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BRYSON SENIOR LIVING	314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713

(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 Swain County Department of Social Services conducted an initial survey on August 20-22, 2018.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure theraputic diets were served as ordered for 2 of 5 residents sampled with orders for theraputic diets of no added table salt (Resident #3) and chopped meats (Resident #4). The findings are: 1. Review of Resident #3's current FL2 dated 07/16/18 revealed: -Diagnoses included hypertensive chronic kidney disease and nontraumatic intracerebral hemorrhage. -There was a physician's order for a no added salt diet (NATS). Review of a diet order for Resident #3 dated 07/18/18 revealed an order for a no added salt.	D 310		

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D 310	Continued From page 1 Review of the diet list in a notebook in the kitchen contained resident diet orders the cook went by revealed Resident #3 was on a no added salt diet. Observation of the lunch meal service on 08/20/18 from 12:36pm to 1:05pm revealed: -Resident #3 was served a plate with a slice of ham, peas and carrots, scalloped potatoes and a biscuit. -There was a salt shaker on the table in front of Resident #3. -At 12:44pm, Resident #3 used the salt shaker to sprinkle salt on the food on his plate. Interview with the personal care assistant (PCA) on 08/20/2018 at 12:55pm revealed: -The kitchen staff told the dining room staff whose plate it was when they brought it to the kitchen door. -Many times, the dietary staff just brought the residents plate out and placed it in front of the resident. -Salt shakers were on all the tables for the residents use. -She was not aware that Resident #3 was on a NATS diet. Interview with the medication aide/supervisor (MA/S) on 08/20/18 at 12:55pm revealed: -He frequently assisted in the dining room. -He had assisted in the dining room on 08/20/18. -Salt shakers were on the table for residents use at each meal. -He was not aware Resident #3 was on a NATS diet. Interview with the Cook on 08/20/2018 at 1:05pm revealed: -There was a list of diets posted in the book in the	D 310		

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kitchen of what each resident was supposed to be served.
-Resident #3 was supposed to be on a no added table salt diet.
-"We just didn't think about the salt shaker being on his table."

Observation of the breakfast meal service on 08/21/2018 at 7:50am-8:27am revealed:
-Resident #3 entered the dining room at 7:50am.
-Resident #3 was served scrambled eggs, 2 sausage links, biscuit, and pineapple in a small bowl.
-He used the salt on the table 2 separate times during his meal.
-At 8:27am Resident #3 finished his breakfast and left the dining room.

Telephone interview with the Nurse at Resident #3's dialysis center on 08/22/18 at 9:46am revealed:
- "If he had an increase in fluid it would be detrimental, but he has been OK."
-The physician wanted him on a NATS diet so he did not hold fluid.
-"If he was to begin holding excess fluid our Dietician would call the facility and talk with them about his diet."

Interview with Resident #3 on 08/22/2018 at 9:55pm revealed:
-He was not aware he was not supposed to be using salt.
-"It's on the table, thought I could use it."

Interview with the Administrator on 08/22/2018 at 11:00am revealed:
-Everyone was on a liberal diet even if they had an order for NATS it was "his right" to have it.
-"We still put the salt shaker on the table."

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D 310	Continued From page 3 -"We can't take it away, just remind him not to eat it." 2. Review of Resident #4's current FL-2 dated 06/30/18 revealed: -Diagnoses included hypertension, hypothyroidism, -A physician's order for a regular, chopped meats diet, no concentrated sweets diet. Review of Resident #4's Resident Register dated 6/29/18 revealed food preferences was for a regular chopped diet. Review of a diet order for Resident #4 dated 07/11/18 revealed a physician's order for a chopped meats. Review of the diet list in a notebook in the kitchen contained resident diet orders the cook went by revealed Resident #4 was on a chopped meats diet. Review of the therapeutic diet spreadsheet for a chopped diet lunch menu posted in the kitchen on 08/20/2018 revealed the menu included 3 ounces (oz.) of chopped spiral ham. Observation on 08/20/2018 at 12:36pm of the lunch meal service revealed: -The Cook brought out Resident #4's lunch plate out from the kitchen and placed it in front of him. -Resident #4 was served a plate with a whole slice of ham, peas and carrots, scalloped potatoes and a biscuit. -He did not appear to have any difficulties eating the ham. Interview with Resident #4 on 08/20/18 at 12:36pm revealed:	D 310		

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-He did not know his meat was to be chopped.
-He did not remember having any difficulties with eating meat.

Interview with the personal care assistant (PCA) on 08/20/2018 at 12:55pm revealed:
-The kitchen told the dining room staff whose plate it was when they brought it to the kitchen door.
-Many times the dietary staff just brought the residents plate out and placed it in front of them.
-She was unaware Resident #4's meat was supposed to be chopped.
-The Cook had brought out Resident #4's meal to him.
-She only knew whose plate it was if the dietary staff told her when they handed her a plate.

Interview with the medication aide/supervisor (MA/S) on 08/20/18 at 12:55pm revealed:
-He frequently assisted in the dining room.
-He had assisted in the dining room on 08/20/18.
-He did not know that Resident #4 was supposed to have chopped meats.

Interview with the Cook on 08/20/2018 at 1:05pm revealed:
-Resident #4 was supposed to get chopped meats.
-"It was just an oversight."
-"He sure is (as she looked at the diet list in the notebook)."
-"We probably knew and just forgot."
-"We only go by the book" (referring to the resident diet order book in the kitchen).
-She had not used the diet list (08/20/2018) when she served Resident #4's lunch meal.

Interview with the Administrator on 08/22/2018 at 11:00am revealed he could not explain why

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D 310	Continued From page 5 Resident #4 did not get the chopped meat as the physician had ordered.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered to 1 of 3 sampled residents for record review (Resident #1) including errors with morphine sulfate, Bactrim DS, doxycycline, and miconazole/zinc cream; and for 2 of 6 sampled residents (Residents #5 and #6) observed during the medication passes including errors with clopidogrel (#5) and pravastatin (#6). The findings are: 1. Review of Resident #1's current FL2 dated 08/08/18 revealed diagnoses included cervical disc disorder with myelopathy, muscle weakness, difficulty walking, osteoarthritis, type 2 diabetes, and chronic obstructive pulmonary disease.	D 358		

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Review of Resident #1's Resident Register revealed an admission date of 08/03/18.

a. Review of a hospice physician's order dated 08/14/18 for Resident #1 revealed morphine ER (used to treat pain) 15mg 1 tablet every 12 hours.

Review of Resident #1's hospice nursing assessment note dated 08/19/18 revealed:
-The visit was made to assess for decline and effectiveness of medication regimen.
-The resident had an unstageable sacral pressure ulcer measuring 5 cm. in length by 8 cm. in width.

Review of a hospice physician's order for Resident #1 dated 08/19/18 revealed:
-There was an order for morphine sulfate (used to treat pain) 20mg/ml 10mg by mouth sublingual every 6 hours.
-There was an order for morphine sulfate 20mg/ml 10mg by mouth sublingual every 2 hours as needed for pain.
-"Morphine-will need pre-filled syringes."

Review of Resident #1's hospice nursing assessment note dated 08/20/18 at 1:57pm revealed:
-The visit was made to assess for decline and effectiveness of medication regimen.
-"Upon arrival at facility and after assessment discovered comfort meds ordered late yesterday morning had not yet been delivered to facility."
-"Patient crying out 'I can't take it anymore.'"
-The nurse assisted to get an escript for the medications sent to a local pharmacy, so the pain medication could be administered.
-"Expressed urgency in this prescription."
-"Discussed lack of delivery with RCM [Resident Care Manager] and facility administrator to have

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staff inform [local hospice] when meds are not received in a timely manner."

Interview with a hospice nurse on 08/20/18 at 4:15pm revealed:
-She was there to ensure Resident #1's new pain medications were effective and to assess the wound.
-Another hospice nurse had visited the resident on 08/19/18 and had started a new form of morphine "to help with his pain."
-"I came to change the dressing, but I didn't want to move him when he's in that much pain."
-The resident was in so much pain "he was stiff."
-The facility could not get the morphine sulfate from their pharmacy.
-The resident had not had any of the morphine ordered 08/19/18 "yet."
-"I'm trying to get it through Hospice and from the Hospice pharmacy."

Interview with the Administrator on 08/20/18 at 4:32pm revealed:
-"We are trying to work out what happened with his medications right now."
-"They were ordered yesterday, but they didn't come in from the pharmacy."
-"We are working with hospice now to get the medications here."

Observation of Resident #1's medications on hand on 08/21/18 at 10:44am revealed:
-There were two clear plastic bags of 0.5ml syringes with morphine sulfate 20mg/ml.
-The dispense date was 08/20/18 on both labels.

Interview with a medication aide (MA) on 08/21/18 at 11:02am revealed Resident #1's morphine sulfate was not delivered to the facility until 4am on 08/21/18.

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D 358	Continued From page 8 Interview with a second MA on 08/21/18 at 4:45pm revealed: -She had worked from 10:30pm on 08/20/18 through 7:00am on 08/21/18. -Resident #1 had "moaned all night in pain" on 08/20/18 and part of her shift on 08/21/18. -"I called the pharmacy and told them I have somebody here in critical pain." -The pharmacy told her the morphine sulfate was in transit, but would be delivered late. -"When I realized that, I tried repositioning him with pillows" to help make him more comfortable. -The morphine had arrived to the facility at 4:30am on 08/21/18. -She immediately administered a dose of the morphine sulfate to Resident #1. Interview with a third MA on 08/22/18 at 11:45am revealed: -She had worked on 08/19/18 evening shift. -The day shift MA had left her a copy of the hospice medication order changes for Resident #1. -"We were still waiting for the medications to come in" from the pharmacy. -There was an after hours phone number medication staff were supposed to call if they needed a medication delivered on days when the pharmacy did not normally deliver. -The pharmacy did not normally deliver on weekends. -The contracted facility pharmacy was responsible for contacting the backup pharmacy to arrange to provide the medication. Review of Resident #1's August 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for morphine sulfate	D 358		

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D 358	Continued From page 9 20mg/ml give 0.75ml (15mg) every 4 hours. -The morphine sulfate 20mg/ml give 0.75ml (15mg) every 4 hours was documented administered on 08/21/18 at 8pm and 08/22/18 at 12:00am, 4:00am, and 8:00am. -There was an entry for morphine sulfate 20mg/ml give 0.75ml (15mg) every 2 hours as needed for pain. -The morphine sulfate 20mg/ml give 0.75ml (15mg) every 2 hours as needed was documented on 08/20/18 at 8:00pm and 10:00pm as "waiting for pharm to deliver." -The morphine sulfate 20mg/ml give 0.75ml (15mg) every 2 hours as needed was documented on 08/21/18 at 1:58am, 08/21/18 at 3:33am were documented as "waiting on delivery" , 08/21/18 at 9:01am and 11:27am were documented as "administered late." Interview with the Administrator on 08/21/18 at 12:00pm revealed: -On 08/19/18, hospice had written a telephone order for Resident #1's medication changes. -The order was a narcotic medication and the pharmacy would not fill it until the physician provided a signed prescription with the quantity and DEA# on it to the pharmacy. -The facility pharmacy representative did not receive the script from the physician until "mid-morning" on 08/20/18. -The facility staff had tried to get the morphine from the local backup pharmacy, but the backup pharmacy didn't have the morphine sulfate in syringes. -The morphine sulfate was delivered from the contracted facility pharmacy on 08/21/18 at 4:30am. -"I didn't find out they actually wrote the orders until the hospice nurse got here yesterday (08/20/18) before lunch."	D 358		

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-When the hospice nurse had asked him why the morphine sulfate was not in the facility "that's when I found out about the orders."
-He had administered another medication Resident #1 had ordered to help with pain control.
-The hospice nurse asked the Administrator had the medications come in and he told her they had not.
-"Then she got on the phone with the triage nurse and they got a new prescription written."

Telephone interview with the contracted facility pharmacy representative on 08/21/18 at 12:12pm revealed:
-The pharmacy had received a faxed order for morphine sulfate for Resident #1 on 08/19/18 at 12:52pm.
-The escribed order came in "around the same time."
-The pharmacy did not deliver on Sundays.
-The order was processed 08/20/18 and was "delivered last night."
-Best practice would be for facility staff to call the pharmacy and "let us know they need the morphine immediately."
-"As long as we had the escript, we could process" the order.
-"We don't send out from backup unless the facility lets us know."

Interview with Resident #1's family member on 08/21/18 at 1:15pm revealed:
-Resident #1 was still "hollering out."
-The resident had "so much pain."
-The resident was unable to eat breakfast as he was "in so much pain."
-"I love him, it's so hard to see him suffer like this."

Observation of Resident #1 on 08/21/18 at

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D 358	Continued From page 11 1:25pm revealed: -The resident was lying in bed. -He was grimacing and yelled out several times in pain. Interview with a MA on 08/21/18 at 1:26pm revealed: -"I just game him pain medicine literally 40 minutes ago." -"If I could give him something else, I would." Interview with the Administrator on 08/21/18 at 1:30pm revealed: -He was not aware Resident #1's pain was not controlled. -He would notify hospice. Observation of Resident #1 on 08/21/18 at 3:45pm revealed the resident was lying in bed resting comfortably and no longer calling out in pain. Interview with the Resident Care Coordinator on 08/21/18 at 4:00pm revealed: -The backup pharmacy closed at 5pm on Saturdays, and 6pm on Sundays, and 7pm during the week. -"They do not carry morphine syringes." Interview with the facility Licensed Health Professional Support Nurse on 08/21/18 at 4:32 pm revealed the medication aide staff "should have reported to the chain of command" when they did not have the morphine to administer to Resident #1. Attempted follow-up telephone interview with the hospice nurse on 08/22/18 at 8:25am was unsuccessful.	D 358		

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D 358	Continued From page 12 b. Review of Resident #1's Nurse Practitioner's order dated 08/08/18 revealed a medication order for Bactrim DS (used to treat bacterial infection) 1 tablet two times a day for 10 days for cellulitis sacral pressure ulcer. Review of Resident #1's Nurse Practitioner's New Patient Encounter Note dated 08/10/18 revealed: -There was a stage II pressure ulcer on the sacrum. -"I am going to order antibiotics to hopefully reduce the erythema." Observation of Resident #1's medications on hand on 08/21/18 at 10:44am revealed: -There was one bubble pack of Bactrim DS tablets on hand with 19 tablets remaining in the pack. -The dispense date was 08/19/18. Interview with a medication aide (MA) on 08/21/18 at 11:02am revealed Resident #1 was still taking the Bactrim DS. Review of Resident #1's August 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Bactrim DS 800-160mg 1 tablet twice a day for 10 days scheduled for 8:00am and 8:00pm with a start date of 08/11/18 and an end date of 08/20/18. -From 08/11/18 at 8:00am to 08/20/18 at 8:00pm, the medication was documented as not administered due to "drug/item unavailable" (14 doses). -On 08/15/18 at 8:00pm, 08/16/18 at 8:00am, and 08/20/18 at 8:00pm, the reason documented for the medication not being administered was "waiting for pharmacy to send/deliver."	D 358		

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Telephone interview with the contracted facility pharmacy representative on 08/21/18 at 12:12pm revealed:
-They received an order for Bactrim DS 800-160mg 1 tablet twice daily for 10 days on 08/08/18.
-Resident #1's Bactrim was put into the eMAR system on 08/10/18.
-The medication was filled and sent to the facility on 08/19/18.

Telephone interview with Resident #1's Nurse Practitioner on 08/21/18 at 2:55pm revealed:
-She had ordered the Bactrim DS for "cellulitis" and an "infected bed sore."
-It was "problematic" the resident had not received the antibiotic.
-The facility had not made her aware the resident had not received the antibiotic as ordered.

Interview with the Resident Care Coordinator on 08/22/18 at 10:50am revealed:
-The pharmacy sent Resident #1's Bactrim on 08/18/18.
-The Bactrim had been escripted to them, so the pharmacy should have sent it.
-"I don't know why they didn't send it."
-On 08/16/18 at 9:01am and 7:56pm, she had administered medications and knew the Bactrim was unavailable for Resident #1.
-"I didn't call to check on it."
-The medication aides performed weekly medication cart audits.
-The audits included matching the medications on hand to the eMAR.
-"Somebody should have picked up on it."

c. Review of Resident #1's Nurse Practitioner's order dated 08/08/18 revealed an order for doxycycline (used to treat bacterial infection)

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100mg two times a day for 10 days for cellulitis sacral pressure ulcer.

Observation of Resident #1's medications on hand on 08/21/18 at 10:44am revealed there was no doxycycline available for administration.

Review of Resident #1's August 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for doxycycline hyclate 100mg take 1 capsule twice a day for 10 days scheduled for 8:00am and 8:00pm with a start date of 08/11/18 to end date of 08/20/18.
-From 08/11/18 at 8:00am to 08/20/18 at 8:00pm for 10 occurrences, the medication was documented as not administered due to "drug/item unavailable."
-On 08/16/18 8:56am, 08/16/18 at 7:50pm, 08/20/18 at 8:30pm, the reason documented for the medication not being administered was "waiting for pharmacy to send/deliver."

Telephone interview with the contracted facility pharmacy representative on 08/21/18 at 2:40pm revealed:
-They received an order for doxycycline 100mg 1 capsule twice daily for 10 days on 08/10/18.
-The medication was never dispensed.

Telephone interview with Resident #1's Nurse Practitioner on 08/21/18 at 2:55pm revealed:
-She had ordered the doxycycline for "cellulitis" and an "infected bed sore."
-It was "problematic" the resident had not received the antibiotic.
-The facility had not made her aware the resident had not received the antibiotic as ordered.

Interview with the Resident Care Coordinator on

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08/22/18 at 10:50am revealed:
-The doxycycline had been escripted to the pharmacy.
-"I don't know why they didn't send it."
-On 08/16/18 at 8:56am and 7:50pm, she had administered medications and knew the doxycycline was unavailable for Resident #1.
-"I didn't call to check on it."
-The medication aides performed weekly medication cart audits.
-The audits included matching the medications on hand to the eMAR.
-"Somebody should have picked up on it."

d. Review of Resident #1's current FL2 dated 08/08/18 revealed an order for miconazole nitrate 2% cream/Zinc 20% (used as a skin barrier) 1:1 apply to groin and buttocks each incontinent episode and as needed.

Review of Resident #1's Nurse Practitioner's New Patient Encounter Note dated 08/10/18 revealed:
-There was a stage II pressure ulcer on the sacrum.
-"At the present time, we are applying thick barrier cream to the wound."

Observation of Resident #1's medications on hand on 08/21/18 at 10:44am revealed there was no miconazole nitrate/zinc cream available for administration.

Interview with a medication aide on 08/21/18 at 11:00am revealed:
-"I honestly, don't remember putting anything on him."
-If the miconazole/zinc cream was available, it would be stored on the medication cart.

Telephone interview with the contracted facility

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pharmacy representative on 08/21/18 at 12:12pm revealed:
-They received an order on 08/10/18 for miconazole nitrate 2%/zinc 20% cream apply to groin and buttocks with each incontinent episode and as needed.
-The order was entered into the electronic Medication Administration Record system, however the cream was not sent.

Telephone interview with Resident #1's Nurse Practitioner on 08/21/18 at 2:55pm revealed:
-She had ordered the miconazole nitrate/zinc cream for "a barrier paste until the wound could be evaluated by hospice."
-The facility had not made her aware the resident had not received the cream as ordered.

Interview with the Administrator on 08/21/18 at 3:40pm revealed the miconazole nitrate/zinc ointment had been entered into the electronic Medication Administration Record system by the pharmacy as an as needed medication and therefore did not provide a reminder to staff to administer it with each incontinent episode.

Interview with the Resident Care Coordinator on 08/22/18 at 10:50am revealed:
-The medication aides performed weekly medication cart audits.
-The audits included matching the medications on hand to the eMAR.
-"Somebody should have picked up on it."

2. The medication error rate was 7% as evidenced by 2 errors of 27 opportunities observed during the medication passes on 08/20/18 at 11:58am and 08/21/18 at 8:20am.

a. Review of Resident #5's current FL2 dated

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D 358	Continued From page 17 08/01/18 revealed: -Diagnoses included fracture of the left femur, atherosclerosis heart disease of native coronary artery, and presence of cardiac pacemaker. -There was a medication order for clopidogrel (used to prevent blood clots) 75mg 1 tablet daily. Interview with the medication aide (MA) on 08/21/18 at 7:55am revealed: -The clopidogrel was not on hand to administer. -"I ordered it last night. It should be here." Observation of the 8:00am medication pass on 08/21/18 revealed: -At 7:57am, Resident #5 was administered five oral medication by the MA. -Clopidogrel was not administered. Review of Resident #5's August 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for clopidogrel 75mg 1 tablet daily scheduled at 8:30am. -The clopidogrel was documented as administered daily from 08/03/18 to 08/21/18 for 19 out of 20 opportunities. -On 08/21/18 at 7:57am, the clopidogrel was documented as not administered due to "med not in facility." Interview with the Resident Care Coordinator (RCC) on 08/21/18 at 9:05am revealed: -"If the clopidogrel had been ordered yesterday, it should have come in last night." -If it had come in from the pharmacy, it should have been put on the medication cart. -She would call the pharmacy to see where it was. -She assigned a group of residents to each medication aide.	D 358		

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-The medication aides were supposed to do a cart audit every week to make sure the residents did not run out of any of their medications.
-There was an indicator on the bubble pack that helped the medication aides know when to reorder a medication.
-Refill orders received by the pharmacy by 2:00pm would be delivered by midnight on the same day.
-Refill orders received after 2:00pm, come the next day at midnight.
-The pharmacy deliveries were once daily at midnight.
-"If it's an emergency" the contracted facility pharmacy would call it into the backup pharmacy.

Interview with the RCC on 08/21/18 at 9:45am revealed Resident #5's clopidogrel would be sent "tonight on cycle fill."

Interview with the RCC on 08/22/18 at 10:05am revealed:
-The resident recently had "recently" begun to use the contracted facility pharmacy for her medication supply.
-The resident's clopidogrel "was not in a bubble pack originally" but in a bottle.
-Resident #5 had not yet been assigned to an MA to perform weekly medication cart audits.

b. Review of Resident #6's current FL2 dated 06/27/18 revealed:
-Diagnoses included hyperlipidemia, cerebrovascular accident, and benign hypertension.
-There was a medication order for pravastatin 80mg 1/2 tablet daily.

Observation of a medication aide during the 08/21/18 8:00am medication pass revealed

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Resident #6 was administered 9 oral medications including 1 whole tablet of pravastatin 80mg.

Interview with the medication aide on 08/21/18 at 8:55am revealed:
-He had administered a whole tablet of pravastatin.
-"The order in the computer says a whole tab."

Observation of Resident #6's pravastatin bottle label on 08/21/18 at 8:56am revealed:
-The directions were pravastatin 80mg take (40mg) 1/2 tablet daily.
-Inside the bottle there were 3 whole tablets and 1 half tablet.

Review of Resident #6's August 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for pravastatin 40mg take 1 tablet daily at 8:00am.
-Pravastatin was documented as administered daily from 08/01/18 to 08/21/18 at 8:00am.

Interview with the Resident Care Coordinator on 08/21/18 at 9:05am revealed:
-The pravastatin order for Resident #6 was for 40mg daily.
-There was a pill splitter available on the medication cart.
-The 80mg tablet should have been split to make the 40mg dose.
-Resident #6 did not get her medications from the contracted facility pharmacy.
-Resident #6's medications were obtained from a local pharmacy, so the medications came from the pharmacy in bottles.
-"On the eMAR, it's written as one 40mg tablet."

Telephone interview with Resident #6's Nurse

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D 358	Continued From page 20 Practitioner on 08/21/18 at 2:55pm revealed it was "negligible" impact to the resident to receive an 80mg dose of pravastatin versus the prescribed 40mg dose. _____ The facility failed to assure pain medication and antibiotics were administered as ordered by the physician for 1 of 3 sampled residents resulting in a resident experiencing poor pain control for over 40 hours and leaving a wound infection untreated with antibiotics for 12 days. The facility's failure to administer these medications as ordered, resulted in substantial risk of serious physical harm which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2018.	D 358		
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 observations, interviews, and record	D912		

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D912	Continued From page 21 reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered to 1 of 3 sampled residents for record review (Resident #1) including errors with morphine sulfate, Bactrim DS, doxycycline, and miconazole/zinc cream; and for 2 of 6 sampled residents (Residents #5 and #6) observed during the medication passes including errors with clopidogrel (#5) and pravastatin (#6). [Refer to Tag 0358 10A NCAC 13F.1004(a) Medication Administration (Type A2 Violation)].	D912		