been given as ordered. -She considered it detrimental because it could have led to a congestive heart failure exacerbation. -Resident #4 had not had an exacerbation of congestive heart failure since his admission to the facility on 12/11/17. Interview on 1/31/18 with the Resident Care Coordinator (RCC) at 10:31 am revealed: -She was responsible along with the Nurse Manager (NM) for faxing the new FL2's and orders to the physician for final approval.	D 358		

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D 358	Continued From page 9 -She was responsible along with the NM for receiving the FL2's and orders from the physician's office and entering them into the eMAR. -After orders were entered into the eMAR the FL2's and orders were faxed/scanned to the pharmacy. -The pharmacy was responsible for filling the medication orders and sending them to the facility only. -The pharmacy cannot see the MAR only the resident profiles. -She and the NM were the only ones that could enter new orders or modify orders in the eMAR. -She did not know of the order for carvedilol 3.125 mg twice daily dated 12/8/17 or 12/11/17. -She found out about the order for the carvedilol 3.125 mg twice daily on 12/28/17 after receiving the pharmacy review. -She entered the order on Resident #4's eMAR and the carvedilol 3.125 mg twice a day was started on 12/29/17 at 8:00 am. -She did not have a policy in place to double check the eMARs for holes, errors, or for omissions. -She did not inform the physician's office about the 40 missed doses of Resident #4's carvedilol 3.125 mg twice daily as ordered. Interview on 1/31/18 with the Administrator at 11:15 am revealed: -She did not know the order for carvedilol 3.125 mg twice daily had been missed for 18 days. -It was the RCC's and the NM's responsibility to check all FL2's and new orders, have them clarified with the physician, enter them into the eMAR, and scan/fax to the pharmacy. -The only two staff members at the facility who have access to entering orders or modifying orders in the eMAR were the RCC and the NM.	D 358		

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RANSON RIDGE AT THE VILLAGES OF MECKLENBU	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 358	Continued From page 10 -Her expectation was for the orders to be received, entered onto the eMAR and followed as ordered. -She did not know the RCC or the NM did not notify the physician's office about the 40 missed doses of Resident #4's carvedilol 3.125 mg. Telephone interview on 1/31/18 with a Nurse at Residents #4's Cardiologist's Office at 12:31 pm revealed: -Resident #4 was last seen in the office on 12/14/17 for a pacemaker check. -She did not know of the 40 missed doses of carvedilol 3.125 mg. -There was no documentation in Resident #4's record at the office of any communication from the facility about Resident #4. -This medication should not have been "stopped" without notifying the physician. -Failure to to administer the carvedilol as directed could increase the risk of a CHF exacerbation, causing the resident to have a harder time breathing and his heart to work harder. -She expected the facility to follow the orders as prescribed. Refer to interview on 01/31/18 with the RCC at 10:13 am. Refer to interview on 01/31/18 with the NM at 4:41 pm. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. 2. Review of Resident #2's current FL 2 dated 01/15/18 revealed: -Diagnoses included chronic obstructive pulmonary disease, gastroesophageal reflux disease, neuropathy, history of seasonal	D 358		

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D 358	Continued From page 11 allergies, numbness and tingling of the right leg and history of bilateral shoulder fracture. -A physician's order for gabapentin 300 mg take 2 capsules at night and gabapentin 300 mg take 1 capsule daily. a. Review of Resident #2's eMAR for January 2018 revealed: -There were two entries for gabapentin 300 mg; an entry for gabapentin 300 mg 1 capsule daily with a discontinue date of 01/15/18 and an entry for gabapentin 300 mg 2 capsules at night with a start date of 01/15/18. -There was documentation gabapentin 300 mg 2 capsules at night was administered at 8:00 pm from 01/15/18 to 01/30/18. -There was no documentation gabapentin 300 mg 1 capsule daily had been administered after 01/12/18. Interview on 01/31/18 with the Resident Care Coordinator (RCC) at 4:56 pm revealed: -She had reviewed Resident #2's FL 2 that came back with her from her hospitalization dated 01/15/18. -She thought she had gotten clarification from the physician to give only the gabapentin 300 mg 2 capsules at night and discontinue the gabapentin 300 mg 1 capsule daily but she was unable to locate the order. b. Review of Resident #2's previous FL 2 dated 09/13/17 revealed a physician's order for gabapentin 300 mg 1 capsule at night. Review of Resident #2's signed physician order sheet dated 09/26/17 revealed an order for gabapentin 300 mg take 1 capsule three times daily.	D 358		

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D 358	Continued From page 12 Review of Resident #2's electronic Medication Administration Records (eMAR) for October, November, and December 2017 and January 2018 revealed: -There was an entry for gabapentin 300 mg 1 capsule daily at 8 pm. -There was documentation gabapentin 300 mg was administered once daily from 10/01/17 to 01/12/18 except on 01/05/18 when the medication was not administered due to resident being in the hospital. -There was no entry for gabapentin 300 mg 1 capsule three times daily. Interview on 01/31/18 with the Resident Care Coordinator (RCC) at 12:02 pm revealed: -The former Nurse Manager (NM) was responsible for printing physician order sheets from their computer system every 6 months and getting the physician to sign them. -The former NM had printed Resident #2's medication list early in the month of September 2017 and then the resident was hospitalized and sent to a skilled nursing facility (SNF) for rehabilitation until 09/14/17. -Resident #2's medication order for gabapentin was changed while the resident was in the SNF. -The former NM did not reprint an updated medication list prior to having the physician sign the physician order sheet on 09/26/17. -The former NM did not review the signed physician order sheet to verify its accuracy and did not contact the physician to clarify the orders. Review of Resident #2's medications on hand for administration on 01/31/18 at 3:00 pm revealed a bubble pack containing gabapentin 300 mg 1 capsule to be administered daily, filled on 01/04/18 with 6 out of 30 doses remaining.	D 358		

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D 358	Continued From page 13 Interview on 01/31/18 with Resident #2's Physician Assistant (PA) at 10:13 am revealed: -She was unaware the facility had been administering a different dose of gabapentin compared to what was listed in the physician's orders since 09/26/17. -She recalled having increased Resident #2's gabapentin dose to 300 mg three times daily in May 2017 due to her neuropathy not being well controlled. -She expected the facility to follow physician orders. Interview on 01/31/18 with Resident #2 at 2:50 pm revealed: -She thought she was on gabapentin due to tingling and numbness in her foot. -She was still having a problem with tingling and numbness in her foot that would get progressively worse throughout the day. Interview on 02/01/18 with the RCC at 10:55 am revealed: -She had obtained clarification orders from Resident #2's Nurse Practitioner (NP) on 02/01/18. -The NP ordered for a third gabapentin 300 mg to be added in the mornings. Refer to interview on 01/31/18 with the RCC at 10:13 am. Refer to interview on 01/31/18 with the NM at 4:41 pm. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. 3. Review of Resident #1's current FL 2 dated 10/24/17 revealed:	D 358		

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D 358	Continued From page 14 - Diagnoses included anemia, atrial fibrillation, cardiac defibrillator, coronary artery disease, cardiomyopathy, carotid artery stenosis, congestive heart failure, diabetes mellitus type II, stroke. -Documentation on FL 2 for medications was "see attached." -Review of attachment revealed a physician print out of a medication list from the previous cardiologist dated 10/19/17. -Medications listed on the FL 2 attached list included Coumadin 2.5 mg, take one tablet by mouth in the evening. Review of Resident #1's record revealed: -There was a subsequent physician's order dated 12/13/17 for Coumadin 3 mg to be held on 12/13/17. -There was a physician's order dated 12/13/17 for Coumadin 3 mg to be administered on 12/14/17, 1 tablet in the evening. -There was a physician's order dated 12/13/17 for Coumadin 1.5 mg in the evening on 12/15/17 and 12/16/17 and 12/17/17. -There was a physician's order dated 12/15/17 for Coumadin 1.5 mg to be continued until the next INR on 12/20/17. Review of Resident #1's December 2017 electronic medication administration (eMAR) record revealed: -There was an entry for Coumadin 1.5 mg, 1 tablet three times daily, and scheduled to be administered at 8:00 am, 1:00 pm and 6:00 pm. -It was documented as administered on 12/16/17 and 12/17/17 at 8:00 am, 1:00 pm and 6:00 pm. -It was documented as administered on 12/18/17 at 1:00 pm and 6:00 pm. Interview on 01/31/17 with Nurse Manager (NM)	D 358		

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D 358	Continued From page 15 at 9:30 am revealed: -The phlebotomist came to the facility three times a week and completed any lab draws ordered by prescribing practitioner.- -The laboratory would fax the results to the facility. -The Resident Care Coordinator (RCC) or NM received orders from the prescribing physician. -The RCC and NM were the only staff persons who could transcribe orders to the eMAR system. -The NM did not know Coumadin 1.5 mg was on the eMAR for 38am, 10pm and 6 pm on 12/16/17, 12/17/17 and 12/18/17. -He received the physician's order dated 12/13/17 for Coumadin 1.5 mg to be administered daily on 12/15/17, 12/16/17 and 12/17/17. -The order was entered on the eMAR by the RCC. -There were no "checks or oversight" on the orders that had been entered on the eMAR. -The weekend nurse was "looking over" the Coumadin orders, but resigned over a month ago and his position had not been filled. -The NM stated there is no process for reviewing the eMAR for "holes." Review of Resident #1's orders dated 01/17/18 revealed an order to "hold Coumadin (3mg dose) on 01/17/18", and an order to administer "Coumadin 2 mg on 01/18/18 - 01/23/18." Review of the January 2018 eMAR revealed Coumadin 2 mg was not documented as administered on 01/22/18. Interview on 01/31/18 with the RCC at 9:55 am revealed: -She was not aware that eMAR documentation revealed Coumadin 2 mg was not administered on 01/22/18.	D 358		

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D 358	Continued From page 16 -RCC stated there was currently no process in place to review the MARS for "..holes." Interview on 01/31/18 with the pharmacy representative contracted by facility at 10:15 am revealed: -The pharmacy did not have the capability to interface with the facility eMAR. They are not able to see the physician's orders the facility entered on the eMAR. -The facility faxed orders to the pharmacy and the pharmacy dispensed medications. -No orders were received for Resident #1 from facility between 12/15/17 and 12/17/17. Interview on 01/31/18 with a medication aide (MA) at 12:30 pm revealed: -She was hired in October 2017. -She worked 1st shift and was the primary MA for Resident #1. -She had never administered Coumadin to Resident #1. -When she saw a medication on the eMAR that she did not recognize, she informed RCC or NM. -The MA documented administering Coumadin to Resident #1 on 12/18/17 at 1 pm. -She did not know why she documented administering Coumadin on that date. -She does not sign for medication she does not administer. Telephone interview on 01/31/18 with a second MA at 5:00 pm revealed: -She had been "licensed" since 2006; worked at the facility since October 2017 and currently worked the first shift weekends. -She had never administered Coumadin to Resident #1 on her shift. -She does not know why she documented that she administered Coumadin on 12/16/17 at 8am	D 358		

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D 358	Continued From page 17 and 1pm; 12/17/17 at 8 am and 1 pm. -She does not remember seeing Coumadin on the eMAR for Resident #1. -She does not sign for medications she does not give. Interview on 02/1/18 with a third MA at 10:00 am revealed: -She signed the eMAR after administering the medications when she returned to the medication cart. -If the medication was highlighted yellow it was within the time frame to administer; if it was highlighted red it had not been administered and was past due. -If the medication was administered and signed for, the medication was removed from the screen. -If there was a new order on the computer screen and the medication was not on the cart, the MA would check the backup room, the orders and the pharmacy. Then she would let the supervisor know. -She questioned new orders for residents with her supervisor. -She only worked first shift and had never administered Coumadin. Interview on 02/1/17 with a fourth MA at 10:30am revealed: -She documented the medications had been administered on the eMAR. -Coumadin was administered at night. If it was on the first shift eMAR she would report to a supervisor. -She had never administered Coumadin on the day shift. Refer to interview on 01/31/18 with the RCC at 10:13am.	D 358		

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D 358	Continued From page 18 Refer to interview on 01/31/18 with the NM at 4:41pm. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. 4. Review of Resident #6's current FL 2 dated 10/31/16 revealed: -Diagnoses included congestive heart failure (CHF); atrial fibrillation; aka left; dyslipidemia; depressive disorder; metastatic lung cancer. - The medications on the FL 2 included warfarin sodium 2.5 mg tablet administered at bedtime. Review of Resident #6's physician order dated 12/4/17 revealed: -An order for Coumadin 3 mg tablet; give 1 tablet every other day at bedtime, alternating with 4mg. -Coumadin 4 mg tablet was scheduled to be administered on 12/12/17. Review of the December 2017 eMAR revealed: -An order for Coumadin 4 mg was documented as "Not Scheduled" to be administered on 12/12/17. -Coumadin 4 mg dose was not documented as administered on the eMAR or the progress notes12/12/17. Review of Resident #6's physician order dated 12/18/17 revealed an order to administer Coumadin 3 mg tablet, give 1 tablet every other day alternating dose with 4 mg tab. Review of the December 2017 eMARs revealed: - An order for Coumadin 4mg was documented as "Not Scheduled" to be administered on 12/25/17 to Resident #6. -Coumadin 4mg was not documented as administered on the eMar or the progress notes	D 358		

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D 358	Continued From page 19 on 12/25/17. Review of Resident #6's physician order dated 01/3/18 revealed an order for Coumadin 3 mg tablet, give 1 tablet every other day, alternating dose with Coumadin 4 mg tablet. Review of the January 2018 eMAR revealed: - On 01/9/18 Coumadin 3 mg was documented as "Not Scheduled" to be administered to Resident #6. -Coumadin 3mg was not documented on the eMAR or progress notes as being administered on 01/9/18. Interview on 01/31/18 with NM and RCC at 11:15 am revealed: -NM and RCC were the only staff persons who could transcribe orders to the eMAR. -They did not know why the Coumadin doses on those dates were entered as "Not Scheduled." -There was no oversite for orders entered into the eMAR system or medications not administered. Interview at 11:30 am with PA on 01/31/18 revealed: -She was not notified that Coumadin 4 mg dose was not administered on 12/12/17 and 12/25/17 as ordered. -She was not notified that Coumadin 3 mg dose was not administered on 1/9/18 as ordered. -The PA would be concerned Coumadin 3 mg and 4 mg was not administered on those dates (12/12/17, 12/25/17, 01/9/18) if the (resident's) INR was significantly out of (therapeutic) range (2.0-3.0). Review of laboratory results for INR revealed: -On 12/13/17 INR was 2.55. -On 12/18/17 INR was 2.70.	D 358		

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D 358	Continued From page 20 -On 01/10/18 INR was 3.76. Refer to interview on 01/31/18 with the RCC at 10:13 am. Refer to interview on 01/31/18 with the NM at 4:41 pm. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. 5. Review of Resident #5's current FL 2, dated 7/12/17, revealed: -The resident had diagnoses of cerebrovascular accident, hypertension, atrial fibrillation, congestive heart failure. -An order for Coumadin 4 mg to be administered on Monday, Tuesday, Thursday, and Saturday. -An order for Coumadin 2 mg to be administered on Wednesday, Friday, and Sunday. Review of a physician's order dated 1/24/18 revealed: -Coumadin 5 mg to be administered on 1/24/18 and 1/25/18. -Coumadin 2.5 mg to be administered each day until 1/31/18. -INR on 1/31/18. Review of Resident #5's January 2018 electronic medication administration records (eMAR) revealed on 1/24/18 and 1/25/18, both Coumadin 5 mg and 2 mg were documented as administered both days at 9 pm. Review on 1/31/18 of Resident #5's medications on hand at 10:50 am revealed:	D 358		

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D 358	Continued From page 21 -There were no Coumadin 5 mg tablets. -A card of warfarin (substituted for Coumadin) 2.5 mg with 6 tablets filled on 1/17/18 with 1 tablet remaining. The labeled instructions, "give 1 tablet by mouth once daily in the evening". -A card of warfarin 2.5 mg with 6 tablets filled on 1/24/18 with 4 tablets remaining. The labeled instructions, "give 1 tablet by mouth once daily in the evening***Start 1/26/18". -A card of warfarin 2.5 mg with 6 tablets filled on 1/29/18, with 6 remaining. The labeled instructions, "give 1 tablet by mouth once daily in the evening ***start on 1/26/18". Interview on 1/31/18 with Resident #5 at 8:45 am revealed: -Prior to coming to the facility her Coumadin dosage was more consistent. -She rarely required adjustments to Coumadin to be made, and she did not have to have lab work done as frequently. -She was not sure why her lab work fluctuated so much now and required constant changes to be made to her Coumadin dosage. -She was not sure how much Coumadin she was currently receiving because it changed so often. -She did not recall if she had gotten two Coumadin pills at once in the past month. She did not know what her Coumadin pills looked like. -She had lab work done this morning, but did not know if the facility had gotten the results back yet. Interview on 1/31/18 with medication aide (MA) at 10:50 am revealed: -She always worked 1st shift. -She was familiar with Resident #5's medications, and was aware that she received Coumadin at night. -She never administered Coumadin to residents on 1st shift, and if the MAR reflected it should be	D 358		

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D 358	Continued From page 22 given on 1st shift, she would ask the RCC or Nurse Manager (NM) if this was accurate prior to administering the medication. Interview on 1/31/18 with a second MA at 4:00 pm revealed: -She had worked in the facility for about two years as a MA. -Only the RCC and the NM had access to enter new orders into the electronic MAR (eMAR) system. -Once a new order was entered into the eMAR system, the person who entered it (either the RCC or NM) would leave the "pink" copy of the order on the medication cart. -The MA was supposed to review the "pink" copies of orders daily, and compare them to what was appearing in the eMAR system, to ensure it matched. -If the order on the pink copy and the eMAR did not match, the MA was supposed to alert either the RCC or the NM so they could review it and make the corrections. -She never observed a discrepancy between the pink copy and the eMAR system. -The MA had the ability to view the entire MAR for the month by clicking on "current MAR" in the eMAR system. -Resident #5 usually received only 1 Coumadin pill in the evening. She recalled a few times when she had administered 2 - 2.5 mg pills to equal the required 5 mg dosage. -She did not recall documenting that she had administered both the 5 mg and 2.5 mg pills in the eMAR system on 1/24/18. -She would have only given the 5 mg pill, because that was what the original order required. She was not sure how or why it was documented she had given both the 5 mg and the 2.5 mg pills, but she was certain that she did not	D 358		

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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
D 358	Continued From page 23 actually give both pills. -She was not sure why there was 1 pill left of Coumadin 2.5 mg in the card dated 1/17/18, but the pharmacy "sometimes sent an extra pill" in case the resident's lab results did not come back in time for the pharmacy to get a new order filled and delivered to the facility. -She was not sure why there were 4 pills left of Coumadin 2.5 mg in the card that was filled on 1/24/18. -She thought the two pills that were missing from this card must have been an instance where they were to administer a total of 5mg, by administering 2 - 2.5 mg pills -She had put a new card away in the storage room so that MAs would not start pulling pills from it because there were other warfarin cards currently on the cart with pills remaining. -She stated they often had multiple cards on the cart, so she tried to put new cards in storage until they were needed. -The card she had put in storage was filled on 1/29/18, and the instructions read, "give 1 tablet by mouth once daily in the evening ***start on 1/26/18." -She was not sure why the pharmacy had refilled the order previously filled on 1/24/18 again on 1/29/18. Telephone interview on 1/31/18 with facility's pharmacy at 11:05 am and 2/1/18 at 10:10 am revealed: -They had filled Resident #5's medication since 7/2017. -The pharmacy only sent out what was ordered by the doctor, and they never send out additional Coumadin cards until a INR was scheduled by the doctor. -Sometimes they would package one "extra dose" of Coumadin so the resident would not be without	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060147	A. BUILDING: _____ B. WING _____	02/02/2018

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D 358	Continued From page 24 a dose if an INR was scheduled for that day, and a pill was needed. -There was a refill sent to the facility on 1/29/18, for the same order sent on 1/24/18 with instructions for Warfarin 2.5 mg "give 1 tablet by mouth once daily in the evening ***start 1/26/18." -She was not sure why this refill was sent to the facility because this order did not have any refills on it. -The pharmacy would not have sent this refill out without it having been requested by the facility. Interview on 1/31/18 with Physician's Assistant (PA) at 10:30 am revealed: - She did not know the eMAR system reflected that Resident #5 had gotten both the 5 mg and 2.5 mg Coumadin on 1/24/18 and 1/25/18 at bedtime. -Resident #5 was ordered Coumadin, 5 mg at bedtime on 1/24/18 and 1/25/18, and then Coumadin 2.5 mg was to have started on 1/26/18, through today (1/31/18). -Resident #5 was having labs drawn today to check her international normalized ratio (INR) results. -She should know by the end of the day if there was a concern regarding Resident #5's Coumadin dose. Telephone Interview on 2/1/18 with the PA at 9:20 am revealed: -She considered Resident #5 to be a "fairly stable" Coumadin patient. -The ideal INR range for Resident #5 was between 2 and 3. -She did not have Resident #5's information with her, but thought her lab results received yesterday afternoon were "within range" and thought she had ordered Coumadin 2.5 mg for last night and today, with another lab draw	D 358		

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D 358	Continued From page 25 scheduled for tomorrow (2/2/18). -After becoming aware on 1/31/18 that Resident #5 may have received more Coumadin than ordered on 1/24/18 and 1/25/18, she had also ordered a Complete Blood Count (CBC) to check her hemoglobin. She had not received the results of the CBC yet. -She was not "overly concerned" that Resident #5 had possibly received more Coumadin than ordered on 1/24/18 and 1/25/18 because the resident had not experienced any falls, bruising or bleeding, and also because she believed her INR result from yesterday was within range. Interview on 2/1/18 with Nurse Manager (NM) at 9:30 am revealed: -He had worked at the facility for a few months. -Only he and the RCC had access to enter orders into the eMAR system. -He entered the order for Coumadin 5 mg to start on 1/24/18 and stop on 1/25/18 into the eMAR system. -He entered Coumadin 2.5 mg, with the directions "Give one tablet by mouth at bed time starting on 1/26/18", but mistakenly entered a "start date" of 1/24/18, which made it appear that it needed to be administered by the MAs. He was not sure how he made this error. -He was not sure why the pharmacy would have sent two cards for the same order on 1/24/18 and 1/29/18. -The pharmacy would not have done this without it being requested. -It was possible that a card could have been misfiled on the cart, which could have prompted someone to request the refill. -He was not sure how there would be 4 pills left on the card dated 1/24/18, if the medication had been administered as ordered. -The pharmacy would send an extra pill in an	D 358		

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D 358	Continued From page 26 order, and thought perhaps MAs could have been pulling from cards that had an extra pill left on it. _____ Interview on 01/31/18 with the NM at 4:41 pm revealed: -He and the RCC were responsible for reviewing physician orders and FL2s and entering information into the eMAR system. -There had been no system in place since he had started working at the facility in December 2017 for auditing eMARs for accuracy to ensure they matched the physician's orders. Interview on 01/31/18 with the RCC at 10:13 am revealed: -She had been employed with this facility since August 2017. -She and the facility's NM were the only two staff in the facility who could enter orders into the eMAR. -It was her and the NM's responsibility to review all FL 2s and signed physician orders and enter the orders into the eMAR system so they would appear on the computer screen for Medication Aides (MA) to know to administer the medications. -The MAs could only administer medications and doses that were on the eMAR. -She and the new NM had not established a process of auditing and comparing orders to eMARs yet but they had met last week to come up with a plan. -No one had taken over the process of printing physician order sheets and having the physician sign them since the former NM had left the facility in December 2017. Interview on 01/31/18 with the Administrator at	D 358		

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D 358	Continued From page 27 5:15 pm revealed: -The RCC and the NM were responsible for reviewing orders that came into the facility and comparing them to the current eMAR and then entering the correct doses of medications into the eMAR system. -She would expect them to contact the physician to clarify if new orders were different from the current orders they had. -MAs could only dose medications based on what they could see in the eMAR system. The failure of the facility to ensure medications were administered as ordered by a licensed prescribing practitioner related to carvedilol (Resident #4) and Coumadin (a medication to prevent harmful blood clots and help reduce the risk of stroke or heart attack), (Residents #5 and #6), was detrimental to the health, safety and welfare of the residents resulting in Resident #4 with an increased risk of congestive heart failure, and Residents #5 and #6 with an increased risk of stroke or heart attack and these failures constitute a B violation. The facility provided a Plan of Protection dated 1/31/18 revealed: -An audit of all of the resident's records will be conducted by the RCC and the NM to ensure all of the physician's orders are complete, accurate and match the eMAR's. -The eMARs will be checked to ensure the correct dosages are being administered from the pharmacy. -Any errors noted will be called to the physician immediately. -The Corporate Nurse will educate the MA's on the correct procedure for administering medications by following the physician's orders and what to do if an error/omission occurs.	D 358		

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D 358	Continued From page 28 -The RCC and the NM will review all eMAR's weekly to ensure medications were administered as ordered. -The Corporate Nurse will be responsible for checking the eMARs monthly to ensure the medications were given as ordered. -The Administrator will be responsible to ensure the policy and procedures are implemented and followed by the staff and to make changes in the system as needed. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2018.	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	D 367	D 367 10A NCAC13F .1004(j) Medication Administration WHAT MEASURES WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: All current residents' medical chart (all orders and MAR/TAR) will be audited to ensure that medications are being administered as ordered by the licensed prescribing practitioner. If discrepancies are identified, the physician and/or licensed prescribing practitioner will be notified for clarification. The facility will continue with the policy that the Resident Care Coordinator, the Monday-Friday LPN Nurse Manager and the newly hired weekend LPN Nurse Manager will be the only staff that will receive and process physician and/or prescribing practitioner orders. The Resident Care Coordinator and the Monday-Friday LPN Nurse Manager have received additional training on receiving, processing, reconciling, clarifying and transcribing orders by the Corporate Registered Nurse. They have demonstrated competency to the Corporate RN. The newly hired (Date of Hire: (02-20-18) week end LPN Nurse Manager will receive training and education on receiving, processing, reconciling, clarifying and transcribing orders by the consultant RN and must demonstrate competency. A new policy that all orders received from a licensed prescribing practitioner once received, reconciled, clarified (if needed) processed and transcribed by one nurse must be check for accuracy by one of the other nurses within 24	3-15-18

			hours M-F and 48 hours Saturday and Sunday for accuracy in processing. An in-service will be held with all Medication Aides on March 15, 2018 for accurate documentation of medication administration. WHAT MEASURES WILL BE PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURING AGAIN: Following completion of the medical record audit for all current residents, four (4) medical records (including MAR/TARs) for four (4) residents receiving new orders during the week will be audited by the Consultant RN for receiving, reconciling, clarifying, processing and accurate transcribing of orders and accurate documentation on the MAR/TAR for the next four (4) weeks. If errors are found, the individual responsible for the error will be re-educated for one additional time; thereafter, disciplinary action will be taken up to and including termination. Following four (4) weeks of auditing new orders, the Consultant RN will review a total of six (6) per month as an ongoing quality assurance measure. WHO WILL MONITOR THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN: The Consultant RN will monitor the situation to ensure it does not occur again. She will audit four (4) charts (including the MAR/TAR) of residents receiving new orders during the week for four (4) weeks; then six (6) per month ongoing. HOW OFTEN THE MONITORING WILL TAKE PLACE: The Consultant RN will monitor the situation to ensure it does not occur again. She will audit four (4) charts (including the MAR/TAR) of residents receiving new orders during the week for four (4) weeks; then six (6) per month ongoing. COMPLETION DATES BY WHICH THE PLAN OF CORRECTION WILL BE COMPLETED: The POC will be completed by 3-15-18.	

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D 367	Continued From page 29 administration record (MAR). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure accurate documentation on the electronic Medication Administration Record (eMAR) for 5 of 6 sampled residents related to carvedilol [(a medication used for treating high blood pressure and congestive heart failure) #4], gabapentin [(a medication used to treat nerve pain) #2], Coumadin [(a medication used to prevent harmful blood clots and helps to reduce the risk of stroke or heart attack)] #1, #5, #6. The findings are: 1. Review of Resident #4's current FL 2 dated 12/08/17 revealed: -Diagnoses included hypertension, coronary artery disease, chronic pain, diabetes, an ejection fraction of 10% - 15%, atrial fibrillation, and congestive heart failure. -An order for Carvedilol 3.125 mg two times a day. Review of Resident #4's clarification orders dated 12/11/17 revealed an order for carvedilol 3.125 mg two times a day. Review of Resident #4's pharmacy review dated 12/28/17 revealed: -Documentation the carvedilol 3.125 mg two times a day was not on the December 2017 electronic Medical Record (eMAR). -A recommendation to get a clarification for carvedilol 3.125 mg two times a day that was not shown on the eMAR in December 2017.	D 367		

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D 367	Continued From page 30 Review of Resident #4's December 2017 eMAR revealed: -No order documented as administered for carvedilol 3.125 mg two times a day 12/08/17 through 12/28/17. -An order documented as administered for carvedilol 3.125 mg two times a day 12/29/17 through 12/31/17. Interview on 1/31/18 with a Medication Aide (MA) at 7:00 am revealed: -She was hired in November 2017. -She did not give Resident #4 the carvedilol 3.125 mg twice a day before 12/29/17 because it was not on the eMAR. -The Resident Care Coordinator (RCC) or the Nurse Manager (NM) were the only two staff capable of entering or modifying orders in the eMAR. Interview on 1/31/18 with the Resident Care Coordinator (RCC) at 10:31 am revealed: -She is responsible along with the Nurse Manager (NM) for faxing the new FL2's and orders to the physician for final approval. -She is responsible along with the NM for receiving the FL2's and orders from the physician's office and entering them into the eMAR. -After those orders are entered into the eMAR the FL2's and orders are faxed/scanned to the pharmacy. -She and the NM are the only ones that can enter new orders or modify orders in the eMAR. -She does not have a policy in place to double check the eMARs for holes, errors, or for omissions. Interview on 1/31/18 with the Administrator at	D 367		

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D 367	Continued From page 31 11:15 am revealed: -She was not aware the order had been missed for the carvedilol 3.125 mg. -It was the RCC's and the NM's responsibility to check all FL2's and new orders, have them clarified with the physician, enter them into the eMAR, and scan/fax the pharmacy. -The only two staff at the facility that have access to entering orders or modifying orders in the eMAR were the RCC and the NM. -Her expectation was for the orders to be received, clarified, enter into the eMAR and followed as ordered. Refer to interview on 01/31/18 with the RCC at 10:13 am. Refer to interview on 01/31/18 with the NM at 4:41 pm. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. 2. Review of Resident #2's current FL2 dated 01/15/18 revealed: -Diagnoses included chronic obstructive pulmonary disease, gastroesophageal reflux disease, neuropathy, history of seasonal allergies, numbness and tingling of the right leg and history of bilateral shoulder fracture. -A physician's order for gabapentin 300 mg take 2 capsules at night and gabapentin 300 mg take 1 capsule daily. a. Review of Resident #2's eMAR for January 2018 revealed: -There were two entries for gabapentin 300 mg; an entry for gabapentin 300 mg 1 capsule daily with a discontinue date of 01/15/18 and an entry for gabapentin 300 mg 2 capsules at night with a	D 367		

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D 367	Continued From page 32 start date of 01/15/18. -There was documentation gabapentin 300 mg 2 capsules at night was administered at 8:00 pm from 01/15/18 to 01/30/18. -There was no documentation gabapentin 300 mg 1 capsule daily had been administered after 01/12/18. Interview on 01/31/18 with the Resident Care Coordinator (RCC) at 4:56 pm revealed: -She had reviewed Resident #2's FL 2 that came back with her from her hospitalization dated 01/15/18. -She thought she had gotten clarification from the physician to give only the gabapentin 300 mg 2 capsules at night and discontinue the gabapentin 300 mg 1 capsule daily but she was unable to locate the order. b. Review of Resident #2's previous FL 2 dated 09/13/17 revealed a physician's order for gabapentin 300 mg 1 capsule at night. Review of Resident #2's signed physician order sheet dated 09/26/17 revealed an order for gabapentin 300 mg take 1 capsule three times daily. Review of Resident #2's electronic Medication Administration Records (eMAR) for October, November, and December 2017 and January 2018 revealed: -There was an entry for gabapentin 300 mg 1 capsule daily at 8 pm. -There was documentation gabapentin 300 mg was administered once daily from 10/01/17 to 01/12/18 except on 01/05/18 when the medication was "not administered due to resident not available." -There was no entry for gabapentin 300 mg 1	D 367		

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D 367	Continued From page 33 capsule three times daily. Interview on 01/31/18 with the Resident Care Coordinator (RCC) at 12:02 pm revealed: -The former Nurse Manager (NM) was responsible for printing physician order sheets from their computer system every 6 months and getting the physician to sign them. -The former NM had printed Resident #2's medication list early in the month of September 2017 and then the resident was hospitalized and sent to a skilled nursing facility (SNF) for rehabilitation until 09/14/17. -Resident #2's medication order for gabapentin was changed while the resident was in the SNF. -The former NM did not reprint an updated medication list prior to having the physician sign the physician order sheet on 09/26/17. -The former NM did not review the signed physician order sheet to verify its accuracy and did not contact the physician to clarify the orders. Interview on 02/01/18 with the RCC at 10:55 am revealed: -She had obtained clarification orders from Resident #2's Nurse Practitioner (NP) on 02/01/18. -The NP ordered for a third Gabapentin 300 mg to be added in the mornings. Refer to interview on 01/31/18 with the RCC at 10:13 am. Refer to interview on 01/31/18 with the NM at 4:41 pm. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. 3. Review of Resident #1's current FL 2 dated	D 367		

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D 367	Continued From page 34 10/24/17 revealed: - Diagnoses included anemia, atrial fibrillation, cardiac defibrillator, coronary artery disease, cardiomyopathy, carotid artery stenosis, congestive heart failure, diabetes mellitus type II, stroke. -Documentation on FL 2 for medications was "see attached." -Review of attachment revealed a physician print out of a medication list from the previous cardiologist dated 10/19/17. -Medications listed on the FL 2 attached list included Coumadin 2.5 mg, take one tablet by mouth in the evening. Review of Resident #1's record revealed: -There was a subsequent physician's order dated 12/13/17 for Coumadin 3 mg to be held on 12/13/17. -There was a physician's order dated 12/13/17 for Coumadin 3 mg to be administered on 12/14/17, 1 tablet in the evening. -There was a physician's order dated 12/13/17 for Coumadin 1.5 mg in the evening on 12/15/17 and 12/16/17 and 12/17/17. -There was a physician's order dated 12/15/17 for Coumadin 1.5 mg to be continued until the next INR on 12/20/17. Review of Resident #1's December 2017 electronic Medication Administration (eMAR) record revealed: -There was an entry for Coumadin 1.5 mg, 1 tablet three times daily, and scheduled to be administered at 8:00 am, 1:00 pm and 6:00 pm. -It was documented as administered on 12/16/17 and 12/17/17 at 8:00 am, 1:00 pm and 6:00 pm. -It was documented as administered on 12/18/17 at 1:00 pm and 6:00 pm.	D 367		

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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
D 367	Continued From page 35 Interview on 1/31/17 with Nurse Manager (NM) at 9:30 am revealed: -The Resident Care Coordinator (RCC) or NM received orders from the prescribing physician. -The RCC and NM were the only staff persons who could transcribe orders to the eMAR system. -The NM did not know Coumadin 1.5 mg was on the eMAR for 8 am, 10 pm and 6 pm on 12/16/17, 12/17/17 and 12/18/17. -He received the physician's order dated 12/13/17 for Coumadin 1.5 mg to be administered daily on 12/15/17, 12/16/17 and 12/17/17. -The order was entered on the eMAR by the RCC. -There were no "checks or oversight" on the orders that had been entered on the eMAR. -The weekend nurse was "looking over" the Coumadin orders, but resigned over a month ago and his position had not been filled. -The NM stated there is no process for reviewing the eMAR for "..holes." Review of Resident #1's orders dated 01/17/18 revealed an order to "hold Coumadin (3 mg dose) on 01/17/18"; and an order to administer "Coumadin 2 mg on 01/18/18 - 01/23/18." Review of the January 2018 eMAR revealed Coumadin 2 mg was not documented as administered on 01/22/18. Interview on 1/31/18 with RCC at 9:55 am revealed: -She was not aware that eMAR documentation revealed Coumadin 2 mg was not administered on 01/22/18. -RCC stated there was currently no process in place to review the MARS for "..holes." Interview on 01/31/18 with the pharmacy	D 367		

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	HAL060147	A. BUILDING: _____ B. WING _____	02/02/2018

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D 367	Continued From page 36 representative contracted by facility at 10:15 am revealed: -The pharmacy did not have the capability to interface with the facility eMAR. They are not able to see the physician's orders the facility entered on the eMAR. -The facility faxed orders to the pharmacy and the pharmacy dispensed medications. -No orders were received for Resident #1 from facility between 12/15/17 and 12/17/17. Interview on 01/31/18 with a medication aide (MA) at 12:30 pm revealed: -She was hired in October 2017. -She worked 1st shift and was the primary MA for Resident #1. -She had never administered Coumadin to Resident #1. -When she saw a medication on the eMAR that she did not recognize, she informed RCC or NM. -The MA documented administering Coumadin to Resident #1 on 12/18/17 at 1 pm. -She did not know why she documented administering Coumadin on that date. -She does not sign for medication she does not administer. Telephone interview on 01/31/18 with a second MA at 5:00 pm revealed: -She had been "licensed" since 2006; worked at the facility since October 2017 and currently worked the first shift weekends. -She had never administered Coumadin to Resident #1 on her shift. -She does not know why she documented that she administered Coumadin on 12/16/17 at 8 am and 1 pm; 12/17/17 at 8 am and 1 pm. -She does not remember seeing Coumadin on the MAR for Resident #1. -She does not sign for medications she does not	D 367		

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D 367	Continued From page 37 give. Interview on 02/1/18 with a third MA at 10:00 am revealed: -She signed the eMAR after administering the medications when she returned to the medication cart. -If the medication was highlighted yellow it was within the time frame to administer; if it was highlighted red it had not been administered and was past due. -If the medication was administered and signed for, the medication was removed from the screen. -If there was a new order on the computer screen and the medication was not on the cart, the MA would check the backup room, the orders and the pharmacy. Then she would let the supervisor know. -She questioned new orders for residents with her supervisor. -She only worked first shift and had never administered Coumadin. Interview on 02/1/17 with a fourth MA at 10:30 am revealed: -She documented the medications had been administered on the eMAR. -Coumadin was administered at night. If it was on the first shift eMAR she would report to a supervisor. -She had never administered Coumadin on the day shift. Refer to interview on 01/31/18 with the RCC at 10:13 am. Refer to interview on 01/31/18 with the NM at 4:41 pm. Refer to interview on 01/31/18 with the	D 367		

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D 367	Continued From page 38 Administrator at 5:15 pm. 4. Review of Resident #6's current FL 2 dated 10/31/16 revealed: -Diagnoses included congestive heart failure (CHF); atrial fibrillation; aka left; dyslipidemia; depressive disorder; metastatic lung cancer. - The medications on the FL 2 included warfarin sodium 2.5 mg tablet administered at bedtime. Review of Resident #6's physician order dated 12/4/17 revealed: -An order for Coumadin 3 mg tablet; give 1 tablet every other day at bedtime, alternating with 4 mg dose. -An order for Coumadin 4 mg tablet was scheduled to be administered on 12/12/17. Review of the December 2017 eMAR revealed an order for Coumadin 4 mg was documented as "Not Scheduled" to be administered on 12/12/17. Review of Resident #6's physician order dated 12/18/17 revealed an order to administer Coumadin 3 mg tablet, give 1 tablet every other day alternating dose with 4 mg. Review of the December 2017 eMARs revealed on 12/25/17 Coumadin 4 mg was documented as "Not Scheduled" to be administered to Resident #6. Review of Resident #6's physician order dated 01/3/18 revealed an order for Coumadin 3 mg tablet, give 1 tablet every other day, alternating dose with Coumadin 4 mg tablet. Review of the January 2018 eMAR revealed on 01/9/18 Coumadin 3 mg was documented as "Not Scheduled" to be administered to Resident #6.	D 367		

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D 367	Continued From page 39 Interview on 01/31/18 with NM and RCC at 11:15 am revealed: -NM and RCC were the only staff persons who could transcribe orders to the eMAR. -They did not know why the Coumadin doses on those dates were entered as "Not Scheduled." -There was no oversite for orders entered into the eMAR system or medications not administered. Interview at 11:30 am with PA on 1/31/18 revealed: -She was not notified Coumadin 4 mg dose was not administered on 12/12/17 and 12/25/17 as ordered. -She was not notified Coumadin 3 mg dose was not administered on 1/9/18 as ordered. -She would be concerned Coumadin 3 mg and 4 mg was not administered on those dates (12/12/17, 12/25/17, 1/9/18) if the (resident's) INR was significantly out of (therapeutic) range (2.0-3.0). Review of laboratory results for INR revealed: -On 12/13/17 INR was 2.55. -On 12/18/17 INR was 2.70. -On 1/10/18 INR was 3.76. Refer to interview on 01/31/18 with the RCC at 10:13 am. Refer to interview on 01/31/18 with the NM at 4:41 pm. Refer to interview on 01/31/18 with the Administrator at 5:15 pm. 5. Review of Resident #5's current FL 2 dated 7/12/17 revealed:	D 367		

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D 367	Continued From page 40 -Diagnoses included cerebrovascular accident, hypertension, atrial fibrillation, and congestive heart failure. -A physician's order for Coumadin 4 mg to be administered on Monday, Tuesday, Thursday, and Saturday. -A physician's order for Coumadin 2 mg to be administered on Wednesday, Friday, and Sunday. Review of a physician's order, dated 1/24/18 revealed: -Coumadin 5 mg to be administered on 1/24/18 and 1/25/18. -Coumadin 2.5 mg to be administered each day until 1/31/18. -INR on 1/31/18. Review of Resident #5's January 2018 electronic medication administration records (eMAR) revealed on 1/24/18 and 1/25/18, both Coumadin 5 mg and 2 mg were documented as administered both days at 9 pm. Observation of Resident #5's medications on hand on 1/31/18 at 10:50 am revealed: -There were no Coumadin 5 mg tablets. -A card of warfarin (substituted for Coumadin) 2.5 mg with 6 tablets filled on 1/17/18 with 1 tablet remaining. The labeled instructions, "give 1 tablet by mouth once daily in the evening". -A card of warfarin 2.5 mg with 6 tablets filled on 1/24/18 with 4 tablets remaining. The labeled instructions, "give 1 tablet by mouth once daily in the evening***Start 1/26/18". -A card of warfarin 2.5 mg with 6 tablets filled on 1/29/18, with 6 remaining. The labeled instructions, "give 1 tablet by mouth once daily in the evening ***start on 1/26/18".	D 367		

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D 367	Continued From page 41 Interview on 1/31/18 with the RCC at 10:46 am revealed: -She did not know the eMAR reflected that Resident #5 had gotten both the Coumadin 5 mg and the Coumadin 2.5 mg on 1/23/18 and 1/24/18. -The pharmacy only sent Coumadin for the current order, so in general, there was never "extra" Coumadin in the facility. -Only she and the Nurse Manager had access to enter orders into the eMAR system. -She would have to research to find out why it was entered onto the eMAR that both the 2.5 mg and 5mg Coumadin were to start on 1/24/18. Review of Pharmacy Return log revealed no medications had been documented as being sent back to the pharmacy for Resident #5 during the time period of October 2017 - January 2018. Interview on 2/1/18 with Nurse Manager at 9:30 am revealed: -He had worked at the facility for a few months. -Only he and the RCC had access to enter orders into the eMAR system. -He entered the order for Coumadin 5mg to start on 1/24/18 and stop on 1/25/18 into the eMAR system. -He entered Coumadin 2.5 mg, with the directions "Give one tablet by mouth at bed time starting on 1/26/18", but mistakenly entered a "start date" of 1/24/18. -He was not sure how he made this error. -He did not believe that both doses of Coumadin had been administered, even though they had all been checked off both days, because the MAs that would have administered Resident #5's medications on those days were very familiar with her regimen and would have questioned her getting two pills, especially since the written	D 367		

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D 367	Continued From page 42 instructions on the eMAR clearly said that the 2.5 mg was to start on 1/26/18. -He was not sure why the pharmacy would have sent two cards for the same order on 1/24/18 and 1/29/18. -The pharmacy would not have done this without it being requested. -It was possible that a card could have been misfiled on the cart. -He and the RCC were responsible for reviewing physician orders and the FL 2's and entering the information into the eMAR system. -There had been no system in place since he started working at the facility in December 2017 for auditing eMARs for accuracy to ensure they matched the physician's orders. _____ Interview on 01/31/18 with the RCC at 10:13 am revealed: -She had been employed with this facility since August 2017. -She and the facility's Nurse Manager (NM) were the only two staff in the facility who could enter orders into the eMAR. -It was her and the NM's responsibility to review all FL2's and signed physician orders and enter the orders into the eMAR system so they would appear on the computer screen for Medication Aides (MA) to know to administer the medications. -The MAs could only administer medications and doses that were on the eMAR. -She and the new NM had not established a process of auditing and comparing orders to eMARs yet but they had met last week to come up with a plan. -No one had taken over the process of printing physician order sheets and having the physician sign them since the former NM had left the facility	D 367		

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D 367	Continued From page 43 in December 2017. Interview on 01/31/18 with the NM at 4:41 pm revealed: -He and the RCC were responsible for reviewing physician orders and FL2's and entering information into the eMAR system. -There had been no system in place since he had started working at the facility in December 2017 for auditing eMARs for accuracy to ensure they matched the physician's orders. Interview on 01/31/18 with the Administrator at 5:15 pm revealed: -The RCC and the NM were responsible for reviewing orders that came into the facility and comparing them to the current eMAR and then entering the correct doses of medications into the eMAR system. -She would expect them to contact the physician to clarify if new orders were different from the current orders they had. -MAs could only dose medications based on what they could see in the eMAR system. --- The failure of the facility to assure accurate documentation on the electronic Medication Administration Record (eMAR) related to carvedilol [(a medication used for treating high blood pressure and congestive heart failure) #4], and Coumadin [(a medication used to prevent harmful blood clots and helps to reduce the risk of stroke or heart attack) #1, #5, #6] was detrimental to the health, safety and welfare of the residents resulting in Resident #4 with an increased risk of congestive heart failure, and Residents #1, #5 and #6 with an increased risk of stroke or heart attack and these failures constitute a B violation.	D 367		

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D 367	Continued From page 44 The facility provided a Plan of Protection dated 1/31/18 revealed: -An audit of all of the resident's records will be conducted by the RCC and the NM to ensure all of the physician's orders are complete, accurate and match the eMAR's. -The eMARs will be checked to ensure the correct dosages are being administered from the pharmacy. -Any errors noted will be called to the physician immediately. -The Corporate Nurse will educate the MA's on the correct procedure for administering medications by following the physician's orders and what to do if an error/omission occurs. -The RCC and the NM will review all eMAR's weekly to ensure medications were administered as ordered,timely and the physician will be notified about errors for further instructions. -The Corporate Nurse will be responsible to ensure the process/procedure identified is being carried out on a monthly basis by the RCC and NM. -The Administrator will be responsible to ensure the policy and procedures are implemented and followed by the staff and to make changes in the system as needed. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2018.	D 367		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and	D 406	D 406 10A NCAC13F .1009(b) Pharmaceutical Care WHAT MEASURES WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: The Week End LPN Nurse Manager will be responsible for receiving and following up on the Consultant Pharmacist Recommendations. She will work one day per week during	3-15-18

			the week and following the receipt of the monthly Consultant Pharmacist Review of Resident's drug regimen she will process the report with follow up on all pharmacist recommendations within seven days. She has received one on one instruction and education by an RN on the proper procedure in following up and documenting follow up on the pharmacist's recommendations. All current resident charts will be audited to ensure that allergies are flagged on the medical record as well as the MAR/TAR WHAT MEASURES WILL BE PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURING AGAIN: The Consultant RN will conduct a monthly quality assurance audit to review the consultant pharmacist's report to ensure the recommendations have been processed and follow up has been completed. WHO WILL MONITOR THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN: The Consultant RN will submit a monthly QA report to the facility Administrator that will include review of the monthly consultant pharmacist's reports. The Administrator will be responsible for monitor this Q.A. report and the situation to ensure it will not occur again. HOW OFTEN THE MONITORING WILL TAKE PLACE: The Consultant RN will submit a monthly QA report to the facility Administrator that will include review of the monthly consultant pharmacist's reports. The Administrator will be responsible for monitor this Q.A. report and the situation to ensure it will not occur again. COMPLETION DATES BY WHICH THE PLAN OF CORRECTION WILL BE COMPLETED: The POC will be completed by 3-15-18.	

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D 406	Continued From page 45 documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow up on medication review recommendations for 5 of 5 sampled residents related to documented allergies (#1, #3, #4, #5) and copies of physician's orders for gabapentin, ferrous sulfate, omeprazole and ranitidine, #2. The findings are: 1. Review of Resident #4's current FL 2 dated 12/08/17 revealed diagnoses included hypertension, coronary artery disease, chronic pain, diabetes, an ejection fraction of 10% - 15%, atrial fibrillation, and congestive heart failure. Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility 12/11/17. a. Review of Resident #4's pharmacy review dated 12/28/17 revealed a recommendation to list carvedilol 3.125 mg twice daily on the December 2017 electronic Medication Administration Record (eMAR). Review of Resident #4's current FL 2 dated 12/08/17 revealed: -Diagnoses included hypertension, coronary artery disease, chronic pain, diabetes, an ejection fraction of 10% - 15%, atrial fibrillation, and congestive heart failure. -An order for carvedilol 3.125 mg two times a day. Review of Resident #4's clarification orders dated	D 406		

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D 406	Continued From page 46 12/11/17 revealed an order for carvedilol 3.125 mg two times a day. Review of Resident #4's December 2017 eMAR revealed there was no entry for carvedilol 3.125 mg twice daily and it was not documented as administered on the eMAR as of 12/28/17. Refer interview on 01/31/18 with the Resident Care Coordinator (RCC) at 2:27 pm. Refer to interview on 02/01/18 with the Administrator at 10:45 am. b. Review of Resident #4's pharmacy review dated 12/28/17 revealed a recommendation to list Resident #4's allergies on the eMAR. Review of Resident #4's December 2017 and January 2018 eMAR revealed no allergies were listed. Interview on 1/31/18 with a Medication Aide (MA) at 7:00 am revealed the Resident Care Coordinator (RCC) or the Nurse Manager (NM) were the only two staff capable of entering, modifying orders or adding allergies in the eMAR. Telephone interview on 1/31/18 with a Pharmacy representative at 9:16 am revealed: -Resident #4 does not have allergies documented in the eMAR. -The only way the allergies would be noted in Resident #4's profile was if the facility entered them into the eMAR. -They did not dispense medications for the residents unless those allergies were listed or the field was addressed on the eMAR. -When the allergies were not listed in the resident's profiles, a call was made to the facility	D 406		

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D 406	Continued From page 47 to get the information so the medications would be filled. -She requested allergies for Resident #4 from the facility on 12/12/18 and 1/25/18 in order to fill prescriptions that were needed. Interview on 1/31/18 with the Resident Care Coordinator (RCC) at 10:31 am revealed: -She was responsible along with the Nurse Manager (NM) for entering the allergies in the eMAR or addressing that field with an "NKDA" (no known drug allergies). -When the pharmacy would call about not having the allergy information, she would give the pharmacy that information over the phone. -She was aware the medications could not be dispensed until the allergy field had been addressed. -She had not had a chance to address those pharmaceutical reviews yet. Interview on 1/31/18 with the Administrator at 11:15 am revealed: -She did not know the allergies were not entered into the eMAR for all of the residents. -It was the RCC's and the NM's responsibility to check all eMAR's for the allergy information. -The only two staff at the facility that had access to entering information/orders or modifying orders in the eMAR were the RCC and the NM. -Her expectation was for the pharmacy review recommendations to be followed and the physician/pharmacy called for clarifications. Refer interview on 01/31/18 with the Resident Care Coordinator (RCC) at 2:27 pm. Refer to interview on 02/01/18 with the Administrator at 10:45 am.	D 406		

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	HAL060147	A. BUILDING: _____ B. WING _____	02/02/2018

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D 406	Continued From page 48 2. Review of Resident #2's current FL 2 dated 01/15/18 revealed diagnoses included chronic obstructive pulmonary disease, gastroesophageal reflux disease, neuropathy, history of seasonal allergies, numbness and tingling of the right leg and history of bilateral shoulder fracture. Review of Resident #2's signed physician order sheet dated 09/26/17 revealed: -A physician's order for gabapentin 300 mg take 1 capsule three times daily (a medication used to treat nerve pain). -A physician's order for ferrous sulfate 325 mg take 1 tablet daily (a medication used to treat low blood levels of iron). -A physician's order for ranitidine 150 mg take 1 tablet by mouth twice daily (a medication used to treat gastroesophageal reflux disease). -A physician's order for omeprazole 20 mg take 1 capsule daily (a medication used to treat gastroesophageal reflux disease). Review of Resident #2's quarterly Consultant Pharmacist's Medication Review dated 12/28/17 revealed: -There was documentation staff needed to locate the gabapentin order change to the night only dose that was on the Electronic Medication Administration Record (eMAR). -There was documentation staff needed to locate the order for the increase of omeprazole to 40 mg daily that was on the eMAR. -There was documentation staff needed to locate the discontinued orders for ferrous sulfate 325 mg and ranitidine 150 mg because they were on the physician order sheet but not on the eMAR. Review of Resident #2's record revealed: -There were no physician orders subsequent to the physician order sheet dated 09/26/17 for a	D 406		

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D 406	Continued From page 49 night only dose for gabapentin, discontinue orders for ferrous sulfate, or discontinue orders for ranitidine. -There were no physician orders subsequent to the physician order sheet dated 09/26/17 for a dose increase of omeprazole to 40 mg until the FL 2 dated 01/15/18. Refer to interview on 01/31/18 with the Resident Care Coordinator (RCC) at 2:27 pm revealed: -She was responsible for reviewing recommendations made by the consultant Pharmacist during the quarterly medication reviews. -She was responsible for ensuring follow up of the recommendations made. -She had not reviewed the Pharmacist's recommendations from December 2017 because she had not had time to do so. Refer interview on 01/31/18 with the Resident Care Coordinator (RCC) at 2:27 pm. Refer to interview on 02/01/18 with the Administrator at 10:45 am. 3. Review of Resident #3's current FL2 dated 1/30/18 revealed diagnoses included dementia, hypertension, hyperlipidemia, depression, and anxiety. Review of Resident #3's current pharmacy review dated 11/29/17 revealed "Please fax allergy of penicillin to the pharmacy so it prints on the MAR". Review of Resident #3's November 2017, December 2017, and January 2018, electronic medication administration records (eMAR)	D 406		

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D 406	Continued From page 50 revealed no documentation of allergies listed on the eMARs. Review of Resident #3's physician progress notes from 4/12/17-1/17/18 revealed penicillin was documented as an allergy. Interview on 2/1/18 with a representative from the contracted facility pharmacy at 10:14 am revealed: -The pharmacy did have penicillin documented as an allergy in their records for Resident #3. -Allergies were not typically documented on the FL2 or admission orders, the pharmacy typically had to call the Resident Care Coordinator (RCC) to determine allergies for new residents. -Medications were never filled by the pharmacy without receiving allergy information. -Resident #3's allergies were received via telephone call with the previous RCC when she was admitted to facility. -The pharmacy computer system and eMAR systems did not communicate, therefore they does not have access to the facility eMAR system. Interview on 2/1/18 with the RCC at 10:23 am revealed: -She worked in the facility as the RCC for about 6 months. -She was responsible for documenting allergies on the eMAR. -She would call and notify the pharmacy of allergies for new residents and when updates were required. -She had not documented the allergies on the eMAR for any residents because she had not had time. -She had not had the time to review the recommendations of the medication reviews	D 406		

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D 406	Continued From page 51 completed November 2017. Interview on 2/1/18 with the Administrator at 10:45 am revealed: - The RCC or the Nurse Manager was responsible to assure the pharmacy consultant recommendations were followed-up. -She expected the RCC or the Nurse Manager to review the recommendations within 7 days of receiving them. -There would be training within the next week for staff regarding the eMAR system. Refer interview on 01/31/18 with the Resident Care Coordinator (RCC) at 2:27 pm. Refer to interview on 02/01/18 with the Administrator at 10:45 am. 4. Review of Resident #1's current FL 2 dated 10/24/17 revealed diagnoses included: anemia; atrial fibrillation; cardiac defibrillator; coronary artery disease; congestive heart failure; diabetes mellitus type II; and stroke. Review of Resident #1's current pharmacy Medication Review dated 01/30/17 revealed on 10/24/17 the recommendation was to enter allergy information on electronic Medication Administration record (eMAR). Review of Resident #1's November 2017, December 2017, and January 2018, revealed there was no documentation of allergies present on the eMARs. Telephone interview on 01/31/18 with a representative of the pharmacy at 9:16 am revealed:	D 406		

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D 406	Continued From page 52 -Resident #1 did not have allergies documented in the eMAR. -Allergies would be noted in Resident #1's profile when the facility transcribed them into the eMAR. -They cannot dispense medications for the residents unless those allergies are listed or the field is addressed on the eMAR. -She has requested allergies for Resident #1 from the facility on 12/12/18 and 01/25/18 in order to fill prescriptions that were needed. Interview on 01/31/18 with the Resident Care Coordinator (RCC) at 10:31 am revealed: -She is responsible along with the Nurse Manager (NM) for entering the allergies in the eMAR or addressing that field with an "NKDA" (no known drug allergies). -When the pharmacist called regarding the allergy information, she would give the pharmacist that information over the phone. -She was aware the medications could not be dispensed until the allergy field had been addressed. -She had not had a chance to address the pharmaceutical reviews. -She had not reviewed pharmacy recommendations lately. Refer interview on 01/31/18 with the Resident Care Coordinator (RCC) at 2:27 pm. Refer to interview on 02/01/18 with the Administrator at 10:45 am. Interview on 01/31/18 with the Resident Care Coordinator (RCC) at 2:27 pm revealed: -She was responsible for reviewing recommendations made by the consultant Pharmacist during the quarterly medication reviews.	D 406		

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D 406	Continued From page 53 -She was responsible for ensuring follow up of the recommendations made. -She had not reviewed the Pharmacist's recommendations from December 2017 because she had not had time to do so. Interview on 1/31/18 with the Administrator at 11:15 am revealed: -She was not aware the allergies were not entered into the eMAR for all of the residents. -It was the RCC's and the NM's responsibility to check all eMAR's for the allergy information. -The only two staff at the facility that have access to entering information/orders or modifying orders in the eMAR were the RCC and the NM. -Her expectation was for the recommendations from the pharmacy reviews to be followed and to call the physician/pharmacy for clarification.	D 406		
D912	G.S. 131D-21(2) Declaration of Residents' Rights 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 as related to medication administration and the accuracy of the electronic Medication Administration Record.	D912	D 912 G.S. 131D-21(2) Declaration of Residents Rights WHAT MEASURES WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: By correcting citation D.344, D.358, D.367 and D. 406, the facility will be in compliance with the resident's right to receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and the accuracy of the electronic Medication Administration Record. WHAT MEASURES WILL BE PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURING AGAIN: The Consultant RN will audit six (6) medical records and MARs/TARs monthly to ensure that resident's receive care and services that are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and the accuracy of the electronic medication administration record. WHO WILL MONITOR THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN:	3-15-18

			The Consultant RN will report her findings from her monthly QA audits of six (6) medical charts and MARS each month to the facility administrator. The Facility Administrator will be responsible for monitoring the situation to ensure it does not occur again. HOW OFTEN THE MONITORING WILL TAKE PLACE: The Consultant RN will report her findings from her monthly QA audits of six (6) medical charts and MARS each month to the facility administrator. The Facility Administrator will be responsible for monitoring the situation to ensure it does not occur again. COMPLETION DATES BY WHICH THE PLAN OF CORRECTION WILL BE COMPLETED: The POC will be completed by 3-15-18.	

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D912	Continued From page 54 The findings are: A. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 4 of 6 sampled residents related to carvedilol [(a medication used for treating high blood pressure and congestive heart failure) #4], gabapentin [(a medication used to treat nerve pain) #2], Coumadin [(a medication to prevent harmful blood clots and help reduce the risk of stroke or heart attack) #5, #6]. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure accurate documentation on the electronic Medication Administration Record (eMAR) for 5 of 6 sampled residents related to carvedilol [(a medication used for treating high blood pressure and congestive heart failure) #4], gabapentin [(a medication used to treat nerve pain) #2], Coumadin [(a medication used to prevent harmful blood clots and helps to reduce the risk of stroke or heart attack)] #1, #5, #6. [Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration (Type B Violation)].	D912		