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MAGNOLIA COTTAGE CARE BLDG #2	5643 HWY 70 DOVER, NC 28526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 2/28/18, 3/1/18 and 3/2/18 with an exit conference on 3/6/18.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider (PCP) of acute health care concerns for 2 of 3 sampled residents (#2 and #3), which included Resident #2 having symptoms of a urinary tract infection (UTI) with a fall and elbow injury four days later and continued elbow pain four days after the fall; and Resident #3 having untreated symptoms of a UTI for 9 days. The findings are: 1. Review of Resident #3's current FL-2 dated 11/15/17 revealed diagnoses included cerebral vascular accident, coronary artery disease, hypertension, osteoarthritis, Alzheimer's dementia, anxiety and stage 4 chronic kidney disease. Review of staff log notes dated 2/18/18 through 3/1/18 revealed: -On 2/18/18 from 7:00am - 7:00pm, staff documented Resident #3's "urine was horrible smelling." -On 2/18/18 from 7:00pm - 7:00am, staff	C 246		

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documented Resident #3 called out to use the bathroom twice through the night.
-On 2/26/18 from 7:00am - 7:00pm, staff documented Resident #3 "kept spitting on the floor, very quiet, will not eat or drink."
-On 2/26/18 from 7:00pm - 7:00am, staff documented Resident #3 "ate two bites of eggs only and spit them on the floor, drank hardly any water, but managed to get am (morning) meds in her."
-On 2/27/18 from 7:00pm - 7:00am, staff documented Resident #3 was changed and washed up in the am, she had urinary incontinence, undergarments were removed and the bed was soaked. Staff attempted to get a urine specimen but Resident #3 was incontinent and did not urinate in the cup.
-There was no documentation Resident #3's Primary Care Provider (PCP) was notified about Resident #3 having foul smelling urine, urinary frequency and increased urinary incontinence from 2/18/18 through 3/1/18.

Observations on 2/28/18 from 11:54am until 12:19pm revealed:
-Resident #3 was brought to the lunch table at 11:54am and immediately pushed the plate of food away from her to the center of the table.
-Staff encouraged Resident #3 to eat some of her meal, but the resident said she did not want any.
-Resident #3 told the staff she did not like nor want the supplement shake.
-Resident #3 had a few sips of water and left the table at 12:19pm.

Interview with the Medication Aide (MA) on 2/28/18 at 11:54am revealed Resident #3 had not been eating well for a week, she prepared supplement shake for the resident, but she had not been really drinking those either.

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C 246	Continued From page 2 Interview with the Administrator on 2/28/18 at 12:32pm revealed Resident #3 had been having a decreased appetite for several days and staff was concerned the resident may have a UTI. Based on observations, interviews and record reviews, Resident #3 was not interviewable. Telephone interview with Resident #3's Power of Attorney (POA) on 3/5/18 at 3:07pm revealed: -Resident #3 had a lot of UTIs in the past and the resident just had a urine specimen come back positive for another UTI. -She was notified a week ago (2/26/18) by the facility that Resident #3 had symptoms of a UTI and the urine culture was sent out on that Wednesday (2/28/18) which came back positive for a UTI on 3/5/18. -Resident #3's UTI symptoms included leaking urine (she normally used the toilet), decreased appetite and fatigue. -Resident #3 had never worn incontinence briefs until after she was admitted to the facility. Interview with a Medication Aide (MA) on 3/2/18 at 1:00pm revealed: -She had written the note on 2/18/18 about Resident #3's urine smelling "horrible." -She thought the Administrator or facility Licensed Practical Nurse (LPN) was aware. -She was not sure who informed the Administrator and/or facility LPN or when. -Normally, staff would notify the Administrator and/or facility LPN to check for a UTI. -She had written the note on 2/26/18 about Resident #3 spitting food on the floor, not eating or drinking and being quiet. -On occasions like what she documented on 2/26/18, she would give the resident time and just	C 246		

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keep checking back to see if she would eat or drink.

Interview with the Administrator on 3/2/18 at 1:00pm and 1:30pm revealed:
-Staff notify her or the facility LPN whenever they had concerns about a resident having a UTI.
-She or the facility LPN contacted the resident's PCP and would get an order for urine specimen for urinalysis and culture.
-The urine specimen for Resident #3 had been sent out earlier in the week (2/26/18).
-Staff had reported concerns about Resident #3's urine, but could not remember when staff reported concerns about Resident #3's urine.
-She had contacted Resident #3's PCP, typed up the telephone order on her computer, placed the order in the bag with the urine and sent the urine specimen and the telephone order to the lab; she could not remember the date of the telephone order.
-She was not sure if a urine specimen had been sent on 2/18/18 or anytime before 2/28/18.
-She did not have any documentation of when she contacted the PCP or a copy of the order for the urine specimen.
-Results for the urine specimen were not available as of 3/2/18.
-Her normal practice was to spot check the shift log notes and she was aware of the concern for Resident #3.
-Normally she contacted PCPs, documented notes on her computer and placed a copy of the note in the resident's record.
-A lot of times if Resident #3 was not eating and drinking, her urine would smell bad and as soon as she started eating and drinking her urine would be better.

Interview with Resident #3's Primary Care

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Provider (PCP) on 3/1/18 at 4:12pm revealed:
-He visited Resident #3 at the facility every couple of months.
-He visited Resident #3 on 3/1/18 to follow up on UTI symptoms.
-He was not sure when he was notified about the UTI symptoms.
-Any faxed notifications would have been in the records at his office.

Telephone interview with Resident #3's PCP's Registered Nurse (RN) on 3/5/18 at 4:22pm revealed:
-There was no documentation the PCP's office had been contacted prior to 2/27/18 regarding Resident #3 having symptoms of a UTI.
-The PCP's office obtained the urine specimen on 2/27/18 and Resident #3 was started on empirical treatment for a UTI on 3/5/18.
-The urinalysis showed white blood cells and trace red blood cells, but the culture indicated contamination.

Interview with the facility LPN on 3/6/18 at 5:45pm revealed:
-She only became aware recently that Resident #3 had symptoms of a UTI and sent a sample of urine to the laboratory.
-She could not remember the exact date she was notified by staff and when the urine sample was sent.
-She "rounded at the facility daily" for staff to inform her of any resident concerns.
-There were no formal notes of resident concerns and what was done for the resident.

Interview with the Administrator on 3/6/18 at 4:59pm revealed Resident #3 was sent to the hospital on 3/6/18 and they were considering admission for a UTI.

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C 246	Continued From page 5 Refer to interview with the facility LPN on 3/5/18 at 11:22am. 2. Review of Resident #2's current FL-2 dated 6/14/17 revealed diagnoses included: frequent falls, history of right ankle fracture, long term medication use, atrial fibrillation, chronic renal failure, coronary artery disease, benign essential hypertension, anxiety. Review of staff log notes dated 2/7/18 through 2/10/18 revealed: -On 2/7/18 from 7:00pm-7:00am, staff documented Resident #2 was "so confused ...pee smells terrible". -On 2/8/18 from 7:00am-7:00pm, staff documented Resident #2 was "just out there, don't know if it's an act or not". -On 2/10/18 from 7:00am-7:00pm, staff documented Resident #2 was "extra pitiful- can't do anything". Review of Primary Care Provider (PCP) visit notes, orders and lab results dated for February 2018 for Resident #2 revealed there was no documentation of PCP notification, order for a urine specimen or results of a urinalysis and culture. Review of staff log notes dated 2/12/18 through 2/16/18 revealed: -On 2/12/18 from 7:00am-7:00pm, staff documented Resident #2 fell again. Hit elbow. Needs to be in W/C (wheelchair) until the Administrator says otherwise. -On 2/16/15 from 7:00am-7:00pm, staff documented Resident #2 complained about her elbow.	C 246		

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C 246	Continued From page 6 Review of Primary Care Provider's (PCP) visit notes, orders and lab results dated for February 2018 for Resident #2 revealed there was no documentation of PCP notification for UTI or fall. Observations on 3/2/18 at 1:00pm revealed: -Resident #2 had a bruise approximately the size of a quarter and an area of a healed abrasion also the approximate size of a quarter next to the bruise on her right elbow. -Resident #2 had multiple bruises from approximately dime sized to half dollar sized on her left forearm from her hand to her elbow Interview with a Medication Aide (MA) on 3/2/18 at 1:00pm revealed: -She had written the note on 2/8/18, and what she meant was that Resident #2 just wasn't herself. -She had written the note on 2/12/18, and Resident #2 had fallen twice in a short period of time. -Resident #2 had fallen once in the dining room and a second time near the hallway by the dining room and living room area. -The fall near the hallway was when Resident #2 hurt her elbow. -Resident #2 was had a Band-Aid on the abrasion and full range of motion to her right arm after the fall. -When a resident fell she checked them to make sure they were okay and notified the Administrator. -The Administrator or staff nurse notified the physician if needed. -To prevent future falls, staff had instructed Resident #2 not to get up by herself. -Resident #2 was able to understand staff instructions and remember them. -Resident #2 knew that she could fall without staff assistance.	C 246		

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C 246	Continued From page 7 -She had written the note on 2/16/18, and Resident #2 had complained of her elbow hurting. -She did not know if Resident #2's PCP was notified, no x-rays were done that she was aware. Telephone interview with the staff from Resident #2's PCP's office on 3/5/18 at 2:24pm revealed: -Resident #2 had last been seen by her physician on 12/4/17. -There was no documentation Resident #2 had symptoms of a UTI on 2/7/18, that the resident had fallen on 2/12/18 and injured her elbow, or that the resident had continued elbow pain on 2/16/18. -It was the expectation of the doctor's office that the facility call or fax over any request for medical services needed including appointments. -The staff stated the physician prefers to see UTI patients in person. Telephone interview with Resident #2's Power of Attorney (POA) on 3/5/18 at 2:48pm revealed: -The Administrator told him Resident #2 fell and was bleeding from her elbow. -There were no staff notes that she was bleeding. -He was aware that it was a witnessed fall -He reported that she got the 'treatment that she needed'. The POA decided the treatment was sufficient for the incident. Interview with the facility Licensed Practical Nurse (LPN) on 3/6/18 at 5:45pm revealed: -Resident #2 had told her that she injured her elbow. -She was not aware of Resident #2 having a fall. -She "rounded at the facility daily" for staff to inform her of any resident concerns. -There were no formal notes of resident concerns or what was done for the resident.	C 246		

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C 246	Continued From page 8 Interview with the Administrator on 3/2/18 at 1:30pm revealed: -Resident #2 always had pain and she did not see anything that indicated Resident #2's PCP needed to be notified. -There was no formal follow up if a resident complained about pain frequently. -The fall wasn't actually a fall, Resident #2 slid down the wall and did not actually fall. Refer to interview with the facility LPN on 3/5/18 at 11:22am. Interview with the facility LPN on 3/5/18 at 11:22am revealed: -Staff were expected to call the Administrator for any change in a resident's condition and she and the Administrator would come to the facility to assess the resident. -If the concern was related to a UTI, she would contact the PCP and get an order for a urine specimen or schedule an appointment. -If the concern was acute, she would call 911 and send the resident to the emergency room. -She had worked at the facility for approximately six months and could not recall sending a resident to the emergency room. -She kept her own notes of when she contacted a resident's PCP, but there were no notes documented in the resident's record. -The PCP's office would have a record of when she contacted the PCP regarding a resident.	C 246		
C 273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the	C 273		

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C 273	Continued From page 9 following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to serve at least 8 oz of milk two times daily as required to 3 of 3 sample residents. The findings are: Review of the supper menu for 2/28/18 revealed the beverages on the menu were milk, coffee, tea and water. Observation of the supper meal on 2/28/18 at 4:30 pm revealed: -The beverages served were ice tea, diet soda and water. -Milk was not offered. Review of the breakfast menu for 3/1/18 revealed the beverages on the menu were orange juice or Vitamin C fortified 100% fruit juice, milk, coffee, tea and water. Observation of the breakfast meal on 3/1/18 at 7:53am revealed: -The beverages served were tea, water and coffee. -Milk was not served. Observations of the breakfast meal on 3/1/18 from 7:53am to 8:10am revealed:	C 273		

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C 273	Continued From page 10 -The beverages offered to residents were water, iced tea and coffee. -Milk was not served. Observations of the lunch meal on 3/1/18 at 11:24am to 11:38 am revealed: -The beverages offered to residents were diet soda, water and iced tea. -Milk was not served. Interview with Administrator on 2/28/18 at 4:00 pm revealed: -She was aware that milk needed to be served twice a day. -She said milk was delivered 2-3 times per week. -She said her husband bought the milk. Interview with Medication Aide on 3/1 /18 at 11:38 revealed she only offered milk to residents with coffee or oatmeal. Observation of kitchen on 3/1/18 at 10:18 am revealed there was no milk.	C 273		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or	C 315		

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clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to contact the Primary Care Provider for clarification of indications for administration of as needed psychiatric medications (Alprazolam and Haloperidol) for 1 of 3 sampled residents (#3).

The findings are:

Review of Resident #3's current FL-2 dated 11/15/17 revealed:
-Diagnoses included cerebral vascular accident, coronary artery disease, hypertension, osteoarthritis, Alzheimer's dementia, anxiety and stage 4 chronic kidney disease.
-Medication orders included Xanax 1 mg three times daily as needed (PRN). (Xanax is used to treat anxiety.)

a. Review of Resident #3's December 2017 Medication Administration Record (MAR) revealed:
-There was a hand written entry for Xanax 1mg three times daily as needed.
-Staff documented 51 doses were administered from 12/1/17 through 12/31/17 for anxiety or agitation.

Review of Resident #3's January 2018 MAR revealed:
-There was a preprinted entry for Xanax 1mg one tablet three times daily as needed.
-Staff documented 62 doses were administered from 1/1/18 through 1/31/18 for anxiety or agitation.

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C 315	Continued From page 12 Review of Resident #3's February 2018 MAR revealed: -There was a preprinted entry for Xanax 1mg one tablet three times daily as needed. -Staff documented 42 doses were administered from 2/1/18 through 2/28/18 for anxiety or agitation. Review of Resident #3's March 2018 MAR revealed: -There was a preprinted entry for Xanax 1mg one tablet three times daily as needed. -There were no doses documented as administered. Observations of medications on hand for Resident #3 on 3/1/18 at 3:32pm revealed: -There was a bubble pack with a pharmacy label dated 1/22/18 which had Resident #3's name and instructions for Xanax 1mg one half to one tablet three times daily PRN. -There was no indication for use of the Xanax on the pharmacy label. -The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18. -There were 119 half tablets remaining. Telephone interview with the Pharmacist on 3/2/18 at 4:51pm revealed the pharmacy did not have an indication for Resident #3's Xanax. Interview with Resident #3's Primary Care Provider (PCP) on 3/1/18 at 4:12pm revealed: -Resident #3 was on Xanax for worsening behaviors related to Pseudo bulbar disorder. -He had verbally discussed clarification for the Xanax at his visit to the facility about one month ago (January 2018) with staff.	C 315		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 315	Continued From page 13 Observation on 3/1/18 at 4:12pm revealed the interview with Resident #3's PCP was interrupted by the Administrator who requested "to go ahead and write for clarification of the Xanax today (3/1/18)." Review of a physician's order sheet dated 3/1/18 for Resident #3 revealed a clarification order for Xanax 1mg as needed for anxiety signed by the resident's PCP. b. Review of a physician's order sheet dated 11/29/17 for Resident #3 revealed an order for Haldol 2mg every six hours PRN signed by Resident #3's PCP. (Haldol is used to treat psychiatric behaviors.) Review of Resident #3's December 2017 MAR revealed: -There was a hand written entry for Haldol 2mg tablet give one tablet every six hours as needed for anxiety. -Staff documented 32 doses were administered from 12/13/17 through 12/31/17 for anxiety or agitation. Review of Resident #3's January 2018 MAR revealed: -There was a preprinted entry for Haldol 2mg one tablet every six hours as needed. -Staff documented 93 doses were administered from 1/1/18 through 1/31/18 for anxiety or agitation. Review of Resident #3's February 2018 MAR revealed: -There was a preprinted entry for Haldol 2mg one tablet every six hours as needed. -Staff documented 32 doses were administered from 2/1/18 through 2/13/18 for anxiety or	C 315		

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C 315	Continued From page 14 agitation. Review of Resident #3's March 2018 MAR revealed: -There was a preprinted entry for Haldol 2mg one tablet every six hours as needed. -There were no doses documented as administered. Observation of medications on hand for Resident #3 on 3/1/18 at 3:32pm revealed there was no Haldol on hand for Resident #3. Interview with the Medication Aide (MA) on 3/1/18 at 3:32pm revealed she had requested a refill of Resident #3's Haldol from the pharmacy, but she could not remember when. Telephone interview with the Pharmacist on 3/2/18 at 4:51pm revealed the pharmacy did not have an indication for Resident #3's Haldol. Interview with Resident #3's PCP on 3/1/18 at 4:12pm revealed: -Resident #3 was on Haldol for worsening behaviors related to Pseudo bulbar disorder. -He had verbally discussed clarification for the Haldol at his visit to the facility about one month ago (January 2018) with staff. Observation on 3/1/18 at 4:12pm revealed the interview with Resident #3's PCP was interrupted by the Administrator who requested "to go ahead and write for clarification of the Haldol today (3/1/18)." Review of a physician's order sheet dated 3/1/18 for Resident #3 revealed a clarification order for Haldol 2mg as needed for anxiety signed by the resident's PCP.	C 315		

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C 315	Continued From page 15 Interview with the MA on 3/1/18 at 3:32pm revealed she did not do anything with PCP orders, the facility nurse took care of all PCP orders. Interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am revealed: -She and the Administrator were responsible for reviewing, faxing, transcribing and implementing PCP orders for the residents. -She and the Administrator were responsible for contacting the PCP if FL-2's or PCP orders were unclear or incomplete. -She would check PRN orders and make sure there was a reason the medication should be given and if there was no reason with the order, she would contact the PCP and clarify the order. -She kept her own notes of when she contacted a resident's PCP, but there were no notes documented in the resident's record. -The PCP's office would have a record of when she contacted the PCP regarding a resident. Interview with the Administrator on 3/2/18 at 8:25am revealed: -The facility nurse was new and her role was still developing. -The facility nurse was responsible for doctor's appointments, follow up on orders from the doctor's office and to make sure the MARs were updated. Interview with the Administrator on 3/6/18 at 5:34pm revealed: -She and the facility nurse were responsible for clarifying PCP orders. -They would normally get an order or a prescription, wait for the medication to come from the pharmacy and if they were not the same, they	C 315		

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C 315	Continued From page 16 would contact the pharmacy. -Clarification requests were usually faxed to the PCP's office and then placed in the resident's record.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer a Benzodiazepine (Xanax) as ordered by the Primary Care Provider for 1 of 3 residents (#3). The findings are: Review of Resident #3's current FL-2 dated 11/15/17 revealed: -Diagnoses included cerebral vascular accident, coronary artery disease, hypertension, osteoarthritis, Alzheimer's dementia, anxiety and stage 4 chronic kidney disease. -Medication orders included Xanax 1 mg three times daily as needed (PRN). (Xanax is a Benzodiazepine used to treat anxiety.) Observations of medications on hand for Resident #3 on 3/1/18 at 3:32pm revealed: -There was a bubble pack marked "2," with a	C 330		

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C 330	Continued From page 17 pharmacy label dated 1/22/18 which had Resident #3's name and instructions for Xanax 1mg, one half to one tablet three times daily PRN. -The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18. -There were 60 tablets half tablets in the bubble pack. -There was a second bubble pack marked "3," with a pharmacy label dated 1/22/18 which had Resident #3's name and instructions for Xanax 1mg, one half to one tablet three times daily PRN. -The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18. -There were 59 tablets half tablets in the bubble pack. Interview with the Medication Aide (MA) on 3/1/18 at 3:32pm revealed: -The Administrator had contacted the pharmacy and was informed that one half tablet equaled 1mg and that each bubble on the Xanax medication card contained one dose of 1mg. -She could not remember when the pharmacy was contacted. Review of Resident #3's December 2017 Medication Administration Record (MAR) revealed: -There was a hand written entry for Xanax 1mg three times daily as needed. -Staff documented administering 51 doses from 12/1/17 through 12/31/17. Review of Resident #3's January 2018 MAR revealed: -There was a preprinted entry for Xanax 1mg one tablet three times daily as needed. -Staff documented 62 doses were administered from 1/1/18 through 1/31/18 for anxiety or agitation.	C 330		

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C 330	Continued From page 18 Review of Resident #3's February 2018 MAR revealed: -There was a preprinted entry for Xanax 1mg one tablet three times daily as needed. -Staff documented 42 doses were administered from 2/1/18 through 2/28/18 for anxiety or agitation. Review of Resident #3's March 2018 MAR revealed: -There was a preprinted entry for Xanax 1mg one tablet three times daily as needed. -There were no doses documented as administered. Review of a controlled drug record dated 1/22/18 for Resident #3 revealed: -There was a pharmacy label which had Resident #3's name and instructions for Xanax 1mg take one half - one tablet three times daily as needed. -The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18. -Staff documented 61 doses (half of a 1mg tablet = 0.5mg) were administered from 1/23/18 at 3:30pm through 2/28/18 at 7:00pm. -Under the section amount given, staff entered "1" for each of the 61 doses documented. -There were 119 doses documented as remaining on 2/28/18. Review of a second controlled drug record dated 1/22/18 for Resident #3 revealed: -There was a pharmacy label which had Resident #3's name and instructions for Xanax 1mg, take one half - one tablet three times daily as needed. -The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18. -There were no entries on the controlled drug record.	C 330		

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C 330	Continued From page 19 Telephone interview with the Pharmacist on 3/2/18 at 4:51pm revealed: -The current order on file at the pharmacy Resident #3 was for Xanax 1mg one half to one tablet three times daily PRN from a hard copy script dated 1/22/18. -The previous order for Resident #3 was for Xanax 1mg three times daily PRN from the FL-2 dated 11/15/17. -There was no further information on file for Resident #3's Xanax. Interview with Resident #3's Primary Care Provider (PCP) on 3/1/18 at 4:12pm revealed: -The Xanax should have been 1mg three times daily, that's what the resident was taking prior to coming to the facility. -Resident #3 should not have been taking one half of a 1mg tablet of Xanax. -Resident #3 was on Xanax for worsening behaviors related to Pseudo bulbar disorder. -He had verbally discussed clarification for the Xanax at his visit to the facility about one month ago (January 2018) with staff. Interview with Resident #3's PCP's Registered Nurse (RN) on 3/1/18 at 4:25pm revealed: -She had reviewed the PCP last visit note and noted that Xanax for Resident #3 was listed as 1mg one half to one tablet three times daily on the residents current medication list. -The PCP was going to write a clarification order on 3/1/18. Review of a physician's order sheet dated 3/1/18 for Resident #3 revealed a clarification order for Xanax 1mg as needed for anxiety signed by the resident's PCP.	C 330		

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C 330	Continued From page 20 Interview with the facility nurse on 3/5/18 at 11:22am revealed: -She and the Administrator were responsible for reviewing, faxing, transcribing and implementing PCP orders for the residents. -She and the Administrator were responsible for contacting the PCP if FL-2's or PCP orders were unclear or incomplete. -She would check PRN orders and make sure there was a reason the medication should be given and if there was no reason with the order, she would contact the PCP and clarify the order. -She kept her own notes of when she contacted a resident's PCP, but she did not document notes in the resident's record. -The PCP's office would have a record of when she contacted the PCP regarding a resident. -She and the Administrator reviewed the medication and the order whenever a new medication was delivered. -She and the Administrator were responsible for checking MARs for accuracy every month and whenever there were new orders. -She and the Administrator were at the facility every week to check medications and MARs. Interview with the Administrator on 3/2/18 at 5:20pm revealed staff were expected to triple check the medication bubble pack against the MAR before they punched the medication out of the bubble, punch the dose, administer the medication and then document on the MAR after observing the resident take the medication.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration	C 335		

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C 335	Continued From page 21 (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure medications which were prepared in advance, were kept in an	C 335		

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enclosed container that identified the name and strength of each medication, the resident's name and planned administration time for 5 of 5 residents and included high risk medications such as Xanax and Tramadol (controlled drugs); Haldol, Seroquel and Risperdal (antipsychotics); Xarelto (blood thinner); and Sorbitrate, Zestril, Hydralazine, Ranexa and Lopressor (cardiac and blood pressure lowering).

The findings are:

Confidential interview with a staff revealed:
-Staff were scheduled to work two to three 12 hour shift rotations.
-At the start of a rotation, the morning medications were already poured and staff was responsible for preparing the lunch, evening and morning medications for the remainder of their shift rotation.
-Staff prepared medications in advance by putting medications inside plastic cups that were placed in each resident's section inside the top drawer of the medication cart.
-The time the medication was supposed to be given was written on a piece of paper inside the section or the medication cup.
-Staff did not write down the names of each medication inside the cup and did not cover or seal the medications inside the cup.
-The staff that prepared the medications was not always the staff that administered the medications and not always the staff that documented medications had been administered.
-The staff that gave residents the medications were the staff that signed the Medication Administration Record (MAR).
-Staff were trained by the Administrator to prepare medications this way.
-Medications might have been prepared in

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advance because some staff were not Medication Aides (MAs).
-The staff that were not MAs mainly worked at night.
-Staff did not know who signed the MAR if the staff member giving medications was not a MA and did not know how as needed medications were administered if the staff on duty was not a MA.

Observations on 2/28/18 at 11:20am revealed:
-The Administrator opened the door to the medication closet without a key.
-The top drawer of the medication cart was not fully closed leaving a gap of approximately two inches.
-The top drawer was sectioned off with dividers that had pieces of tape at each individual space.
-There were residents' names and "7am, 12 noon, 7pm" hand written on the pieces of tape.
-There were uncovered plastic medication cups stacked two high with medications in ten divided sections.
-Each medication cup had several pills of various shapes, sizes and colors.

Interview with the Administrator on 2/28/18 at 11:20am and 12:32pm revealed:
-She had just been in the medication closet and that was why it had been unlocked.
-Medications were pre-poured for the current Medication Aide's (MA's) 12 hour shift by the MA on duty on 2/28/18 for 7:00am - 7:00pm.
-The facility had always pre-poured medications for the 12 hour shift.
-Only routine scheduled medications were pre-poured for a 12 hour shift, there were no as needed medications or controlled drugs pre-poured.
-She did not know why the cups were stacked two

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high with the same pills.
-The MA on duty must have thought her shift meant her shift as in her two days on duty.
-She thought that the rules and regulations allowed for MAs to prepare medications in advance for their shift and the guidelines must have changed since she opened the facility.
-She would talk to the MA about pre-pouring medications for more than one 12 hour shift.

Interview with a Medication Aide (MA) on 3/1/18 at 8:08am revealed:
-She had prepared the medications that were observed in the top drawer of the medication cart on 2/28/18 at 11:20am.
-She did not know what each pill was (name of medication) by looking at the pill and the medications inside the medication cups.
-When she prepared the medications, she matched the medication card (bubble pack) to the MAR (Medication Administration Record), double checked the medication was right before punching the medication and this was how she knew the right medications were in each cup.
-Medications were administered at the scheduled time except as needed medications which were given when the resident needed the medication.

1. Review of Resident #3's current FL-2 dated 11/15/17 revealed:
-Diagnoses included cerebral vascular accident, coronary artery disease, hypertension, osteoarthritis, Alzheimer's dementia, anxiety and stage 4 chronic kidney disease.
-Medication orders included Aspirin 81mg daily (an anti-inflammatory used to prevent blood clots), Paxil 20mg daily (a psychotropic used to treat depression), Crestor 40mg daily (a statin used to lower cholesterol levels), Xanax 1mg three times daily PRN (as needed) (a

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Benzodiazepine used to treat anxiety), Sorbitrate 10mg two tablets daily (a nitrate used to treat heart failure), , Colace 100mg one to three tablets daily PRN (a stool softner used to treat constipation), Detrol LA 4mg one tablet daily (used to treat overactive bladder symptoms) and Zestril 20mg daily (an angiotensin converting enzyme inhibitor used to treat high blood pressure).

Review of a physician's order sheet dated 11/29/17 for Resident #3 revealed an order for Haldol 2mg every six hours PRN signed by Resident #3's Primary Care Provider (PCP).

Review of a physician's order dated 12/28/17 at 8:50am revealed an order for Nuedexta 20mg/10mg one tablet daily for seven days, then one tablet twice daily signed by the resident's PCP. (Nuedexta is used to treat pseudo bulbar affect.)

Review of Resident #3's February 2018 Medication Administration Record (MAR) revealed:
-There were entries for scheduled doses of Aspirin, Sorbitrate, Zestril, Paxil, Detrol LA, Colace, Crestor and Nuedexta.
-There was one staff's initials documented for the 8:00am medications and a second staff's initials entered for the 8:00pm medications on 2/27/18 and 2/28/18.
-There was an entry for Xanax PRN and staff documented 42 doses were administered from 2/1/18 through 2/28/18.
-There was an entry for Haldol PRN and staff documented 32 doses were administered from 2/1/18 through 2/13/18.

Review of Resident #3's March 2018 MAR

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revealed:
-There were entries for scheduled doses of Aspirin, Sorbitrate, Zestril, Paxil, Detrol LA, Colace, Crestor and Nuedexta.
-The facility nurse documented administering the 8:00am medications on 3/1/18.
-Staff documented administering medications at 8:00pm on 3/1/18 and 8:00am on 3/2/18.
-There were entries for Xanax PRN, Haldol PRN and no doses were documented as administered.

Based on observations, interviews and record reviews, Resident #3 was not interviewable.

Refer to interview with a Medication Aide (MA) on 3/1/18 at 2:45pm.

Refer to interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am.

Refer to interview with the Administrator on 3/2/18 at 8:25am and 5:20pm.

Refer to review of the facility's undated policy on Medication Pre-pouring.

2. Review of Resident #4's current FL-2 dated 9/20/17 revealed:
-Diagnoses included cognitive communication resonance disorder, major depression disorder, tremor and malaise.
-Medication orders included Cymbalta 30 mg daily (an antidepressant used to treat depression and pain), Lasix 40mg daily (a diuretic used to reduce fluid in the body), Toprol XL 25mg daily (a beta blocker used to treat high blood pressure and chest pain), Vitamin D3 1000units at bedtime (a nutritional supplement), Calcium plus Vitamin D 500mg twice daily (a nutritional supplement), Zestril 10mg twice daily (an angiotensin

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converting enzyme inhibitor used to treat high blood pressure), Melatonin 1mg four tablets at bedtime (hormonal supplement used for sleep), Remeron 15mg one half tablet at bedtime (an antidepressant used to treat depression and insomnia) and Zofran 4mg every four hours as needed (PRN) for nausea (used to treat nausea and vomiting).

Review of Resident #4's February 2018 Medication Administration Record (MAR) revealed:
-There were entries for scheduled doses of Cymbalta, Lasix, Toprol XL, Vitamin D3, Calcium, Zestril, Melatonin, Remeron and Zofran.
-There was one staff's initials documented for the 8:00am medications and a second staff's initials entered for the 8:00pm medications on 2/3 - 2/5/18, 2/8/18, 2/9/18, 2/13/18, 2/14/18, 2/17/18 and 2/18/18.
-There was an entry for Zofran PRN and no doses were documented as administered.

Review of Resident #4's March 2018 MAR revealed:
-There were entries for scheduled doses of Cymbalta, Lasix, Toprol XL, Vitamin D3, Calcium, Zestril, Triamcinolone cream, Melatonin and Remeron.
-The facility Licensed Practical Nurse (LPN) documented administering the 8:00am medications on 3/1/18 and staff documented administering the 8:00pm medications on 3/1/18 and the 8:00am medications on 3/2/18.
-There was an entry for Zofran PRN and no doses were documented as administered.

Based on observations, interviews and record reviews, Resident #4 was not interviewable.

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C 335	Continued From page 28 Refer to interview with a Medication Aide (MA) on 3/1/18 at 2:45pm. Refer to interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am. Refer to interview with the Administrator on 3/2/18 at 8:25am and 5:20pm. Refer to review of the facility's undated policy on Medication Pre-pouring. 3. Review of Resident #5's current undated FL-2 revealed: -Diagnoses included congestive heart failure, hypertension, chronic obstructive pulmonary disease, history of hip fracture, hypothyroidism, chronic anemia, temporomandibular joint disorder and acute kidney disease. -Medication orders included Aspirin 81mg daily (an anti-inflammatory used to prevent blood clots), Aricept 5mg at bedtime (used to treat dementia), Lasix 40mg daily (a diuretic used to reduce fluid in the body), Synthroid 88mcg daily (hormonal replacement used to treat hypothyroidism), Zestril 25mg daily (an angiotensin converting enzyme inhibitor used to treat high blood pressure), Zoloft 50mg one and one half tablets daily (an antidepressant used to treat depression), Aldactone 25mg daily (a diuretic used to reduce fluid in the body), Vitamin B12 500mcg daily (a nutritional supplement), Colace 100mg twice daily (a stool softner used to treat constipation), Neurontin 300mg twice daily (an anticonvulsant used to treat seizures and nerve pain), Lopressor 50mg one and one half tablets twice daily (a beta blocker used to treat high blood pressure and chest pain), Zyrtec 5mg at bedtime (an antihistamine used to treat allergies), Trazadone 50mg at bedtime (an	C 335		

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antidepressant used to treat depression), Tegretol 100mg one half tablet four times daily PRN for nerve pain (an anticonvulsant used to treat seizures and nerve pain).

Interview with the Administrator on 3/2/18 at 1:00pm revealed Resident #5's February 2018 Medication Administration Record (MAR) was not available for review because the original was sent to the hospital with the resident on 3/1/18 at 12:30am.

Review of Resident #5's March 2018 MAR revealed:
-There were entries for scheduled doses of Aspirin, Aricept, Lasix, Synthroid, Zestril, Zoloft, Aldactone, Vitamin B12, Colace, Neurontin, Lopressor, Zyrtec, Trazadone and Tegretol.
-An "I" was entered for 3/1/18 for all 8:00am and 8:00pm medications.
-According to the charting code on the MAR, "I" indicated hospital.

Interview with Resident #5 on 2/28/18 at 11:17am revealed she received her medications like she was supposed to and staff were good to her.

Refer to interview with a Medication Aide (MA) on 3/1/18 at 2:45pm.

Refer to interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am.

Refer to interview with the Administrator on 3/2/18 at 8:25am and 5:20pm.

Refer to review of the facility's undated policy on Medication Pre-pouring.

Refer to review of in-services completed by

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C 335	Continued From page 30 facility dated 3/1/18. 4. Review of Resident #1's current FL-2 dated 2/12/18 revealed: -Diagnoses included dementia, osteoarthritis, arthropathy, hypertension, hyperlipidemia and anxiety. -Medication orders included Melatonin 10mg three tablets at bedtime (hormonal supplement used for sleep), Paxil 30mg daily (psychotropic used to treat depression), Xanax 0.5mg every eight hours PRN (as needed) for anxiety (a Benzodiazepine used to treat anxiety), Tramadol 50mg every six hours PRN for pain (an opioid used to treat pain) and Colace 100mg daily (a stool softner used to treat constipation). Review of Resident #1's February and March 2018 Medication Administration Record (MAR) revealed: -There were entries for scheduled doses of Melatonin, Paxil and Colace at 8:00pm which one staff documented administering each day from 2/5/18 through 2/28/18. -There was an entry for Xanax PRN and staff documented administering 10 doses from 2/23/18 through 2/27/18. -There was an entry for Tramadol PRN and staff documented administering 5 doses between 2/11/18 and 2/26/18. -All PRN doses of medications were administered between 7:00am and 7:00pm Based on observations, interviews and record reviews, Resident #1 was not interviewable. Refer to interview with a Medication Aide (MA) on 3/1/18 at 2:45pm. Refer to interview with the facility Licensed	C 335		

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C 335	Continued From page 31 Practical Nurse (LPN) on 3/5/18 at 11:22am. Refer to interview with the Administrator on 3/2/18 at 8:25am and 5:20pm. Refer to review of the facility's undated policy on Medication Pre-pouring. Refer to review of in-services completed by facility dated 3/1/18. 5. Review of Resident #2's current FL-2 dated 6/14/18 revealed: -Diagnoses included frequent falls, history of right ankle fracture, long-term medication use, atrial fibrillation, chronic renal failure, coronary artery disease, benign essential hypertension and anxiety. -Medication orders included Butisol 30mg at bedtime (a barbiturate hypnotic used as a sedative), Seroquel 50mg at bedtime (an antipsychotic used to treat mental/mood disorders), Vitamin B12 1000mcg injection monthly (a nutritional supplement), Risperdal 2mg twice daily (an antipsychotic used to treat mental/mood disorders), Zoloft 200mg daily (an antidepressant used to treat depression), Lasix 40mg daily (a diuretic used to reduce fluid in the body), Protonix 40mg daily (an acid blocker used to treat stomach problems), Sorbitrate 30mg daily (a nitrate used to treat heart failure), Synthroid 175mcg daily (hormonal replacement used to treat hypothyroidism), Xarelto 15mg daily (a blood thinner used to prevent blood clots), Hydralazine 50mg daily (an antihypertensive used to treat high blood pressure), Lopressor 50mg daily (a beta blocker used to treat high blood pressure and chest pain), Ranexa 500mg daily (an anti-anginal used to treat chronic chest pain), Mevacor 20mg daily (a statin used to lower cholesterol levels)	C 335		

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and Folic acid 1mg daily (a nutritional supplement).

Review of Resident #2's February Medication Administration Record (MAR) revealed:
-There were entries for scheduled doses of Folic acid, Lasix, Sorbitrate, Synthroid, Mevacor, Protonix, Zoloft, Xarelto, Hydralazine, Lopressor, Ranexa, Risperdal, Xanax, Seroquel, Vitamin B12 and Trazadone.
-There were entries for Nitrostat PRN, Claritin PRN, Antivert PRN, Mucinex PRN and no doses were documented as administered.
-There was an entry for Tramadol PRN and 56 doses were documented as administered from 2/1/18 through 2/28/18 at 7:00am and 7:00pm.

Review of Resident #2's March 2018 MAR revealed:
-There were entries for scheduled doses of Folic acid, Lasix, Sorbitrate, Synthroid, Mevacor, Protonix, Zoloft, Xarelto, Hydralazine, Lopressor, Ranexa, Risperdal, Xanax, Seroquel, Vitamin B12 and Trazadone.
-The facility Licensed Practical Nurse (LPN) documented administering the 8:00am medications on 3/1/18 and staff documented administering the 8:00pm medications on 3/1/18 and the 8:00am medications on 3/2/18.
-There were entries for Nitrostat PRN, Claritin PRN, Antivert PRN, Mucinex PRN and no doses were documented as administered.
-There was an entry for Tramadol PRN and one dose was documented as administered on 3/1/18 at 7:00pm.

Refer to interview with a Medication Aide (MA) on 3/1/18 at 2:45pm.

Refer to interview with the facility Licensed

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C 335	Continued From page 33 Practical Nurse (LPN) on 3/5/18 at 11:22am. Refer to interview with the Administrator on 3/2/18 at 8:25am and 5:20pm. Refer to review of the facility's undated policy on Medication Pre-pouring. Refer to review of in-services completed by facility dated 3/1/18. Interview with a Medication Aide (MA) on 3/1/18 at 2:45pm revealed: -There was no specific way or routine medications were given at the facility. -Sometimes the night MA would administer the 8:00pm medications and sometimes the day MA would administer the 8:00pm medications. -Sometimes the outgoing MA would administer medications to a couple of residents and then the oncoming MA would administer medications to other residents for 8:00am or 8:00pm. -It depended on if a MA had time to give the medications prior to leaving at the end of a shift. -She administered 8:00pm medications prior to the end of her shift at 7:00pm because there was a one hour window before and after the scheduled time to administer medications. Interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am revealed: -She observed staff administering medications to residents randomly throughout the week while she was in the facility. -She observed medication administration passes to assure staff prepared medications properly, administered medications to residents, observed residents take medications and documented medications administered on the MAR.	C 335		

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C 335	Continued From page 34 Review of the facility's undated policy on Medication Pre-pouring revealed: -It was a rule at the facility to allow routine, oral medications to be pre-poured at the beginning of the 12 hour shift. -Exceptions included, PRN (as needed), controlled, liquid, and powder medications which were only poured at the time of administration. -Pre-poured medications were stored in the resident's individually labeled medication cube and locked in the medication cart. Interview with the Administrator on 3/2/18 at 8:25am and 5:20pm revealed: -She had begun retraining all MAs on 3/1/18. -All MAs were informed not to pre-pour medications. -Staff were expected to triple check the medication bubble pack against the MAR before they punched the medication out of the bubble, punch the dose, administer the medication and then document on the MAR after observing the resident take the medication. -She was going to update the medication administration policy to include no pre-pouring of medications. The facility's failure to assure high risk medications such as Xanax and Tramadol (controlled drugs); Haldol, Seroquel and Risperdal (antipsychotics); Xarelto (blood thinner); and Sorbitrate, Zestril, Hydralazine, Ranexa and Lopressor (cardiac and blood pressure lowering), were protected from spillage and/or contamination and were readily identifiable up to the point of administration, was detrimental to the health, safety and wellbeing of all five residents in the facility, which constitutes a Type B Violation.	C 335		

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C 335	Continued From page 35 Review of the Plan of Protection submitted by the facility on 3/1/18 revealed: -Staff will immediately stop pre-pouring medications. -Medications that were already pre-poured on 2/28/18 were destroyed by placing in cat litter and adding water. -All staff on all shifts were instructed not to pre-pour medications. -All staff on all shifts will be re-inserviced on medication administration and additional training will provided by the consultant Registered Nurse and/or the pharmacy. -Staff will receive formal write up on their performance evaluation for any noted policy violations on pre-pouring medications. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2018.	C 335		
C 379	10A NCAC 13G .1009(a)(5) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (5) provision of a written report of findings and any recommendations for change for Items (1) through (4) of Paragraph (a) of this Rule to the	C 379		

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C 379	Continued From page 36 facility and the physician or appropriate health professional, when necessary; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there was written documentation of and a review of all aspects of medication administration, medication storage areas and medication systems related to medication package, labeling, disposition and records for 3 of 3 sampled residents (#1, #2 and #3). The findings are: 1. Review of Resident #3's current FL-2 dated 11/15/17 revealed: -Diagnoses included cerebral vascular accident, coronary artery disease, hypertension, osteoarthritis, Alzheimer's dementia, anxiety and stage 4 chronic kidney disease. -Medication orders included Xanax 1 mg three times daily as needed (PRN) and Tobrex 0.3% one drop in each eye four times daily PRN. (Xanax is used to treat anxiety and Tobrex is used to treat infections.) Review of a physician's order sheet dated 11/29/17 for Resident #3 revealed an order for Haldol 2mg every six hours PRN signed by Resident #3's PCP. (Haldol is used to treat psychiatric behaviors.) a. Review of Resident #3's December 2017 and January - March 2018 Medication Administration Records (MARs) revealed: -There was an entry for Xanax 1mg three times daily as needed. -There was an entry for Haldol 2mg tablet give	C 379		

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one tablet every six hours as needed for anxiety.
-There was an entry for Tobrex drops 0.3% place one drop in each eye four times a day as needed.

Observations of medications on hand for Resident #3 on 3/1/18 at 3:32pm revealed:
-There was a bubble pack with a pharmacy label dated 1/22/18 which had Resident #3's name and instructions for Xanax 1mg one half to one tablet three times daily PRN.
-There was no indication for use of the Xanax on the pharmacy label.
-There was no Haldol or Tobrex on hand for Resident #3.

Telephone interview with the Pharmacist on 3/2/18 at 4:51pm revealed the pharmacy did not have an indication for use for Resident #3's Xanax, Haldol or Tobrex.

Review of Resident #3's pharmacy review dated 12/12/17 revealed:
-Medications including Aspirin 81mg daily, Prevacid 30mg daily, Paxil 20mg daily, Crestor 40mg daily, Xanax 1mg three times daily PRN, Isosorbide 10mg 2 tablets daily, Elidel 1%to affected areas twice daily PRN, Colace 100mg one to three tablets daily PRN, Detrol LA 40mg daily, Lisinopril 20mg daily and Tobrex 0.3%one drop to both eyes four times daily PRN were documented on the form.
-There was a notation that read, "MAR date 12/1/17 +Haldol 2mg tab one orally every six hours PRN anxiety. Meds as above."
-There were no recommendations documented.
-The facility form was signed by a Registered Nurse (RN).

Telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm

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revealed:
-She had completed the pharmacy review for Resident #3.
-Resident #3's medications (Xanax, Haldol and Tobrex PRN) absolutely should have been clarified, that must have been oversight on her part.

b. Observations of medications on hand for Resident #3 on 3/1/18 at 3:32pm revealed:
-There was a bubble pack marked "2," with a pharmacy label dated 1/22/18 which had Resident #3's name and instructions for Xanax 1mg, one half to one tablet three times daily PRN.
-The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18.
-There was a second bubble pack marked "3," with a pharmacy label dated 1/22/18 which had Resident #3's name and instructions for Xanax 1mg, one half to one tablet three times daily PRN.
-The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18.

Interview with the Medication Aide (MA) on 3/1/18 at 3:32pm revealed:
-The Administrator had contacted the pharmacy and was informed that one half tablet equaled 1mg and that each bubble on the Xanax medication card contained one dose of 1mg.
-She could not remember when the pharmacy was contacted.

Review of Resident #3's December 2017 and January - March 2018 Medication Administration Records (MARs) revealed:
-There was a hand written entry for Xanax 1mg three times daily as needed.
-Staff documented administering 155 doses from 12/1/17 through 2/28/18 .
-There were no doses documented as

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C 379	Continued From page 39 administered for March 2018. Review of a controlled drug record dated 1/22/18 for Resident #3 revealed: -There was a pharmacy label which had Resident #3's name and instructions for Xanax 1mg take one half - one tablet three times daily as needed. -The pharmacy label indicated 90 tablets were halved to make 180 doses dispensed on 1/22/18. -Staff documented 61 doses (half of a 1mg tablet = 0.5mg) were administered from 1/23/18 at 3:30pm through 2/28/18 at 7:00pm. -Under the section amount given, staff entered "1" for each of the 61 doses documented. Telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm revealed: -She had observed staff throughout the medication administration process including pulling the MAR, getting the medications out of the cart, taking the medication cart to the resident's room, popping the medications from the bubble pack, observing the resident taking the medications and signing the MAR. -She had never checked the contents of the medication cart as part of the pharmacy review process Refer to telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm. Refer to interview with the Administrator on 3/2/18 at 8:25am and 3/6/18 at 5:34pm. 2. Review of Resident #1's pharmacy review dated 2/5/18 revealed: -Medications including Xanax 0.25mg one tablet three times daily as needed (PRN) for anxiety, Melatonin 10mg three tablets at bedtime, Paxil	C 379		

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C 379	Continued From page 40 30mg daily, and Tramadol 50mg every six hours PRN for pain were documented on the form. -There were no recommendations documented. Interview with the facility nurse on 3/1/18 at 7:35am revealed: -She was a licensed practical nurse (LPN). -She had completed and signed Resident #1's pharmacy review. -She had signed for the consultant Registered Nurse (RN) who was last at the facility in December 2017 and was due to return March 2018. -She had only signed the form, but the consultant RN completed the pharmacy review and cosigned the form. Telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm revealed: -She had not seen Resident #1's Xanax bubble pack and the label. -Resident #1's FL-2 with the new order should have been faxed to the pharmacy and then the pharmacy should have redone the label. -She did not know why the facility nurse had completed a pharmacy review for Resident #1 because that was not the usual process. -She was responsible for completing pharmacy reviews for each resident every three months and had completed a review for Resident #1 either 2/5/18 or 2/15/18. Review of pharmacy reviews dated for February 2018 for Resident #1 revealed there was no pharmacy review completed by the consultant RN available for review. Refer to telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm.	C 379		

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C 379	Continued From page 41 Refer to interview with the Administrator on 3/2/18 at 8:25am and 3/6/18 at 5:34pm. 3. Confidential interview with a staff revealed: -Staff were scheduled to work two to three 12 hour shift rotations. -At the start of a rotation, the morning medications were already poured and staff was responsible for preparing the lunch, evening and morning medications for the remainder of their shift rotation. -Staff prepared medications in advance by putting medications inside plastic cups that were placed in each resident's section inside the top drawer of the medication cart. -The time the medication was supposed to be given was written on a piece of paper inside the section or the medication cup. -Staff did not write down the names of each medication inside the cup and did not cover or seal the medications inside the cup. -The staff that prepared the medications was not always the staff that administered the medications and not always the staff that documented medications had been administered. -The staff that gave residents the medications were the staff that signed the Medication Administration Record (MAR). -Staff were trained by the Administrator to prepare medications this way. -Medications might have been prepared in advance because some staff were not Medication Aides (MAs). -The staff that were not MAs mainly worked at night. -Staff did not know who signed the MAR if the staff member giving medications was not a MA and did not know how as needed medications were administered if the staff on duty was not a	C 379		

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C 379	Continued From page 42 MA. Observations on 2/28/18 at 11:20am revealed: -The Administrator opened the door to the medication closet without a key. -The top drawer of the medication cart was not fully closed leaving a gap of approximately two inches. -The top drawer was sectioned off with dividers that had pieces of tape at each individual space. -There were residents' names and "7am, 12 noon, 7pm" hand written on the pieces of tape. -There were uncovered plastic medication cups stacked two high with medications in ten divided sections. -Each medication cup had several pills of various shapes, sizes and colors. Interview with the Administrator on 2/28/18 at 11:20am and 12:32pm revealed: -She had just been in the medication closet and that was why it had been unlocked. -Medications were pre-poured for the current Medication Aide's (MA's) 12 hour shift by the MA on duty on 2/28/18 for 7:00am - 7:00pm. -The facility had always pre-poured medications for the 12 hour shift. -Only routine scheduled medications were pre-poured for a 12 hour shift, there were no as needed medications or controlled drugs pre-poured. -She did not know why the cups were stacked two high with the same pills. -The MA on duty must have thought her shift meant her shift as in her two days on duty. -She thought that the rules and regulations allowed for MAs to prepare medications in advance for their shift and the guidelines must have changed since she opened the facility. -She would talk to the MA about pre-pouring	C 379		

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medications for more than one 12 hour shift.

Interview with a Medication Aide (MA) on 3/1/18 at 8:08am revealed:
-She had prepared the medications that were observed in the top drawer of the medication cart on 2/28/18 at 11:20am.
-She did not know what each pill was (name of medication) by looking at the pill and the medications inside the medication cups.
-When she prepared the medications, she matched the medication card (bubble pack) to the MAR (Medication Administration Record), double checked the medication was right before punching the medication and this was how she knew the right medications were in each cup.
-Medications were administered at the scheduled time except as needed medications which were given when the resident needed the medication.

Interview with the MA on 3/1/18 at 3:32pm revealed she had not observed the medication cart being checked for medications on hand during the pharmacy review process.

Telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm revealed:
-She had observed staff throughout the medication administration process including pulling the MAR, getting the medications out of the cart, taking the medication cart to the resident's room, popping the medications from the bubble pack, observing the resident taking the medications and signing the MAR.
-She had never checked the contents of the medication cart as part of the pharmacy review process.
-MAs should not be pre-pouring medications.
-The MAs had pre-poured in the past for their

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C 379	Continued From page 44 shift, but guidelines had since changed. -She had discussed the concerns related to MAs pre-pouring medications over the last weekend (3/3/18) with the Administrator and facility nurse. Refer to telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm. Refer to interview with the Administrator on 3/2/18 at 8:25am and 3/6/18 at 5:34pm. Telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm revealed: -She completed pharmacy reviews quarterly at the facility which included reviewing PCP orders and MARs. -If there were new orders or changes, she would make note of that on her review sheet. -She discussed any concerns from completed pharmacy reviews with the Administrator or made note of the concern on the review. -She had been completing pharmacy reviews for the facility for a couple of years. Interview with the Administrator on 3/2/18 at 8:25am and 3/6/18 at 5:34pm revealed: -The consultant Registered Nurse (RN) had completed pharmacy reviews for the facility. -The consultant RN was not associated with the pharmacy. -She become aware that some things had been missed on the pharmacy reviews and was considering a change in the facility's process for pharmacy reviews.	C 379		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives	C 453		

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C 453	Continued From page 45 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance	C 453		

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C 453	Continued From page 46 in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the use of seatbelts on wheelchairs and full side rails on resident beds were implemented after alternatives to restrictive devices were tried and documented, there was an order by the Primary Care Provider and a care planning process had been completed for 3 of 3 residents (#1, #2 and #4). The findings are: 1. Review of Resident #1's current FL-2 dated 2/12/18 revealed: -Diagnoses included dementia, osteoarthritis, arthropathy, hypertension, hyperlipidemia and anxiety. -There were no orders for the use of a wheelchair seatbelt. Review of Resident #1's current care plan dated 2/20/18 revealed: -Resident #1 used a wheelchair for mobility and had limited range of motion in her left upper extremity. -There was no documentation related to the use of a seatbelt or alternatives. Observation on 3/1/18 at 7:53am revealed: -Resident #1 attempted to stand from sitting in	C 453		

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her chair at the dining room table.
-The Medication Aide (MA) was washing dishes and another resident told the MA that Resident #1 was attempting to stand.
-The MA asked Resident #1, "Where are you trying to go? Are you trying to stand up?"
-The MA assisted Resident #1 from kitchen chair to her wheelchair and fastened the seatbelt around Resident #1's waist.

Based on observations, interviews and record reviews, Resident #1 was not interviewable.

Telephone interview with Resident #1's Power of Attorney (POA) on 3/5/18 at 2:55pm revealed:
-She thought Resident #1 did bring a red wheelchair from home to the facility when she was admitted in February 2017.
-The wheelchair had a seatbelt because Resident #1 would try to get up and the POA was concerned the resident might fall.
-She ordered the wheelchair with a seatbelt to hold Resident #1 in the wheelchair.
-Resident #1 did not have enough strength in her hands to release the seatbelt most of the time.
-Resident #1 had decreased strength in her left hand and may have been able to release the seatbelt with her right hand if she fiddled with it long enough.

Attempted interviews with Resident #1's Primary Care Provider (PCP) on 3/1/18 at 9:48am, 3/2/18 at 4:45pm and 3/6/18 at 12:08pm and 4:33pm were unsuccessful.

Telephone interview with Resident #1's PCP's Medical Assistant on 3/6/18 at 4:33pm revealed she did not have a record of an order for use of a wheelchair seatbelt for Resident #1.

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C 453	Continued From page 48 Interview with the Administrator on 3/2/18 at 5:20pm revealed: -Resident #1 came to the facility with her wheelchair and the Administrator was not aware the resident's wheelchair had a seatbelt. -She was not aware the staff were securing the seatbelt around Resident #1's waist when she was in the wheelchair. -She was not sure if Resident #1 could remove the seatbelt. Refer to interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am. Refer to interview with the Administrator on 3/2/18 at 5:20pm. Refer to review of the facility's February 2018 thirty minute check sheets. 2. Review of Resident #4's current FL-2 dated 9/20/17 revealed: -Diagnoses included cognitive communication resonance disorder, major depression disorder, tremor and malaise. -There were no orders to use side rails. Review of Resident #4's current care plan dated 7/31/17 revealed: -Resident #4 was non-ambulatory and used a wheelchair for transfers and mobility. -Resident #4 had limited range of motion and limited strength in both upper extremities. -There was no documentation related to the use of side rails or alternatives. Review of the Licensed Health Professional Support (LHPS) evaluation dated 12/13/17 for Resident #4 revealed there was no documentation related to the use of side rails or	C 453		

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alternatives.

Observation on 3/1/18 at 7:23am revealed Resident #4 was sleeping in her bed with full length side rails up on both sides.

Interview with the Medication Aide (MA) on 3/1/18 at 7:27am revealed Resident #4 liked to have her side rails up and would ask staff to put the side rails up at night.

Interview with Resident #4 on 3/2/18 at 12:08pm revealed:
-She did not know the side rails were on her bed, however she like the chrome rails that were on her bed.
-She liked to see them when she woke up so she could decide if she was in a dream.

Telephone interview with Resident #4's Responsible Person (RP) on 3/5/18 at 2:30pm revealed:
-Resident #4 had a hospital bed with side rails, but she had never seen the side rails up.
-She could not say if side rails were used for Resident #4.

Attempted interviews with Resident #1's Primary Care Provider on 3/1/18 at 9:48am, 3/2/18 at 4:45pm and 3/6/18 at 12:08pm and 4:33pm were unsuccessful.

Interview with the Administrator on 2/28/18 at 12:32pm revealed the side rails on residents' bed were only used for mobility assistance and assistance with turning and repositioning.

Interview with a Medication Aide (MA) on 3/2/18 at 4:15pm revealed:
-She used side rails for safety and to assist

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residents with turning and repositioning.
-She only put the side rails half way up when she worked.
-She could not say if all staff used side rails the same way.
-She had not seen any alternatives to side rails used at the facility in a long time.
-All residents were checked every 30 minutes over night.

Refer to interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am.

Refer to interview with the Administrator on 3/2/18 at 5:20pm.

Refer to review of the facility's February 2018 thirty minute check sheets.

3. Review of Resident #2's current FL-2 dated 6/14/17 revealed:
-diagnoses included frequent falls, history of right ankle fracture, long term med use, atrial fibrillation, chronic renal failure, coronary artery disease, benign essential hypertension, anxiety.
-Resident was intermittently confused and used a walker for ambulation.

Review of Resident #2's current care plan dated 12/13/17 revealed there was no documentation for use of side rails.

Observation of Resident #2 on 2/28/18 at 7:15am revealed the resident was in bed with full side rails fully raised on both sides.

Review of physician's order sheets and progress notes dated 4/10/17 for Resident #2 revealed:
-There was no order for side rails.
-There was no documentation that alternative

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restraints were tried.

Observation on 3/1/18 at 7:23am revealed Resident #2 was sleeping in her bed with full length side rails up on both sides.

Interview with Resident #2 on 3/2/18 at 12:08pm revealed:
- She did not want the side rails to be up at night.
-She never asked to lower the rails at night.
-The facility told her the rails would be up at night.
-The facility told her if she needed to go to the bathroom she would have to call for help.
-She is unable to lower them herself due to shoulder pain.

Interview with the Medication Aide (MA) on 3/1/18 at 7:27am revealed:
-Resident #2 liked to get up and she was unsteady on her feet which was why staff put the side rails up on Resident #2's bed.
-Resident #2 would use the call bell to ask for staff assistance.
-Resident #2 had fallen prior to coming to the facility, but she had not fallen on any of the shifts the MA had worked.
-She could not say if Resident #2 had fallen on any other shifts.

Telephone interview with Resident #2's Power of Attorney (POA) on 3/5/18 at 9:02am revealed:
-Resident did not use side rails prior to coming to the facility.
-The Resident had a history of falls.
-The rails were used when she had lightheadedness only.

Telephone interview with Resident #2's, POA on 3/5/18 at 2:48pm revealed:
-He was aware of the use of side rails.

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C 453	Continued From page 52 -Resident #2 had a history of hallucinations and that he "probably was the one to suggest the use of bed rails". -She was unable to lower the rails due to her shoulder pain Interview with administrator on 2/28/18 at 4:25pm revealed: -She was aware that restraints needed a physician's order. -She did not know the facility staff put up the whole rail. -She was aware the facility staff put up half rails when Residents were in bed. Refer to interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am. Refer to interview with the Administrator on 3/2/18 at 5:20pm. Refer to review of the facility's February 2018 thirty minute check sheets. _____ Interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am revealed: -She had not observed side rails and/or seatbelts in use at the facility. -The facility's policy was not to use side rails and/or seatbelts without an order from the resident's PCP. -She thought the facility had wedges (triangular shaped foam wedges placed on the bed to prevent rolling out of bed), but she wasn't sure if any other alternatives were available to try. Interview with the Administrator on 3/2/18 at 5:20pm revealed: -She was upset about staff using full side rails. -Staff were expected to put side rails up only half	C 453		

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	FCL052006	A. BUILDING: _____ B. WING _____	03/06/2018

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C 453	Continued From page 53 way on each side for residents that needed assistance with turning and repositioning and/or getting out of bed. -She was aware that full side rails that could not be removed by the resident were a restraint. -The side rails were not meant to restrict residents and therefore no alternatives had been attempted and there was no care plan developed or order from the PCP. -It was the facility standard to complete a check on each resident every 30 minutes overnight. Review of the facility's February 2018 thirty minute check sheets revealed staff entered an "S" for sleeping or "A/B" for awake in bed for each resident every 30 minutes from 9:00pm until 6:30am.	C 453		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and medication aide training requirements. The findings are:	C 912		

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C 912	Continued From page 54 1. Based on observations, interviews and record reviews, the facility failed to assure medications prepared in advance were kept in an enclosed container that identified the name and strength of each medication, the resident's name and planned administration time for 5 of 5 residents and included high risk medications such as Xanax and Tramadol (controlled drugs); Haldol, Seroquel and Risperdal (antipsychotics); Xarelto (blood thinner); and Sorbitrate, Zestril, Hydralazine, Ranexa and Lopressor (cardiac and blood pressure lowering). [Refer to Tag 335 10A NCAC 13G .1004(f) Medication Administration (Type B Violation)] 2. Based on observations, interviews and record reviews, the facility failed to assure 3 of 3 sampled Medication Aides (Staff A, B and C) had completed the required 15 hours of training prior to administering medications to residents. [Refer to Tag 935 G.S. 131D-4.5(b) ACH Medication Aide Training & Competency Evaluation (Type B Violation)]	C 912		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the	C935		

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C935	Continued From page 55 Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 3 of 3 sampled Medication Aides (Staff A, B and C) had completed the required 15 hours of training prior to administering medications to residents. The findings are:	C935		

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C935	Continued From page 56 1. Review of Staff A's, Medication Aide (MA) employment record revealed: -Staff A's hire date was 3/15/17. -Staff A was validated for medication clinical skills on 10/16/17. -Staff A had passed the medication aide test on 10/9/17. -Staff A did not complete 5 and 10 or 15 hour required MA training. Review of Resident #1's February 2018 Medication Administration Record (MAR) revealed Staff A had initialed administering 8:00pm medications including Tramadol, Xanax and Paxil on 11 days from 2/5/18 through 2/25/18. Review of Resident #1's and Resident #4's March 2018 MAR revealed Staff A had initialed administering 8:00pm medications on 3/1/18. Review of Resident #4's February Medication Administration Record (MAR) revealed Staff A had initialed administering 8:00am and 8:00pm medications on 13 days from 2/1/18 through 2/25/18. Interview with Staff A, MA on 3/1 at 9:47 am revealed: -She was unsure what training she had received. -She said most trainings are done in house by a nurse. -She said she did not work with a nurse on a regular basis. -She was unaware of the 5/10/15 hour training. Refer to interview with the Administrator on 2/28/18 at 4:25pm. Refer to interview with the Administrator on 3/2/18	C935		

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C935	Continued From page 57 at 8:25am and 10:30am. Refer to telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm. Refer to review of the facility's undated policy on Medication Staff Training. 2. Review of Staff B's, Medication Aide (MA) employment record revealed: -Staff B was hired on 1/15/13 as a Personal Care Aide (PCA). -Staff B completed the required 5 hour training on 12/17/13. -Staff B was validated for clinical medication skills on 12/17/13. -There was a note in the comment section on the medication clinical skills form that Staff B had completed the 5 hour training and would need to complete the 10 hour required training. -Staff B passed the medication aide exam on 10/21/13. -Staff B did not have documentation for completing the remaining 10 hours of MA training within 60 days. Review of Resident #2's January 2018 Medication Administration Record (MAR) revealed Staff B had initialed 8:00am and 8:00pm medications as administered on 16 days from 1/1/18 through 1/30/18. Review of Resident #2's February 2018 MAR revealed Staff B had initialed 8:00am and 8:00pm medications as administered on 11 days from 2/2/18 through 2/27/18. Review of Resident #2's March 2018 MAR revealed Staff B had initialed 8:00am medications as administered on 3/1/18.	C935		

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C935	Continued From page 58 Interview with Staff B, MA on 3/2/18 at 10:20am revealed: -She had been working at the facility for five years. -She had completed her training for medication administration with the nurse from the pharmacy. -She could not remember the specifics of her training. Interview with the Administrator on 3/2/18 at 10:30am revealed she was not aware of the note on Staff B's medication clinical skills validation that the 10 hour required training would need to be completed. Refer to interview with the Administrator on 2/28/18 at 4:25pm. Refer to interview with the Administrator on 3/2/18 at 8:25am and 10:30am. Refer to telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm. Refer to review of the facility's undated policy on Medication Staff Training. 3. Review of Staff C's, Medication Aide (MA) employment record revealed: -Staff C was hired on 12/6/17 as a Personal Care Aide (PCA). -Staff C was validated for clinical medication skills on 1/23/18. -Staff C passed the medication aide exam on 2/22/18. -Staff C did not have documentation for completing the required 15 hours of MA training. Review of Resident #4's February 2018	C935		

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C935	Continued From page 59 Medication Administration Record (MAR) revealed Staff C had initialed 8:00am medications as administered on 2/27/18 and 2/28/18. Telephone interview with Staff C, MA on 3/1/18 at 12:16pm revealed: -She had worked at the facility since December 2017 as a caregiver and MA. -She had recently taken the medication aide test and was trained on the medication cart. -The facility's consultant nurse did her medication clinical skills validation and training. -The facility's consultant nurse had completed the 5 and 10 hour required training classes with her in January 2018, but she did not get a certificate yet because she had not yet returned to work from her days off (2/28/18 and 3/1/18). Refer to interview with the Administrator on 2/28/18 at 4:25pm. Refer to interview with the Administrator on 3/2/18 at 8:25am and 10:30am. Refer to telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm. Refer to review of the facility's undated policy on Medication Staff Training. _____ Interview with the Administrator on 2/28/18 at 4:25pm revealed: -She was responsible for assuring staff had completed required training and clinical skills validations for MAs. -She was not aware of the changes in training requirements effective 10/2/13. -The majority of the facility's MAs had been hired prior to 10/1/13. -She was going to contact the pharmacy to	C935		

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C935	Continued From page 60 arrange for training as soon as possible. A subsequent interview with the Administrator on 3/2/18 at 8:25am and 10:30am revealed: -She misunderstood about the MAs not administering medications until the required 15 hours of training was completed. -She thought the MAs were able to administer the medications once she completed the Plan of Protection and informed the MAs not to pre-pour medications. -That was why the MAs had administered medications on 3/1/18 and 3/2/18 instead of the facility nurse. -The consultant Registered Nurse (RN) had completed staff trainings and medication clinical skills validation. -The consultant RN was not associated with the pharmacy. Telephone interview with the consultant Registered Nurse (RN) on 3/5/18 at 3:32pm revealed: -She completed medication aide training with newly hired staff at the facility shortly after they started working at the facility. -She trained staff on the medication cart and made sure the MAs knew what medications to give and knew what they were doing on the medication cart. -She had become aware last week (3/2/18) that MAs at the facility needed to complete the 15 hour training. -She had not previously completed the 15 hour training with MAs at the facility. Review of the facility's undated policy on Medication Staff Training revealed only staff that had successfully completed the written medication exam and had been validated on the	C935		

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C935	Continued From page 61 medication administration checklist could give medications or treatments. Review of in-services completed by facility dated 3/5/18 revealed the required 15 hour training had been completed for all medication aides on 3/4/18 and 3/5/18. The facility's failure to assure three medication aides had completed the required 15 hours of medication aide training prior to administering medications to residents was detrimental to the health, safety and wellbeing of residents, which constitutes a Type B Violation. Review of the Plan of Protection submitted by the facility on 2/28/18 revealed: -The facility nurse (Licensed Practical Nurse) will administer all residents' medications until Medication Aides (MAs) have completed approved training according to state requirements. -The Administrator will contact the pharmacy provider/nurse regarding the scheduling of (15 hour training). -All newly hired MAs will receive the required training (prior to administering medications). THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2018.	C935		