STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey on 06/26/18-06/28/18.	{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: UNABATED TYPE B VIOLATION. Based on observations, record reviews and interviews, the facility failed to assure health care referral and follow up to meet the health care needs for 3 of 9 sampled residents (Resident #6, #8, and #9) related to an order for medications to be crushed (#8), fingerstick blood sugar (FSBS) results outside the parameters and notification to the physician (#6 and #9). The findings are: 1. Review of Resident #8's current FL2 dated 10/23/17 revealed: -There were diagnoses of hypertension and depression. -There was an order for omeprazole 40mg DR, take 1 capsule each day for acid reflux. Review of Resident #8's physician order dated 06/08/18 revealed: -There was an order for a urinalysis (U/A), due to	{D 273}		

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{D 273}	Continued From page 1	{D 273}		

the resident's complaints of burning when urinating.
-There was an order for pyridium 100mg take 1 tablet by mouth, scheduled to be administered three times a day for 3 days, starting 06/10/18-06/12/18.

Review of the physician order dated 06/18/18 revealed an order for macrobid 100mg, take 1 capsule, to be administered twice a day for 10 days, if not allergic to the medication.

Review of the laboratory report for the U/A on 06/13/18 revealed a 50,000 colony forming unit (CFU)/ml Escherichia coli (E. Coli). (E.Coli was a type of bacteria commonly found in bladder infections in women).

Review of the June 2018 medication administration record (MAR) revealed:
-There was an entry on the MAR "Please crush all meds unless contraindicated, use applesauce", dated 01/28/17.
-There was an entry for macrobid 100mg, 1 capsule twice a day, scheduled for administration at 8:00am and 8:00pm for 10 days, starting 06/20/18-06/30/18.
-There was an entry for omeprazole 40mg DR, take 1 capsule once a day, scheduled for administration at 7:00am.

Observation of the medication pass on 06/27/18 at 7:15am revealed:
-The medication aide (MA) placed the macrobid and the omeprazole capsules whole into the applesauce cup.
-"I can not crush capsules. She (Resident #8) can take these pills in applesauce."
-The 2 whole capsules, placed in the applesauce, were administered to Resident #8.

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{D 273}	Continued From page 2 -The MA offered a cup of water and asked the resident if she had swallowed the pills. The resident nodded. -The MA left the room and the resident removed both pills (the macrobid and the omeprazole) from her mouth, whole and intact. - The MA disposed of the pills and stated she would "try again later." Review of the bubble pack of macrobid sent from the pharmacy revealed: -On 06/20/18, 20 pills were filled for macrobid 100mg to be administered twice a day for 10 days. -There were 7 pills left in the bubble pack on 06/27/18 during the morning medication pass. Interview with the resident on 06/27/18 at 10:05am revealed: -She could not swallow any pills whole. -She knew she was receiving an antibiotic for a urinary tract infection (UTI), but had not swallowed any of the pills. -She had removed the pills from her mouth and threw them away. -She had not told the MAs she could not swallow the pills. -She reported the burning with urination had continued. Interview with the first shift MA on 06/27/18 at 9:55am revealed: -She knew the capsules could not be crushed with Resident #8's other medications so she administered them whole in applesauce. -She believed the resident was swallowing her medication. -No other MA had reported Resident #8 was not taking these capsules whole. -She did not know the resident was removing the	{D 273}		

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{D 273}	Continued From page 3	{D 273}		

macrobid and omeprazole capsules from her mouth when she left the room.
-She would speak with her supervisor for further instructions. She was not sure what alternatives she had.

Interview with the second shift MA on 06/27/18 at 3:15pm revealed:
-She had administered the macrobid to Resident #8 on 06/20/18.
-She knew the resident had a 'crush all medications and put in applesauce" order.
-She opened the capsule and sprinkled into the applesauce.
-She did not review the drug guide or clarify with the pharmacy to determine if macrobid could be sprinkled on applesauce.
-When she reviewed the drug guide on the cart she read macrobid capsules could not be opened and sprinkled on applesauce to administer.
-She did not know some capsules could not be opened and sprinkled on food.
-She did know she could refer to the drug guide for information regarding drug administration.

Interview with the Resident Care Director (RCD) on 06/27/18 at 4:40pm revealed:
-The MAs had been trained to follow the orders as listed on the MAR.
-If there was a need for clarification, they had been advised to ask her, the RCC or call the physician.
-The MAs had received training on the proper administration of crushed medications and oral medications that could not be taken whole.
-She provided all the training to the MAs.
-She did not know the MAs were administering macrobid and omeprazole in capsule form whole to Resident #8 who had a "crush all medications" order.

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{D 273}	Continued From page 4 -She did not know an MA had opened the capsule and sprinkled the macrobid on applesauce without reviewing the medication guide on the medication cart. -She did not know why the MAs had not clarified the medications on hand with the primary care physician (PCP), regarding the order to crush all medications due to swallowing issues. Interview with the primary care physician (PCP) on 06/28/18 at 10:30am revealed: -The resident had difficulty swallowing due to the progression of her neurological disease process. -Resident #8 has had an order to crush her medications for over a year. -The PCP did not know the resident had been administered macrobid and omeprazole as whole capsules. -She did not know the resident was removing the capsules from her mouth and disposing of them. -She would expect the facility to follow the order to crush the resident's medications, or call her if they needed clarification or a substitution. -She would have changed the delivery of the medication to a liquid form if she knew. -The possible outcome of a resident with a UTI not receiving her antibiotic medication was uremia and hospitalization. 2. Review of Resident #9's current FL2 dated 02/19/18 revealed: -The diagnoses included non-hermatic aortic valve stenosis and type 2 diabetes mellitus. -There was an order for Lantus Solostar insulin pen, 100units/ml, 15 units to be administered every morning at 8:00am. -There was an order for finger stick blood sugar (FSBS) checks twice a day, to be completed before morning and evening meals.	{D 273}		

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{D 273}	Continued From page 5 Review of Resident #9's physician's order dated 04/09/18 revealed: -There was an order for 30 units of Lantus to be administered every day. -There was an order for FSBS checks to be administered twice a day before meals. -The physician was to be notified for blood glucose less than 70mg/dl or greater than 400mg/dl. Review of the FSBS documentation for the month of May 2018 for Resident #9 revealed: -There was an entry on 05/16/18 at 7:30am for a blood glucose of 66mg/dl. -The was an entry on 05/23/18 at 7:30am for a blood glucose of 67mg/dl. -There was no documentation the physician was notified the blood glucose was less than 70mg/dl on 5/16/18 or 5/23/18. Review of the FSBS documentation for the month of June 2018 for Resident #9 revealed: -There was an entry on 06/10/18 at 7:30am for a blood glucose of 64mg/dl. -There was an entry on 06/24/18 at 7:30am for a blood glucose of 57mg/dl. -There was no documentation the physician was notified the blood glucose was less than 70mg/dl on 06/10/18 or 06/24/18. Interview with the RCC on 06/27/18 at 3:31pm revealed: -She reviewed the FSBS readings for all residents at least every 2 weeks for residents who had an order for blood glucose checks. -She recorded the readings entered on the MAR to the FSBS document for each resident which was kept in a separate binder in her office. -She did not review the readings for blood glucose parameters.	{D 273}		

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{D 273}	Continued From page 6 -Her expectation was the MAs would notify the PCP if the blood glucose fell below or rose above the ordered parameters. -She faxed the FSBS readings to the physicians monthly. Interview with Resident #9's hospice registered nurse (RN) on 06/28/18 at 10:15am revealed: -She was the primary case nurse for Resident #9. -She had been assigned to this resident's care since April 2018. -She visited the resident weekly or as needed for acute care. -She had never been notified that the blood glucose for Resident #9 had been less than 70mg/dl. -The hospice team, including the PCP, discussed the care of each resident at their monthly interdisciplinary team (IGT) meetings. Resident #9's low blood sugar had never been identified. -She did not review the MAR as part of her scheduled visits. She only reviewed the current medications. Attempted phone interview with the PCP on 06/28/18 at 10:00am was unsuccessful. Interview with the RCD on 06/28/18 at 10:35am revealed: -She did not know Resident #9 had blood glucose readings below 70mg/dl four times over the past 2 months. -She knew the facility protocol for diabetic management and treatment of hypo/hyperglycemia, signed by Resident #9's physician, directed the staff to notify the physician if the blood glucose was less than 70mg/dl or greater than 400mg/dl. -She kept a copy of this signed document in the record for the MAs as a reference.	{D 273}		

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{D 273}	Continued From page 7 -She did not know why the MA did not notify the physician on 05/16/18, 05/23/18, 6/10/18 and 06/24/18 for blood glucose less than 70mg/dl. Review of the facility protocol for diabetic management and treatment of hypo/hyperglycemia revealed: -If the blood glucose was 70mg/dl, notify the physician and re-check blood glucose in 15 minutes. -If the blood glucose was less than 70mg/dl, call 911. -If the blood glucose was greater than 400mg/dl, notify the physician for further instructions. Attempted phone interview with the MA on 06/28/18 at 10:15am was unsuccessful. Interview with the Administrator on 06/28/18 at 10:00am revealed: -The RCD had trained the MAs in the policies and procedures of medication administration and follow up or clarification as needed with the physician. -The MAs had received training to notify the PCP when blood glucose was less than 70mg/dl or greater than 400mg/dl. -She did not know why the MAs were not following the procedures. 3. Review of Resident #6's current FL2 dated 06/25/18 revealed: -Diagnoses included diabetes mellitus, hypertension, anemia, and hyperlipidemia. -An order for Humalog mix 75/25 (injection used to treat diabetes) inject 18 units every morning. -An order for Humalog mix 75/25 inject 12 units every evening. -An order FSBS to be taken twice per day; every morning and every evening.	{D 273}		

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{D 273}	Continued From page 8 Review of the protocol for diabetic management and treatment of hypo/hyperglycemia signed by Resident #6's physician on 04/09/18 revealed: -If blood glucose is 70 mg/dl notify physician, re-check blood glucose in 15 minutes; if blood glucose is less than 70, call 911. -If blood glucose is greater than 400 mg/dl notify physician for further instructions. Review of Resident #6's Medication Administration Record (MAR) for April 2018 revealed: -The FSBS were documented at 7:30am and 8:00pm. -The FSBS on 04/24/18 at 7:30am was 41. -Humalog mix 75/25 18 units was documented as administered at 7:30am on 04/24/18. -There was no documentation that the physician was notified that the FSBS was less than 70. Review of Resident #6's MAR for May 2018 revealed: -The FSBS were documented at 7:30am and 8:00pm. -The FSBS on 05/12/18 at 8:00pm was 410. -There was no documentation that the physician was notified that the FSBS was greater than 400. Review of Resident #6's MAR for June 2018 revealed: -The FSBS were documented at 7:30am and 8:00pm. -The FSBS on 06/04/18 at 8:00pm was 402. -The FSBS on 06/15/18 at 7:30am was 41. -The FSBS on 06/21/18 at 7:30am was 60. -The FSBS on 06/26/18 at 7:30am was 62. -Humalog mix 75/25 18 units was documented as administered at 7:30am on 06/15/18, 06/21/18, and 06/26/18.	{D 273}		

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{D 273}	Continued From page 9 -There was no documentation that the physician was notified that the FSBS was less than 70 or greater than 400. Review of Resident #6's record and "Residents Notes" revealed there was no documentation of the physician being notified of FSBS being less than 70 or greater than 400 from 04/24/18-06/28/18. Interview with the medication aide (MA) who worked 1st and 3rd shift on 06/26/18 at 2:11pm revealed: -He had been employed as a MA for about 1 year. -He knew Resident #6 had an order for FSBS to be checked every morning and evening. -He checked Resident #6's FSBS and administered insulin every morning and evening according to physician's orders. -If the FSBS was less than 70 or greater than 400 he would give insulin as ordered by the physician. -"I thought if the FSBS was lower than 100 I should contact the physician, based on prior knowledge". -He had never contacted the physician for FSBS lower than 70 or greater than 400. -"I don't know why the physician wasn't contacted". -He had seen the hypo/hyperglycemia protocol but in the MAR when administering medications, but "I didn't pay attention to it". -He was trained by the Resident Care Coordinator (RCC) when he first began working on the medication cart. -He was instructed to follow the hypo/hyperglycemia protocol but "I forgot". Interview with the RCC on 06/27/18 at 3:31pm revealed: -The hypo/hyperglycemia protocol was signed by	{D 273}		

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{D 273}	Continued From page 10 the physician for each resident and placed in the MAR book for MAs to reference. -She expected MAs to follow the protocol or specific FSBS parameters as ordered by the physician. -MAs were trained by her or the RSD (Resident Services Director) prior to administering medications regarding FSBS. -She reviewed FSBS results every 2 weeks to ensure that they were completed and recorded on the MAR. -She never reviewed the FSBS results and record to determine if MAs followed protocol. -FSBS results were faxed to the physician once per month. Interview with the RSD on 06/27/18 at 4:15pm revealed: -She was responsible for training MAs regarding medication administration and diabetes. -She instructed MAs to follow the hypo/hyperglycemia protocol and then notify the doctor when FSBS were over 400 and less than 70. -Each MA received diabetic care training prior to administering medications and the hypo/hyperglycemia protocol was reviewed. -She instructed MAs to document in the resident notes when they made contact with the physician. Interview with Resident #6 on 06/27/18 at 9:15 am revealed: -She had been a diabetic for more than 20 years. -She knew the signs and symptoms of hypo/hyperglycemia. -She had not experienced any symptoms of hyperglycemia -She thought staff gave her insulin as prescribed. -She did not know if her FSBS had been lower than 70 or higher than 400.	{D 273}		

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{D 273}	Continued From page 11 -"If I feel shaky and blood sugar is low, I will ask staff for orange juice and I will feel better". Telephone interview with Resident #6's physician on 06/28/18 at 10:09am revealed: -She did not remember being notified for FSBS less than 70 or greater than 400. -She expected the facility to contact her each time her FSBS was greater than 400 or less than 70. -She wanted to be notified before insulin was given because resident could have complications" she could pass out or have seizures". -If the FSBS result is too high "it could cause vomiting and cause the resident to be nauseous". -Depending on the FSBS result she would give additional instructions for how to address if over 400 or less than 70. Interview with the Administrator on 2/28/18 at 10:45 am revealed: -She expected the MAs to follow the hypo/hyperglycemia protocol as written. -There were in-services and meetings monthly to discuss medication administration and insulin. -The RCC and RSD were responsible for making sure the MAs knew to contact the physician how to document. -The MAs should follow the parameters for Resident #6's FSBS as ordered. The facility failed to assure health care referral and follow up to meet the health care needs related to an order for medications to be crushed and fingerstick blood sugar (FSBS) results outside the parameters with notification to the physician. These failures to follow-up with and the primary care provider was detrimental to the health and safety and welfare of the residents and harm constitutes a continuing Unabated Type	{D 273}		

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{D 273}	Continued From page 12 B Violation.	{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: UNABATED TYPE B VIOLATION. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 5 of 9 residents (Residents #2, #3, #6, #8, and #10) which included errors with the administration of insulin for (#2, #6, and #10), errors with an antibiotic for a urinary tract infection and an acid reducing medication for gastroesophageal reflux (#8); the facility failed to administer medications as ordered including a supplement (#3); the facility failed to have a medication as needed (PRN) available for administration, including an anti-inflammatory (#3); and the facility failed to follow their medication administration policy requiring medication aides (MAs) to read the medication administration record (MAR) before administering medications to the residents (#2). The findings are:	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 13 1. The medication error rate was 32% as evidenced by the observation of 8 errors out of 25 opportunities during the 11:00am-12:00pm medication pass on 06/26/18 and the 7:00am-9:00am medication pass on 06/27/18. a. Review of Resident #2's current FL2 dated 03/21/18 revealed: -The diagnoses included type 2 diabetes mellitus. -There was an order for Humalog insulin U-100 75/25, (a medication which included a rapid acting insulin and an intermediate acting insulin to lower blood sugar), administer 10 units before the supper meal. Review of Resident #2's physician orders dated 03/24/18 revealed: -There was an order for Humalog 75/25, 10 units, to be administered before supper. -There was an order to check fingerstick blood sugars (FSBS) before meals. -There was an order for Humalog 75/25 sliding scale insulin (SSI) three times a day, as needed, at 7:30am, 11:30am and 4:30pm, with the following parameters: 60-150=0 units; 151-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; 401-450=6 units; 451-500=7 units; call the physician if the FSBS is less than 50mg/dl or greater than 500mg/dl. Review of the June 2018 medication administration record (MAR) revealed: -There was an entry for FSBS checks before meals, scheduled to be administered at 7:30am, 11:30am, 4:30pm. -There was an entry for Humalog 75/25 SSI three times a day, as needed, at 7:30am, 11:30am and 4:30pm, with the following parameters: 60-150=0	{D 358}		

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{D 358}	Continued From page 14 units; 151-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; 401-450=6 units; 451-500=7 units; call the physician if the FSBS is less than 50mg/dl or greater than 500mg/dl. Observation of the medication pass on 06/26/18 at 11:03am revealed: -The medication aide (MA) removed Resident #2's glucometer case from the medication cart. -He opened the MAR but did not refer to the MAR when he verbalized Resident #2's orders. -The Humalog insulin was in a vial in the medication cart labeled with Resident #2's name, and the directions to administer according to the sliding scale three times a day before meals. -The MA gathered the glucometer and supplies and entered the resident's room, where he checked her FSBS. The blood glucose was 248mg/dl. -The MA proceeded to remove a worn, handwritten piece of paper from the glucometer case with what he explained were the SSI parameters. -He did not refer to the MAR to confirm the correct SSI dosage. -He drew up 2 units of Humalog in the insulin syringe, and administered the insulin in the resident's left lower abdomen. -The MA removed his supplies and documented the results on the MAR. Interview with the MA on 06/26/18 at 11:40am revealed: -He knew the correct procedure for administering medications was to refer to the MAR and the medication label for accuracy.. -He did not refer to the MAR before administering the SSI. -He was trained during the 15 hour medication	{D 358}		

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

class he attended last year, taught by the pharmacist, that MAs were
to check the MAR and the medication before administration to the resident.
-The MAs kept the handwritten note in the glucometer case so they would not have to return to the MAR before administering the SSI.
-He knew the SSI order could change and he would not be able to confirm the handwritten note was updated.

Interview with the Resident Care Director (RCD) on 06/26/18 at 12:40pm revealed:
-The MAs were trained on diabetes and insulin administration as part of their initial MA requirements.
-This MA was trained on diabetes and insulin administration on 05/17/17.
-She also conducted monthly training with the MAs, including proper insulin administration.
-The policy of the facility for the administration of medications was a 3-point review system. The MAs were to check the medications with the MAR 3 times; when the medications were removed from the medication cart, when the medications were prepared for administration and before the medications were administered to the resident.
-She did not know that the MAs were using a handwritten slip of paper with the SSI parameters.
-It was her expectation that the MAs were to follow the 3 medication checks when administering medications, always referring to the MAR.

b. Review of Resident #10's current FL2 dated 10/26/17 revealed:
-The diagnoses included diabetes mellitus.
-There was an order for a Novolog FlexPen 100ml insulin, 15 units scheduled to be

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{D 358}	Continued From page 16 administered 3 times daily. Review of Resident #10's physician order dated 12/13/17 revealed an order for FSBS checks before meals and at bedtime. Review of Resident #10's physician order dated 04/23/18 revealed: -There was an order to continue the Novolog FlexPen, 15 units scheduled to be administered 3 times daily. -There was an order to continue FSBS three times daily (before meals) and at bedtime. Review of the June 2018 MAR revealed: -There was an entry for Novolog FlexPen, 15 units scheduled to be administered 3 times daily at 6:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry to check the blood glucose three times daily at 6:30am, 11:30am, 4:00pm and 8:00pm -There was an entry for blood glucose less than 70mg/dl or greater than 400mg/dl, please contact the physician. Observation of the medication pass with the first MA on 06/26/18 at 11:25 revealed: -The MA removed Resident #10's glucometer case from the medication cart. -He removed a Novolog FlexPen labeled with Resident #10's name, the frequency and dosage of insulin, from the medication cart.. -The fill date for the FlexPen was 06/09/18. -The MA gathered the glucometer and supplies and proceeded to the resident's room. -The MA followed the infection control protocol for FSBS on the 4th digit of the right hand. -The right upper arm of the resident was the site for the injection. -He inserted the needle, turning the dose selector	{D 358}		

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{D 358}	Continued From page 17 to 15 units. -The MA did not know the FlexPen should be primed with 2 units of insulin prior to administering the scheduled dose. -He turned the dose selector to 2 units and primed the insulin pen. -He dialed the ordered dose of 15 units of insulin and administered the scheduled dose in the right upper arm. -The dose selector was depressed for less than 5 seconds and the needle was removed from the resident's arm. Review of manufactuers instructions for the Novolog Flexpens revealed: -Insert the pen needle into the end of the insulin pen. -Prime the pen to clear any air from the needle. Turn the dose selector to 2 units. Hold the pen with the needle pointing upward. -Press the dose knob and observe a drop of insulin from the needle. The dose selector will return to zero. -Turn the dose knob to dial the prescribed units of insulin to be administered. -Select an injection site. -Gently pinch up the skin, insert the needle at a 90 degree angle, and depress the dose knob until the dose window is at zero. -Leave the needle in place for 6 seconds to insure proper dosage was received. -If the needle was removed earlier than 6 seconds, the full dose of insulin may not be delivered. Interview with the MA on 06/26/18 at 11:40am revealed: -He did not know the Novolog FlexPen needed to be primed with 2 units of insulin before administering the dosage ordered.	{D 358}		

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{D 358}	Continued From page 18 -He did not know there could be air in the needle which would prevent the prescribed dosage of insulin to be administered to the resident. -He did not know the dose knob should continue to be depressed for 6 seconds to ensure the prescribed dose was administered. Interview with the RCD on 06/26/18 at 12:40pm revealed: -The MAs had been trained in the proper technique of administration of insulin pens during the 'Diabetic and Insulin Training' as part of their initial MA training. -The Diabetic/Insulin training for this MA was completed on 05/17/17. -She conducts mandatory In-Service training to the MAs monthly, which includes a review of insulin administration. -She did not know why the MA did not demonstrate the proper administration technique for the insulin pen. Observation of the medication pass with a second MA on 06/27/18 at 8:20am revealed: -The MA reviewed the MAR and removed a Novolog FlexPen from the medication cart. -The label on the FlexPen had Resident #10's name and the following order: inject 15 units of Novolog 100ml three times daily. -The pen was dated as opened on 06/23/18. -The MA reviewed the insulin label and the MAR for accuracy. -The MA removed Resident #10's glucometer case, gathered the FlexPen and supplies and proceeded to the resident's room. -The MA observed proper infection control protocol when performing the FSBS on the 4th digit of his right hand. -The blood glucose reading was 188mg/dl. -The right upper arm of the resident was the site	{D 358}		

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{D 358}	Continued From page 19 for the injection. -She inserted the needle into the pen, turning the dose selector to 15 units. -She did not know the insulin pen should be primed with 2 units of insulin prior to administering the scheduled dose. -She primed the pen and dialed the prescribed dose of 15 units. -She depressed the injection button on the FlexPen for less than 5 seconds and removed the needle from the resident's arm. Interview with the second MA on 06/27/18 at 8:45am revealed: -She did not know the FlexPen should be primed with 2 units of insulin before each administration. -She did not know air in the needle of the pen would be expelled during priming. -She did not know the injection button should be fully depressed for 6 seconds to ensure the full dose of insulin was delivered. -She did not remember if that information was presented during her Diabetic /Insulin training class.(The training for this MA was completed on 11/08/17). Interview with a third MA on 06/27/18 at 10:00am revealed: -She administered all the medications to the residents on the second floor. -She had administered Lantus insulin using the auto injector pen. -In outlining the steps she completed in the administration of the the Lantus, she did not include priming the pen with 2 units of insulin. -She did not know she should prime the insulin pens to ensure air was not in the needle. -She did not know the injection button on the pen should be depressed completely for 6 seconds before removing the needle from the site.	{D 358}		

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{D 358}	Continued From page 20 -She did not know if this information was presented in the Diabetic and Insulin training she completed on 03/21/18. Refer to interview with the Administrator on 06/27/18 at 11:45am. c. Review of Resident #8's current FL2 dated 10/23/17 revealed: -There were diagnoses of hypertension and depression. -There was an order for omeprazole 40mg DR, administer 1 capsule each day for acid reflux. Review of the physician order dated 06/18/18 revealed an order for macrobid 100mg, take 1 capsule twice a day for 10 days, if not allergic to the medication. Review of the June 2018 MAR revealed: -There was an entry "Please crush all meds unless contraindicated, use applesauce," dated 01/28/17. -There was an entry for macrobid 100mg, take 1 capsule, scheduled for administration twice a day at 8:00am and 8:00pm for 10 days, starting 6/20/18-6/30/18. -There was an entry for omeprazole 40mg DR, take 1capsule once a day at 7:00am, for acid reflux, dated 02/13/16. Observation of the medication pass on 06/27/18 at 7:15am revealed: -The MA removed the bubble packs of all medications for Resident #8 from the medication cart. -She reviewed the MAR and compared the label on the medications to the MAR. -There were 10 medications that were to be administered at 8:00am.	{D 358}		

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{D 358}	Continued From page 21 -The MA crushed 8 of the medications and placed them in a cup with applesauce. -The MA did not crush the macrobid or the omeprazole capsules. She placed them whole in the applesauce. -"I can not crush capsules. She (Resident #8) can take these pills in applesauce." -The medications were administered to Resident #8 with a cup of water. -The MA asked the resident if she had swallowed the pills. The resident subtly nodded. -The MA left the room and the resident removed both pills (the macrobid and the omeprazole) from her mouth, whole and intact. -The MA disposed of the pills and stated she would "try again later." -The MA did not refer to the RCD and inquire as to another form the medication could be administered. -The MA did not contact the prescribing practitioner. Review of the bubble pack of macrobid sent from the pharmacy revealed: -On 06/20/18, 20 pills were filled for macrobid 100mg twice a day for 10 days. -There were 7 pills left in the bubble pack on 06/27/18 during the morning medication pass. Interview with Resident #8 on 06/27/18 at 10:05am revealed: -She could not swallow any pills whole. -She knew she was receiving an antibiotic for a UTI, but had not swallowed any of the pills. -She removed the pills from her mouth and threw them away. -She had not told the MAs she did not swallow the pills. -She reported the burning with urination had continued.	{D 358}		

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{D 358}	Continued From page 22 Interview with the first shift MA on 06/27/18 at 9:55am revealed: -She knew capsules could not be crushed with her other medications so she put them whole in applesauce. -She believed the resident was swallowing her medication. -No other MA had reported Resident #8 was not taking these capsules whole. -She did not know the resident was removing the macrobid and omeprazole from her mouth when she left the room. -She would speak with her supervisor for further instructions. She was not sure what alternatives she had. Interview with the second shift MA on 06/27/18 at 3:15pm revealed: -She had administered the macrobid capsule to Resident #8 on 06/20/18. -She knew the resident had a "Crush all medications and put in applesauce" order. -She opened the capsule and sprinkled the contents on the applesauce. -She did not review the medication guide, or clarify with the pharmacy, to determine if macrobid could be sprinkled on applesauce. -When she reviewed the medication guide on the cart, she read macrobid capsules could not be opened and sprinkled on applesauce to administer. -She did not know some capsules could not be opened and sprinkled on food. -She did know she could refer to the medication guide for information regarding drug administration. Interview with the RCD on 06/27/18 at 4:40pm revealed:	{D 358}		

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{D 358}	Continued From page 23 -The MAs have been instructed to follow orders as they are listed on the MAR. -If there is a need for clarification, they have been advised to ask her, the RCC or call the physician. -The MAs had received training on the proper administration of crushed medications and oral medications that can not be taken whole. -She provided all the training to the MAs. -She did not know the MAs were administering macrobid and omeprazole in capsule form to Resident #8 who was on a "Crush all medications" order. Interview with the primary care physician (PCP) on 06/28/18 at 10:30am revealed: -Resident #8 has had difficulty swallowing due to the progression of her neurological disease process. -She has had an order to crush her medications for over a year. -The PCP did not know the resident had been administered macrobid and omeprazole as whole capsules. -She did not know the resident was removing the capsules from her mouth and disposing of them. -She would expect the facility to follow the order to crush the resident's medications, or call her if they needed clarification. -She would have changed the delivery of the medication to a liquid form if she knew. -The possible outcome of a resident with a UTI not receiving her antibiotic medication was uremia and hospitalization. Refer to interview with the Administrator on 06/27/18 at 11:45am. d. Review of Resident #6's current FL2 dated 06/27/18 revealed: -The diagnoses included diabetes mellitus,	{D 358}		

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{D 358}	Continued From page 24 hypertension and hyperlipidemia. -There was an order for Humalog Mix 75/25, 18 units, to be administered every morning. -There was an order for Humalog mix 75/25, 12 units, to be administered every evening. -There was an order to check the FSBS twice a day scheduled in the morning and the evening. Review of the June 2018 MAR revealed: -There was an entry for Humalog insulin mix 75/25 18 units, scheduled to be administered at 8:00am. -There was an entry for Humalog insulin mix 75/25 12 units, scheduled to be administered at 8:00pm. -There was an entry to check the FSBS twice daily, scheduled at 8:00am and 8:00pm. Observation of the medication pass on 06/27/18 at 8:01 am revealed: -The MA reviewed the MAR and removed a vial of Humalog Mix 75/25 insulin from the medication cart. -The label on the vial had Resident #6's name and the following order: Humalog Mix 75/25, inject 18 units every morning and inject 12 units every evening. 'Milky white' was printed on the side of the box. -The opened date for the insulin vial was 06/12/18. -The MA checked the insulin label and the MAR for accuracy. -She gathered Resident #6's glucometer, the vial of Humalog, and her supplies and proceeded to the resident's room. -The MA observed proper infection control protocol when performing the FSBS on the right index finger. -The blood glucose was 107mg/dl. -The MA did not wipe the insulin vial with alcohol	{D 358}		

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before inserting the needle.
-The MA did not roll the insulin suspension prior to drawing the insulin into the syringe.

Interview with the MA on 06/27/18 at 8:15am revealed:
-She knew a vial of insulin that was cloudy should be gently rolled before administration.
-She did not observe the 'Milky white' label on the vial box.
-She didn't know why she had not remembered to roll the vial of Humalog insulin.
-The RCD had facilitated the diabetic training class and she believed the proper administration of cloudy and clear insulin was reviewed.
-She received her Diabetic/Insulin training on 12/08/17.

Interview with the pharmacist on 06/27/18 at 1:30pm revealed:
-Humalog insulin 75/25 was a suspension liquid.
-It was a mixture of a rapid acting insulin and an intermediate acting insulin.
-It was a cloudy insulin in the vial.
-Failure to roll the insulin vial gently between your palms could decrease its effectiveness and increase the day to day blood sugar fluctuations

Review of the FSBS readings for Resident #6 for June 2018 revealed:
-The 7:30am blood glucose readings ranged from 95mg/dl to 159mg/dl.
-The 8:00pm blood glucose readings ranged from 229mg/dl to 410mg/dl.

Refer to interview with the Administrator on 06/27/18 at 11:45am.

Interview with the Administrator on 06/27/18 at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 26 11:45am revealed: -She did not know the MAs were not following the guidelines for the administration of insulin, including the FlexPens. -She did not know the "Crush all medications in applesauce" was not being followed by the MAs as ordered by the PCP. -She did not know the MA's were not referring to the MAR before administering an SSI. -The RCD administered all training to the MAs. -The RCD held monthly mandatory meetings for the MAs and reviewed proper administration of medications. -She did not know why the MAs were not following policies and procedures 2. Review of Resident #3's current FL2 dated 03/15/18 revealed: -Diagnoses included dementia, congestive heart disease, anticoagulated, atrial fibrillation, and cancer of prostate. a. Review of Resident #3's laboratory results dated 03/12/18 revealed: -Red blood count (RBC) result was 3.67, the reference range was 4.10-6.20. -Hemoglobin result was 10.9, the reference range was 13.5-17.5. -Hematocrit result was 32.1, the reference range was 41.0-53.0. -A physician's order for iron sulfate 325mg daily for 6 months Review of Resident #3's April 2018 MAR revealed: -There was an entry for ferrous sulfate (generic for iron sulfate) 325mg tablet once daily scheduled at 9:00 am for 42 days. -The ferrous sulfate 325mg was documented as	{D 358}		

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{D 358}	Continued From page 27 administered once daily from 04/01/18-04/30/18. Review of Resident #3's May 2018 MAR revealed there was no entry for iron sulfate 325mg tablet and was not documented as administered from 05/01/18 and 05/31/18. Review of Resident #3's June 2018 MAR revealed there was no entry for iron sulfate 325mg tablet and was not documented as administered from 06/01/18 and 06/30/18. Observation of Resident #3's medications on 06/27/18 at 11:15am revealed there was no iron sulfate 325mg available for administration. Interview with a medication aide (MA) on 06/06/18 at 11:15am revealed: -Resident #3 no longer administered iron sulfate, "he might have finished the medication". -She was not sure what happened, "iron is not listed on the MAR, and he is not receiving it". -She administered medications according to the MAR. Telephone interview with the contracted pharmacy provider on 06/27/18 at 3:15pm revealed: -On 03/15/18 they received an order Resident #3's iron sulfate 325mg daily for 6 months. -The order for iron sulfate 325mg daily was entered into the computer system for 6 weeks instead of 6 months incorrectly. -The pharmacy was responsible for entering order onto the MAR. -After 6 weeks the iron sulfate was removed from the pharmacy computer system. -The pharmacy had dispensed 30 iron sulfate 325mg tablets on 03/15/18 and 04/09/18. -The facility had not notified them of any	{D 358}		

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{D 358}	Continued From page 28	{D 358}		

discrepancies with the MAR for April, May, or June for Resident #3 until 06/27/18.

Telephone interview with Resident #3's physician on 06/28/18 at 10:09am revealed:
-Resident #3 was prescribed iron for his low hemoglobin, low RBC, and low hematocrit.
-She ordered the iron sulfate 325mg daily to address low hemoglobin, RBC, and hematocrit levels.
-She had not ordered additional lab work since prescribing the iron sulfate 325mg.
-She expected the facility to give medication as ordered.
-If the iron sulfate had not been being administered as the order was written, then the resident "levels would still be low and he could become anemic".

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

Attempted telephone interview with Resident #3's responsible person on 06/27/18 at 4:03pm was unsuccessful.

Interview with the Memory Care Resident Care Coordinator (MCRCC) on 06/27/18 at 11:35am revealed:
-She did not realize the iron sulfate was no longer on the MAR.
-MAs were responsible for doing an initial check of the previous month MAR, new MAR, and physician orders to ensure that the MAR is accurate.
-There was no specific MA responsible for checking the MAR, any of the MAs could review.
-Once the MA reviewed, she was supposed to also review the previous month MAR, new MAR,

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{D 358}	Continued From page 29	{D 358}		

and physician orders.
-The Wellness Director (WD) completed the final check of the MAR.
-She was not sure how the iron sulfate was missed, "it was not caught, I don't know what happened".
-Cart audits were done weekly and it was missed.

Attempted telephone interview with the WD on 06/28/18 at 10:45am was unsuccessful.

Interview with the Resident Services Director (RSD) on 06/27/18 at 3:31pm revealed:
-The MA and MCRCC were responsible for reviewing the MAR at the end of each month to check for discrepancies.
-Cart audits are also completed weekly to catch discrepancies.
-"I don't understand how the iron sulfate was missed"
-"The pharmacy did recognize that it was an error on their end, but it should have been caught by us"

Interview with the Administrator on 06/06/18 at 3:27pm:
-She expected the MAs to review physician orders and MARs to prevent errors.
-She expected the MCRCC and WD to complete cart audits to prevent medications from being missed.
-"This got by everybody, I am not sure what happened".
-"We are meeting every month to go over the process for reviewing and documenting on the MAR"
-"I expect everyone to follow the process we have in place for reviewing the MAR"

b. Review of Resident #3's current FL2 dated

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{D 358}	Continued From page 30 03/15/18 revealed an order for colchicine 0.6 mg, 2 capsules at the first sign of gout and 1 capsule 1 hour later. Review of Resident #3's April 2018 MAR revealed: -There was an entry for colchicine 0.6 mg, 2 capsules at the first sign of gout and 1 capsule 1 hour later scheduled PRN. -There were no documented administrations from 04/01/18-04/30/18. Review of Resident #3's May 2018 MAR revealed there was no entry for colchicine 0.6 mg, 2 capsules at the first sign of gout and 1 capsule 1 hour later. Review of subsequent physician order dated 06/27/18 revealed an order for colchicine 0.6mg, 2 capsules at the first sign of gout and 1 capsule 1 hour later. Review of Resident #3's June 2018 MAR revealed there was no entry for colchicine 0.6 mg, 2 capsules at the first sign of gout and 1 capsule 1 hour later. Observation of Resident #3's medications on 06/27/18 at 11:15am revealed there was no colchicine 0.6 mg available for administration. Interview with a medication aide (MA) on 06/06/18 at 11:15am revealed: -Resident #3's MAR did not include colchicine, "I don't remember him ever getting that medication". -She had not noticed any flare ups of gout. -She did not know if colchicine was ordered for Resident #3. -She administered medications according to the	{D 358}		

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{D 358}	Continued From page 31 MAR. Telephone interview with the contracted pharmacy provider on 06/27/18 at 3:15pm revealed: -On 03/06/18 they received an order Resident #3's colchicine 0.6mg, 2 capsules at the first sign of gout and 1 capsule. -The order for colchicine 0.6mg was removed from the computer system in error. -The pharmacy had dispensed 30 colchicine 0.6mg tablets on 03/06/18; no additional fill history. -The facility had not notified them of any discrepancies with the MAR for April, May, or June for Resident #3 until 06/27/18. Telephone interview with Resident #3's physician on 06/28/18 at 10:09am revealed: -Resident #3 was prescribed colchicine for gout flare ups. -She was not familiar with his history of gout flare-ups. -She had not been notified of any gout flare-ups since resident was admitted to facility. -She expected the facility to give medication as ordered and have medication available for administration. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's responsible person on 06/27/18 at 4:03pm was unsuccessful. Interview with the Memory Care Resident Care Coordinator (MCRCC) on 06/27/18 at 11:35am revealed:	{D 358}		

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{D 358}	Continued From page 32 -She did not realize the colchicine 0.6mg was no longer on the MAR. -MAs were responsible for doing an initial check of the previous month MAR, new MAR, and physician orders to ensure that the MAR was accurate. -There was no specific MA responsible for checking the MAR, any of the MAs could review. -Once the MA reviewed, she was supposed to also review the previous month MAR, new MAR, and physician orders. -The Memory Care Wellness Director (MCWD) completed the final check of the MAR. -She was not sure how the colchicine was missed, "it was not caught, I don't know what happened". -Cart audits are done weekly and it was missed. Attempted telephone interview with the MCWD on 06/28/18 at 10:45am was unsuccessful. Interview with the Resident Services Director (RSD) on 06/27/18 at 3:31pm revealed: -The MA and MCRCC were responsible for reviewing the MAR at the each month to check for discrepancies. -Cart audits are also completed weekly to catch discrepancies. -"I don't understand how the colchicine was missed". -"The pharmacy did recognize that it was an error on their end, but it should have been caught by us". Interview with the Administrator on 06/06/18 at 3:27pm: -She is expected the MAs, MCRCC, and MCWD to review physician orders, review MARs, and complete cart audits to prevent medications from being missed.	{D 358}		

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{D 358}	Continued From page 33 -"This got by everybody, I am not sure what happened". -"We are meeting every month to go over the process for reviewing and documenting on the MAR". -"I expect everyone to follow the process we have in place for reviewing the MAR". _____ The facility failed to assure medications were administered as ordered as reflected by the observation of the medication pass with a 32% error rate which included errors with the administration of insulin, errors with an administration of an antibiotic for infection, and an acid reducing medication for gastroesophageal reflux. The facility failed to follow their medication administration policy requiring MAs to read the MAR before administering medications to the residents; and failed to administer medications as ordered including a supplement and failed to have a PRN anti-inflammatory medication available for administration. These failures to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and harm constitutes a continued Unabated Type B Violation.	{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	{D 367}		

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{D 367}	Continued From page 34 or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure accurate documentation on the Medication Administration Record (MAR) for 2 of 7 (Resident #2 and #3) related to documenting administration of Eliquis, a blood thinner (Resident #2) and iron sulfate used to treat iron deficiency anemia and colchicine an anti-inflammatory used to treat gout (Resident #3). 1. Review of Resident #2's current FL 2 dated 03/21/18 revealed: -Diagnoses included pneumonia, chronic kidney disease, diabetes mellitus type 2, heart failure, atrial fibrillation and long term anticoagulation therapy. -There was a physician's order for Eliquis 2.5mg twice a day (a medication used to prevent blood clots in people who have atrial fibrillation). Review of Resident #2's Medication Administration Record (MAR) for April 2018 revealed: -There was a computer generated entry for	{D 367}		

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{D 367}	Continued From page 35	{D 367}		

Eliquis 2.5mg twice a day.
-The Eliquis 2.5mg twice a day was documented as administered 04/01/18 - 04/30/2018 at 8:00am and 8:00pm.

Review of Resident #2's MAR for May 2018 revealed:
-There was a computer generated entry for Eliquis 2.5mg once a day.
-The Eliquis 2.5mg once a day was documented as administered 05/01/18 - 05/31/2018 at 9:00am.

Review of Resident #2's MAR for June 2018 revealed:
-There was a computer generated entry for Eliquis 2.5mg once a day.
-The Eliquis 2.5mg once a day was documented as administered 06/01/18 - 06/18/2018 at 9:00am.
-There was a handwritten entry for Eliquis 2.5mg twice a day.
-The Eliquis 2.5mg twice a day was documented as administered 06/19/18 - 06/27/18 at 8:00am and 8:00pm.

Observation of Resident #2's medications available for administration on 06/27/18 at 8:58am revealed there was 1 bottle containing Eliquis 2.5mg twice a day with a "directions changed refer to chart", dispensed on 06/05/18.

Interview with a MA on 06/27/18 at 7:15am revealed:
-She added the entry for Eliquis 2.5mg once a day on the May and June 2018 MAR.
-She did not clarify the order for Eliquis 2.5mg once a day on the May and June 2018 MAR. She must have "missed" the fact the order was ordered for Eliquis 2.5mg twice a day.

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{D 367}	Continued From page 36 Interview with the RCC on 06/27/18 at 12:32pm revealed: -She was the RCC for a year. -She did not catch the entry for Eliquis 2.5mg once a day on May and June 2018 MARs, did not match the physician's order of Eliquis 2.5mg twice a on the FL2 dated 03/21/18. -She did not call the physician for clarification. -She did not know why the error happened. -On 06/18/18 she along with the Administrator did a cart audit where the medication label did not match the entry on the June MAR. -The medication bottle was labeled as Eliquis 2.5mg twice a day and the June 2018 entry was Eliquis 2.5mg once a day. Interview with Resident #2 on 06/27/18 at 1:08pm revealed: -She took Eliquis 2.5mg twice a day for atrial fibrillation. -She took Eliquis for over a year now. Interview with the Health and Wellness Director (HWD) on 06/27/18 at 3:37pm revealed she did know the Eliquis 2.5mg once a day was written on the May and June 2018 MAR incorrectly on 06/18/18. Interview with the Administrator on 06/28/18 at 9:40am revealed: -The June 2018 MAR entry was for Eliquis 2.5mg once a day. -The order was clarified by the physician for Eliquis 2.5 mg twice a day on 06/18/18. -She did not know how the Eliquis 2.5mg once a day was transcribe onto the May and June 2018 MARs. -She expected the staff to transcribed the orders correctly on the MARs.	{D 367}		

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{D 367}	Continued From page 37 2. Review of Resident #3's current FL2 dated 03/15/18 revealed: -Diagnoses included dementia, congestive heart disease, anticoagulated, atrial fibrillation, and cancer of prostate. a. Review of Resident #3's signed physician order written on lab results dated 03/12/18 revealed an order for iron sulfate 325mg daily for 6 months. Review of Resident #3's April 2018 Medication Administration Record (MAR) revealed: -There was an entry for ferrous sulfate (generic for iron sulfate) 325mg tablet once daily scheduled at 9:00 am for 42 days. -The ferrous sulfate 325mg was documented as administered daily from 04/01/18-04/30/18. Review of Resident #3's May 2018 MAR revealed there was no entry for iron sulfate 325mg tablet and was not documented as administered from 05/01/18 and 05/31/18. Review of Resident #3's June 2018 MAR revealed there was no entry for iron sulfate 325mg tablet and was not documented as administered from 06/01/18 and 06/30/18. Observation of Resident #3's medications on 06/27/18 at 11:15am revealed there was no iron sulfate 325mg available for administration. Interview with a medication aide (MA) on 06/06/18 at 11:15am revealed: -She was not sure what happened, "iron is not listed on the MAR, and he is not receiving it". -She administered medications according to the MAR.	{D 367}		

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{D 367}	Continued From page 38 Telephone interview with the contracted pharmacy provider on 06/27/18 at 3:15pm revealed: -On 03/15/18 they received an order Resident #3's iron sulfate 325mg daily for 6 months. -The order for iron sulfate 325mg daily was entered incorrectly into the computer system for 6 weeks instead of 6 months. -After 6 weeks the iron sulfate was removed from the pharmacy computer system. -The facility had not notified them of any discrepancies with the MAR for April, May, or June for Resident #3 until 06/27/18. Interview with the Memory Care Resident Care Coordinator (MCRCC) on 06/27/18 at 11:35am revealed: -She did not realize the iron sulfate was no longer on the MAR. -MAs were responsible for doing an initial check of the previous month MARs, new MARs, and physician orders to ensure that the MARs were accurate. -There was no specific MA responsible for checking the MAR, any of the MAs could review. -Once the MA reviewed, she was supposed to also review the previous months MARs, new MARs, and physician orders. -The Wellness Director (WD) completed the final check of the MAR. -She was not sure how the iron sulfate was missed, "it was not caught, I don't know what happened". Attempted telephone interview with the WD on 06/28/18 at 10:45am was unsuccessful. Interview with the Resident Services Director (RSD) on 06/27/18 at 3:31pm revealed: -The MA and MCRCC were responsible for	{D 367}		

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{D 367}	Continued From page 39	{D 367}		

reviewing the MAR at the each month to check for discrepancies.
-"I don't understand how the iron sulfate was missed"
-"The pharmacy did recognize that it was an error on their end, but it should have been caught by us"

Interview with the Administrator on 06/06/18 at 3:27pm:
-She expected the MAs, MCRCC, and WD to review physician orders, review MARs monthly to prevent medications from being missed.
-"This got by everybody, I am not sure what happened".
-"We are meeting every month to go over the process for reviewing the MAR".
-"I expect everyone to follow the process we have in place for reviewing the MAR".

b. Review of Resident #3's current FL2 dated 03/15/18 revealed an order for colchicine 0.6 mg, 2 capsules at the first sign of gout and 1 cap 1 hour later.

Review of Resident #3's April 2018 Medication Administration Record (MAR) revealed:
-There was an entry for colchicine 0.6 mg, 2 capsules at the first sign of gout and 1 capsule 1 hour later scheduled PRN.
-There were no documented administrations from 04/01/18-04/30/18.

Review of Resident #3's May 2018 MAR revealed there was no entry for colchicine 0.6 mg, 2 capsules at the first sign of gout and 1 capsule 1 hour later.

Review of Resident #3's June 2018 MAR revealed there was no entry for colchicine 0.6 mg,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 40 2 capsules at the first sign of gout and 1 capsule 1 hour later. Telephone interview with the contracted pharmacy provider on 06/27/18 at 3:15pm revealed: -On 03/06/18 they received an order Resident #3's colchicine 0.6mg, 2 capsules at the first sign of gout and 1 capsule. -The order for colchicine 0.6mg was removed from the computer system in error. -The pharmacy had dispensed 30 colchicine 0.6mg tablets on 03/06/18; no additional fill history. -The facility had not notified them of any discrepancies with the MAR for April, May, or June for Resident #3 until 06/27/18. Interview with the Memory Care Resident Care Coordinator (MCRCC) on 06/27/18 at 11:35am revealed: -She did not realize the colchicine 0.6mg was no longer on the MAR. -MAs were responsible for doing an initial check of the previous month MAR, new MAR, and physician orders to ensure that the MAR is accurate. -There was no specific MA responsible for checking the MAR, any of the MAs could review. -Once the MA reviewed, she was supposed to also review the previous month MAR, new MAR, and physician orders. -The Wellness Director (WD) completed the final check of the MAR. -She was not sure how the colchicine was missed, "it was not caught, I don't know what happened". Attempted telephone interview with the WD on 06/28/18 at 10:45am was unsuccessful.	{D 367}		

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{D 367}	Continued From page 41 Interview with the Resident Services Director (RSD) on 06/27/18 at 3:31pm revealed: -The MA and MCRCC were responsible for reviewing the MAR at the each month to check for discrepancies. -"I don't understand how the colchicine was missed". -"The pharmacy did recognize that it was an error on their end, but it should have been caught by us." Interview with the Administrator on 06/06/18 at 3:27pm: -She is expected the MAs, MCRCC, and WD to review physician orders, review MARs, and complete cart audits to prevent medications from being missed. -"This got by everybody, I am not sure what happened". -"We are meeting every month to go over the process for reviewing the MAR". -"I expect everyone to follow the process we have in place for reviewing the MAR".	{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	{D912}		

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{D912}	Continued From page 42 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. The findings are: A. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 7 of 9 residents including the observation of the medication pass (Resident's #2, #6, #7, #8, and #10) which included errors with the administration of insulin for (Residents #2, #6, #9, and #10), errors with an antibiotic for infection and an acid reducing medication for gastroesophageal reflux (Resident #8); the facility failed to follow their medication administration policy requiring medication aides (MAs) to read the medication administration record (MAR) before administering medications to the residents (Resident's #2 and #7); the facility failed to administer medications as ordered including a supplement (Resident #3), and the facility failed to have a PRN available for administration including an anti-inflammatory (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 health care referral and follow up to meet the health care needs for 3 of 9 sampled residents (Resident #6, #8, and #9) related to an order for medications to be crushed, (Resident #8) and fingerstick blood sugar (FSBS) results outside the parameters and notification to the physician (Resident #6 and #9) [Refer to Tag 273 10A NCAC 13F .0902(b) Health	{D912}		

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{D912}	Continued From page 43 Care (Unabated Type B Violation)].	{D912}		