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

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{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County DSS conducted a follow-up survey on March 7-8, 2018.	{D 000}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the primary care provider was notified regarding medications not administered as ordered for 4 of 7 residents related to a thyroid medication (Resident #1), an antidepressant (Resident #4), a blood thinner (Residents #5 and #6). The findings are: 1. Review of Resident #6's current FL 2 dated 2/26/18 revealed: -Diagnoses included dementia, coronary artery disease, diabetes mellitus type 2, hypertension and peripheral artery disease. -There was a physician's order for warfarin sodium 7.5 mg take 1 tablet daily (warfarin is a medication used to prevent blood clots in medical conditions such as atrial fibrillation, pulmonary embolism, and deep vein thrombosis). Review of Resident #6's physician's orders	D 273		

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D 273	Continued From page 1 revealed: -There was an order dated 12/19/17 for warfarin sodium 7.5 mg daily. -There was an order dated 2/7/18 for warfarin sodium 5 mg on Wednesdays and warfarin sodium 7.5 mg the other 6 days. -There was an order dated 2/13/18 to increase warfarin sodium dose back to 7.5 mg daily. -There was an order dated 2/27/18 to administer warfarin sodium 10 mg today, then begin 7.5 mg daily. Review of Resident #6's Medication Administration Record (MAR) for January 2018 revealed: -There was a computer generated entry for warfarin sodium 7.5 mg 1 tablet daily to be administered at 6:00 pm. -There was written documentation of staff initials circled, indicating warfarin sodium 7.5 mg was not administered on 1/2/18 and 1/3/18. -On the back of the MAR, there was written documentation for 1/2/18 warfarin sodium 7.5 mg was not given due to "not in stock/pharmacy faxed." -On the back of the MAR, there was written documentation for 1/3/18 warfarin sodium 7.5 mg was not given due to "awaiting pharmacy delivery." -Resident #6 was not administered warfarin sodium 7.5 mg for two doses. Review of Resident #6's MAR for February 2018 revealed: -There was a computer generated entry for warfarin sodium 7.5 mg 1 tablet daily to be administered at 6:00 pm. -There was a handwritten entry for warfarin sodium 5 mg 1 tablet daily on Wednesdays dated 2/07/18.	D 273		

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-There was a handwritten entry for warfarin sodium 10 mg today dated 2/27/18.
-There was a second handwritten entry for warfarin sodium 7.5 mg daily dated 2/27/18.
-There was no documentation warfarin sodium had been administered on 2/7 or 2/26/18.

Review of "Resident's Notes" for Resident #6 revealed:
-There was no documentation the medical provider was notified in regards to Resident #6 warfarin sodium on 1/2/18 and 1/3/18.
-There was no documentation the medical provider was notified in regards to Resident #6 not receiving warfarin sodium on 2/7 and 2/26/18.
-There was no documentation the medical provider was notified in regards to Resident #6 receiving 2 doses of warfarin sodium on 2/22/18.

Telephone interview on 3/8/18 with the Registered Nurse (RN) at Resident #6's cardiac clinic at 4:01 pm revealed:
-She was responsible for monitoring Resident #6's international normalized ratio [(INR), a blood test used to monitor how well the blood-thinning medication warfarin sodium was working to prevent blood clots] and making adjustments to his dose of warfarin sodium based on this test result.
-She did not know warfarin sodium 7.5 mg was not administered to Resident #6 on 1/2/18 and 1/3/18.
-She did not know warfarin sodium was not documented as being administered to Resident #6 on 2/7 and 2/26/18.
-She did not know warfarin sodium 5 mg and warfarin sodium 7.5 mg both were documented as being administered to Resident #6 on 2/22/18.
-She expected the facility to notify her if a resident missed 1 dose of warfarin sodium, or if they

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received an incorrect dose so she could elect to have another INR drawn and possibly adjust the dose.
-Resident #6 was on warfarin sodium for stroke prevention due to a diagnosis of atrial fibrillation (an irregular and often rapid heart rhythm).
-Not receiving the ordered doses of warfarin sodium could cause Resident #6 to form a blood clot which could lead to a heart attack, stroke or pulmonary embolism.

Interview on 3/8/18 with the Special Care Unit (SCU) Director at 5:20 pm revealed:
-Even though there was no official policy in place, common practice was for medication aides (MA) to notify the medical provider when a resident missed 3 consecutive doses of a medication or the first time a resident received an incorrect dose.
-Contact with the medical provider would be documented in the "Resident's Notes" section of the medical record.

Interview on 3/8/18 with the SCU Resident Care Coordinator (RCC) at 5:29 pm revealed:
-MAs should notify her if a resident missed a dose of medication or received an incorrect dose so she could notify the medical provider.
-Night shift MAs were responsible for performing audits of the MARs.
-Once complete, they gave a copy to her.
-If errors or "holes" were found in the MARs, the MAs were to leave a note for her and the LPN so they could address them.
-She was unaware Resident #6 had not received warfarin sodium on 1/2/18 and 1/3/18, had "holes" in his MAR on 2/7 and 2/26/18 for warfarin sodium administration and was unaware there were 2 doses documented as administered on 2/22/18.

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D 273	Continued From page 4 Interview on 3/8/18 with the Administrator at 5:05 pm revealed she expected the MAs to notify the medical provider with any issues related to a resident receiving their medications. 2. Review of Resident #1's current FL 2 dated 12/12/17 revealed: -Diagnoses included dementia, cognitive dysfunction, and hypothyroidism. -There was a physician's order for levothyroxine sodium 50mcg 1 tablet daily. Review of Resident #1's MAR for February 2018 revealed: -There was a computer generated entry for levothyroxine sodium 50 mcg 1 tablet daily to be administered at 7:00 am. -There was handwritten documentation of staff initials circled indicating levothyroxine sodium 50 mcg was not administered on 2/23, 2/24, 2/25, 2/26, 2/27, and 2/28/18. -On the back of the MAR, there was written documentation on 2/23/18 indicating "will notify family." -On the back of the MAR, there was written documentation on 2/24/18 indicating "will notify family again." -On the back of the MAR, there was written documentation on 2/25/18 indicating "levothyroxine unavailable." -There was no documentation indicating why levothyroxine sodium 50 mcg was not administered on 2/26, 2/27 and 2/28/18. -Resident #1 was not administered 6 doses of levothyroxine sodium 50 mcg. Review of Resident #1's "Resident's Notes," revealed: -There was no documentation the physician had	D 273		

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been contacted regarding the missed doses of levothyroxine sodium.
-There was documentation dated 3/8/18 that staff had not notified the physician until that day Resident #1 had missed doses of levothyroxine sodium 50 mcg, signed by the RCC.
-The physician ordered for Resident #1 to have labs drawn next lab draw to check "levels" and then he would advise them on what to do.

Interview on 3/7/18 with the Assisted Living Resident Care Coordinator (AL-RCC) at 1:46 pm revealed Resident #1 was not administered her levothyroxine sodium from 2/23 to 2/28/18 because it had fallen behind the drawers of the medication cart and was "lost."

A second interview with the AL-RCC on 3/8/18 at 10:27 am revealed:
-On 2/28/18, a MA notified her that Resident #1 had not received her levothyroxine sodium for 6 days and the pharmacy would not refill it because it was not due to be refilled.
-"I tore the cart apart until I found it (the levothyroxine sodium 50 mg)."
-She did not notify the physician Resident #1 had missed 6 doses of levothyroxine sodium because "it was the responsibility of the MA to do so."
-If a physician was notified, it would be documented on a "physician notification form" and placed in the resident's medical record in the physician's order section, or it would be documented on the "Resident's Notes" form in the medical record.

Interview on 3/8/18 with a first shift MA at 1:47 pm revealed:
-She had been employed as a MA at this facility for 1 year.
-She was aware Resident #1 was not

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administered her levothyroxine sodium 50 mcg, but did not why.
-She was the MA who administered medications to Resident #1 on 2/26, 2/27, and 2/28/18.
-She was trained to notify the physician via fax if a resident missed 3 consecutive doses of medication.
-She had not notified Resident #1's physician in regards to her missing 6 doses of levothyroxine sodium because she "assumed someone else had done so."

Interview on 3/8/18 with a second shift MA at 4:45 pm revealed:
-She always worked the second shift.
-She was unsure if there was a policy for when the physician should be notified in regards to missed medications.

Attempted telephone interview on 3/8/18 with Resident #1's Primary Care Physician at 1:35 pm was unsuccessful.

Refer to interview on 3/8/18 with the Administrator at 5:05 pm.

3. Review of Resident #4's current FL 2 dated 10/26/17 revealed:
-Diagnoses included cerebral infarction, stenosis of cerebral artery, cerebral artery occlusion, and other symbolic dysfunction.
-A physician's order for citalopram hydrobromide 20 mg (a medication used to treat depression) take 1 tablet daily.

Review of the medications on hand for Resident #4 on 3/7/18 at 2:00 pm revealed citalopram hydrobromide 20 mg was unavailable.

Review of medication refill book on 3/7/18 that

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contained fax communication with contracted pharmacy revealed:
-There was a fax request sent requesting a refill for citalopram hydrobromide on 3/2/18.
-There was a fax message received from contracted pharmacy representative indicating citalopram hydrobromide was discontinued on 2/8/18.
-There was a fax request sent requesting a refill for citalopram hydrobromide on 3/5/18.

Interview on 3/7/18 with a 1st shift medication aide (MA), at 2:00 pm revealed:
-She knew Resident #4 was out of citalopram hydrobromide and had sent a refill request via fax on 3/5/17.
-She was waiting on a refill to come back from the pharmacy, but it had not come in yet.
-She had not notified the Resident Service Director (RSD), the Assisted Living Resident Care Coordinator (AL-RCC), or the physician because she thought the medication would come in.

Review of Resident #4's January 2018 medication administration record (MAR) revealed an entry dated 10/31/17 for citalopram hydrobromide 20 mg 1 tablet daily at 8:00 am documented as administered from 1/1/18-1/31/18.

Review of Resident #4's February 2018 MAR revealed an entry dated 1/23/18 for citalopram hydrobromide 20 mg 1 tablet daily at 8:00 am documented as administered from 2/1/18-2/28/18.

Review of Resident #4's March 2018 MAR revealed:
-An entry dated 1/23/18 for citalopram hydrobromide 1 tablet daily at 8:00 am

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documented as administered 3/1/18-3/2/18 and documented as unavailable 3/3/18-3/7/18.
-Resident #4 missed 4 doses of citalopram hydrobromide from 3/3/18-3/7/18.

Telephone interview on 3/8/18 with the primary care physician at 1:36 pm revealed:
-She did not know Resident #4 had missed 4 doses of citalopram hydrobromide.
-She expected Resident #4 to receive medication as ordered and to be notified if doses were missed.
-She prescribed citalopram hydrobromide for depression and symptoms of anxiety.
-If Resident #4 went more than a few days without medication she could become more depressed and agitated.

Interview on 3/8/18 with the AL-RCC at 8:00 am revealed:
-She did not know Resident #4 missed 4 doses of citalopram hydrobromide.
-MAs were responsible for notifying the physician if a medication is missed.
-She had not notified the doctor that Resident #4 missed 4 doses of citalopram hydrobromide.

Interview on 3/7/18 with the Resident Service Director (RSD) at 4:45 pm revealed:
-No one noticed that the citalopram hydrobromide was discontinued by the pharmacy.
-She did not know Resident #4 missed 4 doses of citalopram hydrobromide and had not notified the doctor.

Interview on 3/8/18 with the Administrator at 1:05 pm revealed:
-She did not know Resident #4 had been without citalopram hydrobromide.
-There was no policy primary care physician

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notification regarding medication administration.

4. Review of Resident #5's current FL 2 dated 2/19/18 revealed:
-Diagnoses included thrombocytopenia, congestive heart failure, chronic anticoagulation, and atrial fibrillation.
-A physician's order for warfarin 4 mg (warfarin is a medication used to prevent blood clots in medical conditions such as atrial fibrillation, pulmonary embolism, and deep vein thrombosis) take 1 tablet daily.

Review of Resident #5's record revealed:
-There were lab results dated 2/26/18 which revealed an INR of 3.1(INR stands for international normalized ratio and is a measure of the effectiveness of warfarin to prevent blood clots. Depending on the condition being treated, a desired INR range would be 2.0 to 3.0.)
-A subsequent physician order dated 2/28/18 revealed and order for warfarin 3.5 mg 1 tablet daily.
-There were lab results dated 3/5/18 which revealed an INR of 1.22.

Review of Resident #5's February 2018 MAR revealed warfarin 3.5 mg documented as not administered on 2/28/18 due to being unavailable.

Review of Resident #5's March 2018 MAR revealed warfarin 3.5 mg documented as not administered on 3/1/18 due to being unavailable.

Review of Resident #5's record revealed there was no documentation that the physician had been contacted regarding missed doses of warfarin 3.5 mg for 2/28/18-3/1/18.

Interview on 3/8/18 with a 2nd shift medication

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aide (MA), at 4:43 pm revealed:
-After 2 days she would notify the doctor that the resident had not received a medication and document in the "Resident's Notes".
-She had not notified the physician that Resident #5 had not received warfarin 3.5 mg on 2/28/8-3/1/18.

Telephone interview on 3/8/18 with the primary care physician at 1:36 pm revealed:
-She expected Resident #5 to receive medication as ordered.
-She requested Resident #5's warfarin to be lowered because his INR ranged higher than she liked at 3.1.
-She did not know resident had not received warfarin for 2 days and that would explain why his INR dropped to 1.22 on 3/5/18, which was not therapeutic.
-When Resident #5 does not receive warfarin, his blood begins to thicken and he would be at risk for a stroke.
-She expected the facility to notify her via fax or in writing if medication was not administered and she would have ordered further labs or medication instruction.

Interview on 3/8/18 with the AL-RCC at 8:00 am revealed:
-She did not know Resident #5 did not receive two doses of warfarin on 2/28/18 and 3/1/18.
-She expected MAs to notify physician via fax or telephone call if medication was not administered as ordered.

Interview on 3/7/18 with the RSD at 4:45 pm revealed:
-She did not know Resident #5 had not received 2 doses of warfarin as ordered by physician on 2/28/18 and 3/1/18.

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D 273	Continued From page 11 -Any communication with the physician should be documented in the "Resident's Notes" in the record. Interview on 3/8/18 with the Administrator at 1:05 pm revealed: -She did not know Resident #5 had not received warfarin as ordered by the physician on 2/28/18 and 3/1/18. -There was no policy primary care physician notification regarding medication administration. Interview on 3/8/18 with the Administrator at 5:05 pm revealed she expected the MAs to notify the medical provider with any issues related to a resident receiving their medications. The facilities failure to assure the primary care provider was notified regarding medications not being administered as ordered for 4 of 7 residents related to a thyroid medication (Resident #1), an antidepressant (Resident #4), a blood thinner (Residents #5 and #6), missing medications. These failures to notify the primary care provider was detrimental to the health and safety and welfare of the residents and harm constitutes a Type B Violation. The Plan of Protection provided by the facility on 3/8/18 revealed: -Inservice's were conducted today and throughout the next 5 days for all MAs to re-educate them on the requirements to notify the physician if the medications were missed or given in error. -The MAs were also being re-educated and introduced to the new "Unavailable Medications" tool that has been implemented today. -This tool requires the 3rd shift MAs to audit 3 times a week for adequate medication inventory. -The RSD, RCCs, SCU Director, WN and the	D 273		

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D 273	Continued From page 12 Administrator will monitor and review the "Unavailable Medications" tool every Tuesday and Thursday to assure compliance and proper follow up. -Disciplinary actions will be implemented as appropriate. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 22, 2018.	D 273		
{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: FOLLOW UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a physician for 5 of 7 sampled residents related to a thyroid medication (Resident #1), an antidepressant and an allergy medication (Resident #4), a blood thinner (Residents #5 and #6), and a fast acting	{D 358}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNITY	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

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{D 358}	Continued From page 13 insulin (Resident #3). The findings are: 1. Review of Resident #6's current FL 2 dated 2/26/18 revealed: -Diagnoses included dementia, coronary artery disease, diabetes mellitus type 2, hypertension and peripheral artery disease. -There was a physician's order for warfarin sodium 7.5 mg take 1 tablet daily (warfarin is a medication used to prevent blood clots in medical conditions such as atrial fibrillation, pulmonary embolism, and deep vein thrombosis). Review of Resident #6's physician's orders revealed: -There was an order dated 12/19/17 for warfarin sodium 7.5 mg daily. -There was an order dated 2/7/18 for warfarin sodium 5 mg on Wednesdays and warfarin sodium 7.5 mg the other 6 days. -There was an order dated 2/13/18 to increase warfarin sodium dose back to 7.5 mg daily. -There was an order dated 2/27/18 for warfarin sodium 10 mg today, then begin 7.5 mg daily. Review of Resident #6's Medication Administration Record (MAR) for January 2018 revealed: -There was a computer generated entry for warfarin sodium 7.5 mg 1 tablet daily to be administered at 6:00 pm. -There was written documentation of staff initials circled, indicating warfarin sodium 7.5 mg was not administered on 1/2/18 and 1/3/18. -On the back of the MAR, there was written documentation for 1/2/18 warfarin sodium 7.5 mg was not given due to "not in stock/pharmacy faxed."	{D 358}		

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{D 358}	Continued From page 14 -On the back of the MAR, there was written documentation for 1/3/18 warfarin sodium 7.5 mg was not given due to "awaiting pharmacy delivery." Review of Resident #6's MAR for February 2018 revealed: -There was a computer generated entry for warfarin sodium 7.5 mg 1 tablet daily to be administered at 6:00 pm. -There was a handwritten entry for warfarin sodium 5 mg 1 tablet daily on Wednesdays dated 2/7/18. -There was a handwritten entry for warfarin sodium 10 mg today dated 2/27/18. -There was a second handwritten entry for warfarin sodium 7.5 mg daily dated 2/27/18. -There was no documentation any dose of warfarin sodium had been administered on 2/7 or 2/26/18. -There was documentation warfarin sodium 5mg was administered on 2/14 and 2/21/18 rather than the ordered 7.5 mg. -There was documentation both the 5mg dose of warfarin sodium and the 7.5 mg dose of warfarin sodium was administered on 2/22/18. Observation of Resident #6's medications available for administration on 3/8/18 at 11:38 am revealed there was 1 bubble pack containing warfarin sodium 7.5 mg to be administered 1 tablet daily, dispensed on 2/24/18 with 25 out of 30 doses remaining. Telephone interview on 3/8/18 with a representative from the pharmacy at 4:35 pm revealed: -If the facility ordered medications by 5:00 pm, they would be delivered the same day. -They had dispensed 30 tablets of warfarin	{D 358}		

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{D 358}	Continued From page 15	{D 358}		

sodium 7.5 mg for Resident #6 on 2/26/18, 1/29/18, 1/3/18, and 11/5/17.
-They had no record of the facility contacting them to request a refill in December 2017.

Telephone interview on 3/8/18 with the Registered Nurse (RN) at Resident #6's cardiac clinic at 4:01 pm revealed:
-She was responsible for monitoring Resident #6's international normalized ratio [(INR), a blood test used to monitor how well the blood-thinning medication warfarin sodium was working to prevent blood clots] and making adjustments to his dose of warfarin sodium based on this test result.
-She had contacted the facility on 2/27/18 because Resident #6's INR was 1.2, "low despite having increased his dose of warfarin sodium back to 7.5 mg daily on 2/13/18."
-She was told by the facility during her contact with them on 2/27/18, they never received the order to increase his dose so they had continued to give Resident #6 only 5 mg of warfarin sodium on Wednesdays (2/14 and 2/21/18) as previously ordered.
-She was unsure why the facility did not receive the order because she "had received a fax confirmation when she sent the order."
-She then gave them a new order to administer a 10 mg dose of warfarin sodium for that day and then resume 7.5 mg daily thereafter.
-Her goal was "to keep Resident #6's INR level above 2.0."
-She was unaware warfarin sodium 7.5 mg was not administered to Resident #6 on 1/2/18 and 1/3/18.
-She was unaware warfarin sodium was not documented as being administered to Resident #6 on 2/7 and 2/26/18.
-She was unaware warfarin sodium 5 mg and

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{D 358}	Continued From page 16 warfarin sodium 7.5 mg both were documented as being administered to Resident #6 on 2/22/18. -Resident #6 was on warfarin sodium for stroke prevention due to a diagnosis of atrial fibrillation (an irregular and often rapid heart rhythm). -Not receiving the ordered doses of warfarin sodium could cause Resident #6 to form a blood clot which could lead to a heart attack, stroke or pulmonary embolism. Interview on 3/8/18 with the Special Care Unit (SCU) Director at 5:20 pm revealed: -The SCU Resident Care Coordinator (RCC) and the SCU Licensed Practical Nurse (LPN) were responsible for processing physician's orders when received by the facility and transcribing those to the MARs. -If the SCU-RCC nor the SCU-LPN were there when a physician's order was received, the MAs could also process the order and transcribe it to the MAR. -The MAs were instructed to contact the pharmacy immediately if a medication were not available for administration, but should order the medication prior to the last dose being given. -If there was a problem with obtaining the medication, the MAs were responsible for contacting a "back-up" pharmacy to get the medication in as soon as possible. -MAs were responsible for initialing the MAR when medications were administered. -He, the SCU-RCC and the SCU-LPN were performing weekly audits of the MARs to check for accuracy. -They must have "missed" seeing that warfarin sodium was not documented as being administered for Resident #6 on 2/7 and 2/26/18 and he had 2 doses documented as administered on 2/22/18.	{D 358}		

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{D 358}	Continued From page 17 Interview on 3/8/18 with the SCU-RCC at 5:29 pm revealed: -MAs had been instructed to contact the pharmacy to reorder a medication when there were 7 doses left to prevent a resident from running out of medication. -She, the MAs or the SCU-LPN could process physician orders when received and transcribe them to the MAR. -She did not know how Resident #6's warfarin sodium order for increasing back to 7.5 mg daily had gotten misplaced and resulted in him receiving 5 mg instead of the 7.5 mg on 2/14 and 2/21/18. -Night shift MAs were responsible for performing audits of the MARs. -Once complete, they gave a copy to her. -If "holes" were found on the MARs, the MAs were to leave a note for her and the LPN so they could address them. -She was unaware Resident #6 had "holes" in his MAR on 2/7 and 2/26/18 for warfarin sodium administration and was unaware there were 2 doses documented as administered on 2/22/18. Refer to interview on 3/8/18 with the Administrator at 5:05 pm. 2. Review of Resident #1's current FL 2 dated 12/12/17 revealed: -Diagnoses included dementia, cognitive dysfunction, and hypothyroidism. -There was a physician's order for levothyroxine sodium 50mcg 1 tablet daily (a medication used to treat hypothyroidism). Review of Resident #1's MAR for February 2018 revealed: -There was a computer generated entry for levothyroxine sodium 50 mcg 1 tablet daily to be	{D 358}		

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{D 358}	Continued From page 18	{D 358}		

administered at 7:00 am.
-There was handwritten documentation of staff initials circled indicating levothyroxine sodium 50 mcg was not administered on 2/23, 2/24, 2/25, 2/26, 2/27, and 2/28/18.
-On the back of the MAR, there was written documentation on 2/23/18 indicating "will notify family."
-On the back of the MAR, there was written documentation on 2/24/18 indicating "will notify family again."
-On the back of the MAR, there was written documentation on 2/25/18 indicating "levothyroxine unavailable."
-There was no documentation indicating why levothyroxine sodium 50 mcg was not administered on 2/26, 2/27 and 2/28/18.
-Resident #6 missed 6 doses of levothyroxine sodium 50 mcg.

Review of Resident #1's Record, including the "Resident's Notes," revealed there was no documentation the family had been contacted regarding the levothyroxine sodium.

Observation of Resident #1's medications available for administration on 3/8/18 at 4:45 pm revealed there was 1 bubble pack containing levothyroxine sodium 50 mcg to be administered 1 tablet daily, dispensed on 3/1/18 with 23 out of 30 doses remaining.

Telephone interview on 3/7/18 with Resident #1's family member at 3:46 pm revealed he did not recall being contacted by the facility about Resident #1's levothyroxine sodium being unavailable to administer.

Interview on 3/8/18 with a first shift medication aide (MA) at 1:47 pm revealed:

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{D 358}	Continued From page 19 -She had been employed as a MA at this facility for 1 year. -She was aware Resident #1 was not administered her levothyroxine sodium 50 mcg, but did not why. -She had been taught to order a resident's medication when there were 7 doses remaining. -If she realized there was a medication unavailable for administering, she was to contact the pharmacy or check the "order sheet" to ensure the medication had been ordered and notify the Assisted Living Resident Care Coordinator (AL-RCC). -After 3 days, if no medication was available, she was to contact the pharmacy again to follow up. -Any contacts made with the pharmacy would be documented in the resident's medical record. -She was the MA who administered medications to Resident #1 on 2/26, 2/27, and 2/28/18. -She had not contacted the pharmacy or notified the AL-RCC regarding Resident #1's levothyroxine sodium being unavailable for 6 days because she "assumed someone else had done so." -She did not check the "order sheet" or the resident's medical record to see if someone else had done so. Interview on 3/8/18 with a second shift MA at 4:45 pm revealed: -She always worked the second shift. -She had not noticed the levothyroxine sodium was missing off the cart as she never administered morning medications to Resident #1. -If a medication was not on the cart to be administered, she would check the "overstock" and if it was not there she would request a refill. -If the pharmacy was unable to refill the medication, she would notify the AL-RCC and the	{D 358}		

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{D 358}	Continued From page 20 Resident Services Director (RSD). Interview on 3/7/18 with the Assisted Living Resident Care Coordinator (AL-RCC) at 1:46 pm revealed Resident #1 was not administered her levothyroxine sodium from 2/23 to 2/28/18 because it had fallen behind the drawers of the medication cart and was "lost." A second interview with the AL-RCC on 3/8/18 at 10:27 am revealed: -On 2/28/18, a MA notified her that the Resident #1 had not received her levothyroxine sodium for 6 days and the pharmacy would not refill it because it was not due to be refilled. -"I tore the cart apart until I found it (the levothyroxine sodium 50 mg)." -Any contact with the family should be documented in the "Resident's Notes" section of the medical record. -She and the night shift MA were responsible for auditing the MARs and the medication cart each week to ensure medications were being administered as ordered. -She had completed the last audit for Resident #1 on 2/23/18. -She did not notice Resident #1's levothyroxine sodium was not on the medication cart and that it had not been administered on 2/23/18 because she "was more focused on auditing for correct insulin dosing." Telephone interview on 3/8/18 with a pharmacist at the facility's contracted pharmacy at 4:26 pm revealed: -They dispensed medications for the facility's residents when ordered by the facility. -If the facility ordered medications by 1:00 pm, they would be delivered the same day. -They had dispensed 30 tablets of levothyroxine	{D 358}		

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{D 358}	Continued From page 21	{D 358}		

sodium 50 mcg for Resident #1 on 3/1/18, 1/3/18 and 12/14/17.
-They had no record of the facility contacting them to request a refill in February 2018.

Attempted telephone interview on 3/8/18 with Resident #1's primary care physician (PCP) at 1:35 pm was unsuccessful.

Review of Resident #1's "Resident's Notes" revealed:
-There was documentation dated 3/5/18 that staff had not notified the physician until that day Resident #1 had missed doses of levothyroxine sodium 50 mcg, signed by the RCC.
-The physician ordered for Resident #1 to have labs drawn next lab draw to check "levels" and then he would advise them on what to do.

Refer to interview on 3/8/18 with the Administrator at 5:05 pm.

3. Review of Resident #3's current FL 2 dated 2/13/18 revealed:
-Diagnoses included dementia, diabetes mellitus type 1, hypertension and acute kidney failure.
-An order to check finger stick blood sugar (FSBS) before meals, 2:30 pm and at bedtime.
-An order for Novolog (a fast acting insulin used to decrease elevated blood sugars) to be given at 6:30 am, 11:30 am, 2:30 pm, 4:30 pm and 9:00 pm every day and according the sliding scale (SSI) as follows:
Blood sugar range between 61-150 give 0 units.
Blood sugar range between 151-200 give 1 units.
Blood sugar range between 201-250 give 2 units.
Blood sugar range between 251-300 give 3 units.
Blood sugar range between 301-350 give 4 units.
Blood sugar range between 351-400 give 5 units.
Blood sugar range between 401-450 give 6 units.

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{D 358}	Continued From page 22 Blood sugar range between 451-500 give 7 units. Blood sugar range between 500-600 give 8 units and notify the physician. Recheck the FSBS in 1 hour, if FSBS is greater than 600 give 8 units, if less than 600 give SSI coverage. Recheck the FSBS in 1 hour and FSBS is greater than 600 send to the emergency room and notify the physician. If the FSBS is less than 600, notify the physician. If the FSBS is less than 60, follow the hypoglycemia protocol. -An order for Novolog 5 units before lunch. -An order for Novolog 5 units before supper. -An order for Novolog 3 units before bedtime. Review of a physician's order dated 1/10/18 revealed an order for Novolog 5 units to be administered before breakfast. Review of a subsequent order dated 1/12/18 to hold the Novolog 5 units before breakfast. Review of Resident #3's January 2018 Medication Administration Record (MAR) revealed: -A hold for the Novolog 5 units before breakfast was transcribed on the MAR. -The Novolog was not documented as administered at 8:00 am daily 1/10/18 to 1/31/18. -Check FSBS before each meal was transcribed onto the MAR and documented as administered daily at 6:30 am, 11:30 am, 2:30 pm, 4:30 pm and 9:00 pm. -Insulin per SSI was not documented as administered correctly for 4 out of 155 doses documented. Examples are as follows: -On 1/17/18 at 11:30 am, blood sugar result was 342 and 14 units of Novolog was documented as administered. Resident #3 should have been administered 4 units.	{D 358}		

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{D 358}	Continued From page 23 -On 1/25/18 at 11:30 am, blood sugar result was 350 and 5 units of Novolog was documented as administered. Resident #3 should have been administered 4 units. -On 1/8/18 at 2:30 pm, blood sugar result was 267 and 0 units of Novolog was documented as administered. Resident #3 should have been administered 3 units. -On 1/21/18 at 9:00 pm, blood sugar result was 323 and 3 units of Novolog was documented as administered. Resident #3 should have been administered 4 units. Review of Resident #3's February 2018 Medication Administration Record (MAR) revealed: -A hold for the Novolog 5 units before breakfast was transcribed on the MAR. -The Novolog was not documented as administered at 8:00 am daily 1/10/18 to 1/31/18. -Check FSBS before each meal was transcribed onto the MAR and documented as administered daily at 6:30 am, 11:30 am, 2:30 pm, 4:30 pm and 9:00 pm. -Insulin per SSI was not documented as administered correctly for 11 out of 140 doses documented. Examples are as follows: -On 2/8/18 at 11:30 am, blood sugar result was 458 and 6 units of Novolog was documented as administered. Resident #3 should have been administered 7 units. -On 2/12/18 at 6:30 am, blood sugar result was "HI" and 0 units of Novolog was documented as administered. Resident #3 should have been administered 8 units. -On 2/11/18 at 4:30 pm, blood sugar result was 174 and 6 units of Novolog was documented as administered. Resident #3 should have been administered 1 unit. -On 2/13/18 at 11:30 am, blood sugar result was	{D 358}		

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{D 358}	Continued From page 24 336 and 9 units of Novolog was documented as administered. Resident #3 should have been administered 4 units. -On 2/17/18 at 11:30 am, blood sugar result was 500 and 7 units of Novolog was documented as administered. Resident #3 should have been administered 8 units. -On 2/19/18 at 6:30 am, blood sugar result was 318 and 3 units of Novolog was documented as administered. Resident #3 should have been administered 4 units. -On 2/25/18 at 11:30 am, blood sugar result was 297 and 8 units of Novolog was documented as administered. Resident #3 should have been administered 3 units. -On 2/26/18 at 11:30 am, blood sugar result was 351 and 10 units of Novolog was documented as administered. Resident #3 should have been administered 5 units. -On 2/27/18 at 11:30 am, blood sugar result was 216 and 6 units of Novolog was documented as administered. Resident #3 should have been administered 2 units. -On 2/21/18 at 9:00 pm, blood sugar result was 239 and 4 units of Novolog was documented as administered. Resident #3 should have been administered 2 units. -On 2/22/18 at 9:00 pm, blood sugar result was 239 and 4 units of Novolog was documented as administered. Resident #3 should have been administered 2 units. Review of Resident #3's March 2018 Medication Administration Record (MAR) revealed: -A hold for the Novolog 5 units before breakfast was transcribed on the MAR. -The Novolog was documented as administered at 8:00 am daily 3/1/18 to 3/7/18. -Check FSBS before each meal was transcribed onto the MAR and documented as administered	{D 358}		

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daily at 6:30 am, 11:30 am, 2:30 pm, 4:30 pm and 9:00 pm.
-Insulin per SSI was not documented as administered correctly for 7 out of 31 doses documented. Examples are as follows:
-On 3/1/18 at 11:30 am, blood sugar result was 278 and 8 units of Novolog was documented as administered. Resident #3 should have been administered 3 units.
-On 3/2/18 at 11:30 am, blood sugar result was 333 and 9 units of Novolog was documented as administered. Resident #3 should have been administered 4 units.
-On 3/3/18 at 11:30 am, blood sugar result was 285 and 9 units of Novolog was documented as administered. Resident #3 should have been administered 3 units.
-On 3/4/18 at 11:30 am, blood sugar result was 237 and 7 units of Novolog was documented as administered. Resident #3 should have been administered 2 units.
-On 3/4/18 at 4:30 pm, blood sugar result was 267 and 7 units of Novolog was documented as administered. Resident #3 should have been administered 3 units.
-On 3/6/18 at 2:30 pm, blood sugar result was 151 and units administered of Novolog was documented as blank. Resident #3 should have been administered 1 unit.
-On 3/7/18 at 6:30 am, blood sugar result was 353 and 4 units of Novolog was documented as administered. Resident #3 should have been administered 5 units.

Telephone interview on 3/8/18 with Resident #3's primary care physician at 12:50 pm revealed:
-Resident #3 was last seen in the office on 3/5/18.
-Resident #3 had been having fluctuations in her FSBS with many low blood sugars in the morning

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at 6:30 am.
-The order to hold the Novolog 5 units before breakfast was on hold because of the reported FSBS below 60.
-He did not want the insulin to be administered at 8:00 am until the Endocrinologist was consulted because of the FSBS were too unstable.
-Receiving the Novolog at 8:00 am could result in the FSBS continuing to drop below 60 if the 6:30 am FSBS was below 60.
-He was not notified the Novolog was restarted by the facility.
-He was not aware the SSI was given incorrectly.
-It was his expectation the facility followed the hold order until he restarted it again and follow all orders as written.

Interview on 3/8/18 with a medication aide (MA) at 8:52 am revealed:
-She was a SCU MA on first shift.
-She gave sliding scale insulin (SSI) and the 11:30 am dose of Novolog to Resident #3.
-She did not give Novolog 5 units at 8:00 am to Resident #3.
-She did know the Novolog 5 units at 8:00 am was on hold and did not know an order was written to restart the Novolog 5 units at 8 am.
-She documented the amount of SSI insulin given at 11:30 am, and 2:30 pm on the SSI form attached to the MAR.
-She also document the amount of Novolog 5 units administered at 11:30 am on the MAR.
-Resident #3 had issues with maintaining her FSBS.
-Resident #3's husband lives here as well and gives her juice and snacks.
-Because of Resident #3's FSBS being so erratic, Resident #3 required a higher level of care and was in the process of being transferred.
-A reading of "HI" on the glucometer meant the

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{D 358}	Continued From page 27 FSBS was greater than 600. Interview on 3/8/18 with a second MA at 9:15 am revealed: -She worked as a SCU MA on first shift. -She gave Resident #3 Novolog 5 units at 8:00 am a few times in March but did not give any in January or February. -She documented the amount of SSI insulin given at 11:30 am, and 2:30 pm on the SSI form attached to the MAR. -She also document the amount of Novolog 5 units administered at 11:30 am on the MAR. -She did not known why the Novolog 5 units at 8:00 am was on hold. -She did not ask any one at the facility or call the physician for clarification. -She saw previous initials in the administered box so she administered the medication without checking first. -If an order comes in she can fax it to the pharmacy and hand write it on the MAR. -The SCU Director and the SCU-RCC were responsible for checking all MARs weekly for accuracy, holes, or refusals. -The RCD gave the MAs several in-services related to SSI, orders and clarifications and documentation of the orders. -"We were scheduled to have another in-service today on the same thing today (3/8/18)". Interview on 3/8/18 with the Special Care Unit (SCU) Director at 9:20 am revealed: -The MAs were to call the physician for clarifications. -He did not know the Novolog for Resident #3 was restarted without an order from the physician. -There was no order from the physician to restart the Novolog for Resident #3.	{D 358}		

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{D 358}	Continued From page 28 -He was not aware the SSI was administered incorrectly according to the documentation on the MARs. -When a new order was received from the physician, the MA would fax the order to the pharmacy, and the MA would handwrite the new order on the MAR. -The MAR was to be checked by himself and the SCU Resident Care Coordinator (RCC) would check all MARs and orders weekly for holes, clarification, refusals and errors. -The physician would have been notified if the Novolog was given not as ordered. Interview on 3/8/18 with the Wellness Nurse (WN) at 9:20 am revealed: -She was a Licensed Practical Nurse (LPN). -The MAs were to call the physician for clarifications. -She did not know the Novolog was being administered without an order to restart it. -She was not aware the SSI was administered incorrectly according to the documentation on the MARs. -The MARs were checked by the SCU Director and the SCU-RCC for holes, clarification, refusals and errors. -The physician would have been notified if a medication was given not as ordered. Interview on 3/8/18 with the Administrator at 10:00 am revealed: -SSI was considered a high risk medications. -She and the RCD held monthly meetings with the MAs regarding insulin, Coumadin, clarifications and documentation of orders as well as the "checks and balances" to make sure the orders were followed as written. -All MARs were checked at the end of every month by the RSD, RCCs, WN, and the SCU	{D 358}		

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Director for holes, clarification, refusals, errors and orders matching the MARs.
-All MARs were checked at the beginning of the month by the RSD, RCCs, WN and the SCU Director for orders matching the MAR.
-All of the orders received were faxed to the pharmacy and entered onto the MAR for the following month and hand written by the MA, RCD or the SCU Director.
-She does not know why the Novolog 5 units at 8:00 am was on hold or that it was documented as administered in March and still on hold.
-She does not know why the SSI was documented incorrectly on the MARs.
-She expected the staff to follow the physician's order as written and to call with any clarifications.

Telephone interview on 3/8/18 with Resident #3's family member at 12:48 pm revealed:
-Resident #3 get hold of juice in the mornings and she was not to have that.
-She did not know the Novolog 5 units at 8:00 am was on hold or that is was being given in March.
-In February Resident #3 FSBS became uncontrollable.
-She expected the facility to follow the physician's orders.

Interview on 3/8/18 with the SCU Director at 5:20 pm revealed:
-The SCU Resident Care Coordinator (RCC) and the SCU Licensed Practical Nurse (LPN) were responsible for processing physician's orders when received by the facility and transcribing those to the MARs.
-If the SCU-RCC nor the SCU-LPN were there when a physician's order was received, the MAs could also process the order and transcribe it to the MAR.
-MAs were responsible for initialing the MAR

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when medications were administered.
-He, the SCU-RCC and the SCU-LPN were performing weekly audits of the MARs to check for accuracy.

Interview on 3/8/18 with the SCU-RCC at 5:29 pm revealed:
-She, the MAs or the SCU-LPN could process physician orders when received and transcribe them to the MAR.
-Night shift MAs were responsible for performing audits of the MARs.
-Once complete, they gave a copy to her.

4. Review of Resident #4's current FL 2 dated 10/26/17 revealed:
-Diagnoses included cerebral infarction, stenosis of cerebral artery, cerebral artery occlusion, and other symbolic dysfunction.
-A physician's order for citalopram hydrobromide 20 mg (a medication used to treat depression) take 1 tablet daily.

a. Review of the medications on hand for Resident #4 on 3/7/18 at 2:00 pm revealed citalopram hydrobromide 20 mg was unavailable.

Review of medication refill book on 3/7/18 that contained fax communication with contracted pharmacy revealed:
-There was a fax request sent requesting a refill for citalopram hydrobromide on 3/2/18.
-There was a fax message received from contracted pharmacy representative indicating citalopram hydrobromide was discontinued on 2/8/18.
-There was a fax request sent requesting a refill for citalopram hydrobromide on 3/5/18.

Interview on 3/7/18 with a 1st shift medication

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aide (MA), at 2:00 pm revealed:
-She knew Resident #4 was out of citalopram hydrobromide and had sent a refill request via fax on 3/5/17.
-She was waiting on a refill to come back from the pharmacy, but it had not come in yet.
-She was not sure what was going on with the pharmacy, "we fax orders and sometimes it takes days to be delivered".
-Refill requests were faxed and placed in the medication refill book, if no response was received a call would be placed to the pharmacy.
-She had not called the pharmacy to request an update on the refill for the citalopram hydrobromide.
-She had not notified the Resident Service Director (RSD) or the Assisted Living Resident Care Coordinator (AL-RCC) because she thought the medication would come in.
-She had not noticed the response from the pharmacy notifying the medication was discontinued on 2/8/18.

Review of Resident #4's January 2018 medication administration record (MAR) revealed an entry dated 10/31/17 for citalopram hydrobromide 20 mg 1 tablet daily at 8:00 am documented as administered from 1/1/18-1/31/18.

Review of Resident #4's February 2018 MAR revealed an entry dated 1/23/18 for citalopram hydrobromide 20 mg 1 tablet daily at 8:00 am documented as administered from 2/1/18-2/28/18.

Review of Resident #4's March 2018 MAR revealed an entry dated 1/23/18 for citalopram hydrobromide 1 tablet daily at 8:00 am documented as administered 3/1/18-3/2/18 and

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{D 358}	Continued From page 32 documented as unavailable 3/3/18-3/7/18. Resident #4 missed 4 doses of citalopram hydrobromide from 3/3/18-3/7/18. Telephone interview on 3/8/18 with the pharmacist at contracted pharmacy at 3:51 pm revealed: -Citalopram hydrobromide was discontinued from their computer system after receiving a MAR indicating a time change for administering the medication. -There was no discontinue order from the physician for citalopram hydrobromide. -They dispensed 30 tablets of citalopram hydrobromide 20 mg on 11/28/17, 12/22/17 and 1/20/18. -They had no record the facility had requested any more citalopram hydrobromide 20 mg since 1/20/18. -They do not keep a record of requests for the medication after it has been discontinued in their computer system. Interview on 3/8/18 with Resident #4 at 3:30 pm revealed: -She did not know she was prescribed citalopram hydrobromide. -She had never asked staff to change any of her medications times for any reason. Telephone interview on 3/8/18 with the primary care physician at 1:36 pm revealed: -She expected Resident #4 to receive medication as ordered. -She prescribed citalopram hydrobromide for depression and symptoms of anxiety. -If Resident #4 went more than a few days without medication she could become more depressed and agitated.	{D 358}		

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{D 358}	Continued From page 33 Interview on 3/8/18 with the AL-RCC at 8:00 am revealed: -MAs were responsible for requesting refills via fax and placing the request in the medication refill book. -Refills could be requested via telephone call and should be documented in the residents chart on the sheet labeled "Resident's Notes". -Medication should be refilled within 1 week before running out. -She was supposed to receive a copy of the fax from the MAs once it was sent to the pharmacy for refill requests. -She did not receive a fax for the citalopram hydrobromide refill request. -She did not realize Resident #4's citalopram hydrobromide was discontinued by the pharmacy. -She expected the MAs to notify her if they are having problems getting medication from the pharmacy. Interview on 3/7/18 with the Resident Service Director (RSD) at 4:45 pm revealed: -Resident #4 requested citalopram hydrobromide be changed from at night until in the morning because of how it made her feel. -Once the medication was changed on the MAR the pharmacy discontinued the medication out of their computer system. -The previous order was for the medication to be administered at bedtime. -The MAs should notify the AL-RCC if there were requests for administration times for medications. -The MARs were to be checked by the AL-RCC, RSD, and Administrator for changes and the medication time change was missed. -The MAs and AL-RCC were responsible for reviewing the medication refill book for response from the pharmacy.	{D 358}		

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{D 358}	Continued From page 34 -No one noticed that the medication was discontinued by the pharmacy. Interview on 3/8/18 with the Administrator at 1:05 pm revealed: -She did not know Resident #4 had been without citalopram hydrobromide. -She expected MAs to request medication refills 7 days in advance to assure it was dispensed timely. -If a medication did not come in on time MAs, were supposed to notify the AL-RCC. -If MAs follow the process of ordering before they run out, it is expected residents would not run out of medication. b. Review of Resident #4's record revealed a physician's order date 11/9/17 for Flonase 50 mcg (a medication used to treat nasal congestion caused by seasonal allergies) 2 sprays each nostril daily. Review of medications on hand on 3/7/18 for Resident #4 at 2:00 pm revealed Flonase 50 mcg was unavailable. Review of medication refill book on 3/7/18 that contained fax communication with contracted pharmacy revealed there was no fax request sent requesting a refill for Flonase. Review of Resident #4 record revealed no "Resident's Notes" documenting communication with contracted pharmacy for a refill for Flonase 50 mcg. Interview on 3/7/18 with a 1st shift medication aide (MA), at 2:00 pm revealed: -She knew Resident #4 was out of Flonase and	{D 358}		

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had sent a refill request "yesterday".
-She was waiting on a refill to come back from the pharmacy, but it had not come in yet.
-She was not sure what was going on with the pharmacy, "we fax orders and sometimes it takes days to be delivered".
-Refill requests are faxed and placed in the medication refill book, if no response is received a call would be placed to the pharmacy.
-She had called the pharmacy to request an update on the refill for the Flonase and was informed that it should be in today.

Review of Resident #4's January 2018 medication administration record (MAR) revealed an entry dated 11/9/17 for Flonase 50 mcg 2 sprays each nostril daily at 9:00 am documented as administered from 1/1/18-1/31/18.

Review of Resident #4's February 2018 MAR revealed an entry for Flonase 50 mcg 2 sprays each nostril daily 9:00 am documented as administered from 2/1/18-2/28/18.

Review of Resident #4's March 2018 MAR revealed an entry for Flonase 50 mcg 2 sprays each nostril daily at 9:00 am documented as administered 3/1/18-3/5/18 and documented as unable to locate 3/5/18-3/7/18.

Telephone interview on 3/8/18 with the pharmacist at contracted pharmacy at 3:51 pm revealed:
-They dispensed 1 bottle of Flonase 50 mcg 120 sprays on 11/9/17 and 12/9/17.
-The last refill request was received on 3/8/18.
-They had no record the facility had requested any more Flonase 50 mg since 12/9/17.
-Medication refills were normally requested via fax.

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{D 358}	Continued From page 36 Interview on 3/8/18 with Resident #4 at 3:30 pm revealed: -She was prescribed Flonase, "2 sprays in each nostril every day". -Staff administered Flonase to her daily except when waiting for it to come back from the pharmacy, "it normally takes a day" Telephone interview on 3/8/18 with the primary care physician at 1:36 pm revealed: -She expected Resident #4 to receive medication as ordered. -She prescribed Flonase for nasal congestion. -If Resident #4 went more than a few days without medication, the resident would possibly have a runny nose. Interview on 3/8/18 with the AL-RCC at 8:00 am revealed: -MAs were responsible for requesting refills via fax and placing the request in the medication refill book. -Refills could be requested via telephone call and should be documented in the residents chart on the sheet labeled "Resident's Notes". -Medication should be refilled within 1 week before running out. -She was supposed to receive a copy of the fax from the MAs once it was sent to the pharmacy for refill requests. -She did not receive a fax for the Flonase refill request. Interview on 3/7/18 with the RSD at 4:45 pm revealed: -She did not know Resident #4 was out of Flonase. -The MAs are supposed to request medication refills 1 week before it runs out.	{D 358}		

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{D 358}	Continued From page 37 -She checked and a refill request had not been submitted. -A request for Resident #4's refill was faxed to the pharmacy today. Interview on 3/8/18 with the Administrator at 1:05 pm revealed: -She did not know Resident #4 had been without Flonase. -She expected MAs to request medication refills 7 days in advance to assure it was dispensed timely. -If a medication did not come in on time MAs, were supposed to notify the AL-RCC. -If MAs follow the process of ordering before they run out, it was expected residents would not run out of medication. 5. Review of Resident #5's current FL 2 dated 2/19/18 revealed: -Diagnoses included thrombocytopenia, congestive heart failure, chronic anticoagulation, and atrial fibrillation. -A physician's order for warfarin 4 mg (warfarin is a medication used to prevent blood clots in medical conditions such as atrial fibrillation, pulmonary embolism, and deep vein thrombosis) take 1 tablet daily. Review of Resident #5's record revealed: -There were lab results dated 2/26/18 which revealed an INR of 3.1 (INR stands for international normalized ratio and is a measure of the effectiveness of warfarin to prevent blood clots. Depending on the condition being treated, a desired INR range would be 2.0 to 3.0.). -A subsequent physician order dated 2/28/18 revealed and order for warfarin 3.5 mg 1 tablet daily.	{D 358}		

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{D 358}	Continued From page 38 -There were lab results dated 3/5/18 which revealed an INR of 1.22. Review of Resident #5's February 2018 MAR revealed an entry dated 2/28/18 for warfarin 3.5 mg 1 tablet daily at 6:00 pm documented as not administered 2/28/18 due to being unavailable. Review of Resident #5's March 2018 MA revealed an entry dated 2/28/18 for warfarin 3.5 mg 1 tablet daily at 6:00 pm documented as administered 3/2/18-3/7/18 and documented as unavailable 3/1/18. Interview on 3/8/18 with Resident #5 at 3:30 pm revealed: -He knew he was prescribed warfarin. -Staff always administered his medications daily. -He did not remember missing any doses of warfarin. -He had no recent bleeding, emergency room visits, or hospitalizations. Observation on 3/8/18 of Resident #5's medications on hand revealed warfarin 3.5 mg once daily was available for administration. Interview on 3/8/18 with a 2nd shift medication aide (MA), at 4:43 pm revealed: -She did not realize Resident #5 was not administered warfarin 3.5 mg on 2/28/18 and 3/1/18. -If the resident received new orders for warfarin it would be faxed to the pharmacy and if faxed after 1 pm it would not be received until the next day. -Medication requests were faxed and placed in the medication refill book, if no response was received a call would be placed to the pharmacy. -Sometimes it took two days after faxing the order to pharmacy to receive the medication.	{D 358}		

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{D 358}	Continued From page 39 -MAs were supposed to notify the AL-RCC or RSD if there were problems getting the medication from the pharmacy. Telephone interview on 3/8/18 with the pharmacist at contracted pharmacy at 3:51 pm revealed: -They dispensed 30 tablets of warfarin 4mg on 1/2/18, and 2/4/18. -They dispensed 30 tablets of 1 mg and 30 tablets of 2.5 mg for warfarin in the evening on 3/1/18. -They received a new order for the warfarin 3.5 mg on 2/28/18. -The medication was not delivered to the facility until the evening of 3/1/18. -Any orders received before 1 pm should be delivered the same day, after that time, it should be delivered on the next day. Telephone interview on 3/8/18 with the primary care physician at 1:36 pm revealed: -She expected Resident #5 to receive medication as ordered. -She requested Resident #5's warfarin to be lowered because his INR ranged higher than she liked at 3.1. -When Resident #5 does not receive warfarin, his blood begins to thicken and he would be at risk for a stroke. -She did not know resident had not received warfarin for 2 days and that would explained why his INR dropped to 1.22 on 3/5/18, which was not therapeutic. Interview on 3/8/18 with the AL-RCC at 8:00 am revealed: -MAs were responsible administering medication as ordered. -She did not know Resident #5 did not receive	{D 358}		

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{D 358}	Continued From page 40 two doses of warfarin on 2/28/18 and 3/1/18. -She would expect MAs to obtain medication from the back-up pharmacy if it cannot be obtained on the same day and the doctor to be contacted for further instructions. -She expected the MAs to notify her if they were having problems getting medication from the pharmacy. Interview on 3/7/18 with the RSD at 4:45 pm revealed: -She did not know Resident #5 had not received 2 doses of warfarin as ordered by physician on 2/28/18 and 3/1/18. -She expected MAs to administer medication as ordered and if they could not to contact the physician for further instruction. -Any communication with the physician should be documented in the "Resident's Notes" in the record. -MAs should notify AL-RCC or herself if they were having issues with getting medication on the same day. Interview on 3/8/18 with the Administrator at 1:05 pm revealed: -She did not know Resident #5 had not received warfarin as ordered by the physician on 2/28/18 and 3/1/18. -If a medication did not come in on time MAs, were supposed to notify the AL-RCC. Refer to interview on 3/8/18 with the Administrator at 5:05 pm. Interview on 3/8/18 with the Administrator at 5:05 pm revealed: -She expected every resident to receive every medication on time. -She had provided education to the MAs in	{D 358}		

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{D 358}	Continued From page 41 December 2017 and again on 3/8/18. -MAs were to order medications when there were 7 doses left to prevent residents from running out. -MAs were to notify the RCC and the RSD on the first day a dose was not available to administer. -She expected thorough documentation to be done by the MAs on the MARs. -She expected the third shift MAs, the AL-RCC and the SCU-RCC to perform weekly audits of the MARs and the medication carts to ensure medications were being administered as ordered. The failure of the facility to assure medication were administered as ordered for 5 of 7 residents related to a thyroid medication (Resident #1), an antidepressant (Resident #4), a blood thinner (Residents #5 and #6), missing medications, a fast acting insulin documented as administered 7 out of 7 times in March while the medication was on hold for (Resident #3). These failures to administer the medications as ordered was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The Plan of Protection provided by the facility on 3/13/18 revealed: -Inservice education conducted 3/8/18 through 3/13/18 for all MAs to assure and review the accuracy of medication administration, documentation, accuracy of dosage, following physician's orders on the MAR, adequate inventory and storage of the medications. -All MAs were educated on the new MA assignment sheet to be completed every shift, every day, on every cart. -This tool requires each MA to review all aspects of medication administration from their daily shift. -Inuring administration, the Administrator/Designee will review the MA assignments sheets every morning to assure	{D 358}		

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{D 358}	Continued From page 42 consistently in completion, accuracy of any recorded information, follow-up and trends. -These reviews will continue daily and included in the daily nursing administration meetings with the Administrator. -Disciplinary action will occur as appropriate if a MA does not comply with this requirement. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 22, 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 administration record (MAR).	{D 367}		

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{D 367}	Continued From page 43	{D 367}		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure accurate documentation on the Medication Administration Record (MAR) for 2 of 7 residents related to levothyroxine sodium, a thryoid medication (Resident #1), and warfarin sodium, a blood thinner (Residents #6).

The findings are:

1. Review of Resident #1's current FL 2 dated 12/12/17 revealed:
-Diagnoses included dementia, cognitive dysfunction, and hypothyroidism.
-There was a physician's order for levothyroxine sodium 50 mcg 1 tablet daily.

Review of Resident #1's MAR for February 2018 revealed:
-There was a computer generated entry for levothyroxine sodium 50 mcg 1 tablet daily.
-There was written documentation of staff initials circled indicating levothyroxine sodium 50 mcg was not administered on 2/23, 2/24, 2/25, 2/26, 2/27, and 2/28/18.
-On the back of the MAR, there was written documentation on 2/23/18 indicating "will notify family."
-On the back of the MAR, there was written documentation on 2/24/18 indicating "will notify family again."
-On the back of the MAR, there was written documentation on 2/25/18 indicating "levothyroxine unavailable."
-There was no documentation indicating why levothyroxine sodium 50 mcg was not administered on 2/26, 2/27 and 2/28/18.

Interview on 3/8/18 with a morning shift

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{D 367}	Continued From page 44 medication aide (MA) at 1:47 pm revealed: -She was aware Resident #1 was not administered her levothyroxine sodium 50 mcg. -When medications were not administered to residents, the MAs were supposed to document on the back of the MAR the reason for not administering the medication. -She was the MA who had initialed and circled the MAR on 2/26, 2/27, and 2/28/18 indicating the medication was not administered. -She did not know why she had not documented a reason. Interview on 3/8/18 with the Assisted Living Resident Care Coordinator (AL-RCC) 12:15 pm revealed: -MAs were responsible for initialing the residents' MARs when medications were administered. -If medications were not administered, they were to initial the MAR, circle their initials and then indicate on the back of the MAR why the medication was not administered. -She and the night shift MA were responsible for auditing the MARs each week for accuracy. -The last MAR audit for Resident #1 was completed on 2/23/18 by herself, prior to the time frame when documentation was missing in regards to levothyroxine sodium not being administered. Refer to interview on 3/8/18 with the Administrator at 5:05 pm. 2. Review of Resident #6's current FL2 dated 2/26/18 revealed: -Diagnoses included dementia, coronary artery disease, diabetes mellitus type 2, hypertension and peripheral artery disease. -There was a physician's order for warfarin sodium 7.5 mg take 1 tablet daily.	{D 367}		

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{D 367}	Continued From page 45 Review of Resident #6's physician's orders revealed: -There was an order dated 12/19/17 for warfarin sodium 7.5mg daily. -There was an order dated 2/7/18 for warfarin sodium 5 mg on Wednesdays and warfarin sodium 7.5 mg the other 6 days. -There was an order dated 2/13/18 to increase warfarin sodium dose back to 7.5 mg daily. Review of Resident #6's MAR for February 2018 revealed: -There was an entry for warfarin sodium 7.5 mg 1 tablet daily. -There was an entry for warfarin sodium 5 mg 1 tablet daily on Wednesdays. -There were blanks where staff initials should be for indicating warfarin sodium administration on 2/7 and 2/26/18. Interview on 3/8/18 with the Special Care Unit (SCU) Director at 5:20 pm revealed: -Medication aides (MA) were responsible for initialing the MAR when medications were administered. -If medications were not administered, the MAs were to initial the MAR, circle their initials, and indicate the reason on the back of the MAR for not administering the medication. -He, the SCU Resident Care Coordinator (RCC) and the Licensed Practical Nurse (LPN) were performing weekly audits of the MARs to check for blanks and follow up with the MAs on why there were blanks. -They must have "missed" the blanks in Resident #6's MAR during their audit. Interview on 3/8/18 with the SCU-RCC at 5:29 pm revealed:	{D 367}		

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{D 367}	Continued From page 46 -Night shift MAs were responsible for performing audits of the MARs. -Once complete, they gave a copy to her. -If "holes" were found in the MARs, the MAs were to leave a note for her and the LPN so they could address them. -She was unaware Resident #6 had "holes" in his MAR on 2/7 and 2/26/18 for warfarin sodium administration. Interview on 3/8/18 with the Administrator at 5:05 pm revealed: -She expected every resident to receive every medication on time. -She expected thorough documentation to be done by the MAs on the MARs. -She expected the third shift MAs, the AL-RCC and the SCU-RCC to perform weekly audits and check for accuracy of the MARs.	{D 367}		
{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 related to medication administration and health care.	{D912}		

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{D912}	Continued From page 47 The findings are: A. Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a physician for 5 of 7 sampled residents related to a thyroid medication (Resident #1), an antidepressant and an allergy medication (Resident #4), a blood thinner (Residents #5 and #6), and a fast acting insulin (Resident #3). Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)]. B. Based on observations, interviews and record reviews, the facility failed to assure the primary care provider was notified reguarding medications not administered as ordered for 4 of 7 residents related to a thyroid medication (Resident #1), an antidepressant (Resident #4), a blood thinner (Residents #5 and #6). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	{D912}		