Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL087009	A. BUILDING: _____ B. WING _____	R 10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 conducted a follow up survey on 10/03/18.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents with orders for furosemide, levothyroxine and potassium chloride (Resident #1). The findings are: Review of Resident #1's current FL2 dated 09/14/18 revealed: -Diagnoses included congestive heart failure, chronic kidney disease stage 3, coronary artery disease, diabetes mellitus type 2, chronic obstructive pulmonary disease, and a right leg	{D 358}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law. 1. Implemented an order processing system to facilitate the timely processing of orders to ensure that they are prescribed, profiled by pharmacy and entered into health record in a timely manner. 2. All staff will recieve in-service training on the order processing system to ensure that protocols are followed for all incoming, new prescriptions. 3. Weekly chart audits are done by all medication aids to determine that all meds that are listed on the MAR are also in the building and on med carts. 4. Random monthly chart audits will be completed by RCC to ensure that all meds are in building, on the cart, and accounted for.	10/4/18 10/10/18 10/4/18 10/10/18

RD

Reviewed and accepted 10/31/18

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{D 358}	Continued From page 1 wound ulcer. -There was an order for furosemide (treats fluid retention) 20mg every day as needed for edema. -There was an order for levothyroxine (treats thyroid hormone deficiency) 200mcg daily. -There was an order for potassium chloride (treats low blood levels of potassium) ER 10mEq daily. a. Review of Resident #1's order dated 09/21/18 revealed: -Discontinue as needed furosemide. -Furosemide 20mg daily. Review of Resident #1's September 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for furosemide 20mg every day as needed for edema. -The furosemide 20mg was documented as administered on 09/25/18 at 7:33pm for 1 of 9 opportunities from 09/21/18 to 09/30/18. Review of Resident #1's clarification order from the Nurse Practitioner (NP) dated 10/03/18 revealed: -There was an order to discontinue all previous orders for furosemide. -There was an order for furosemide 20mg daily. Review of Resident #1's October 2018 eMAR revealed: -There were two entries for furosemide 20mg 1 tablet every day as needed for edema. -The furosemide 20mg was documented as administered on 10/03/18 for 1 of 3 opportunities from 10/01/18 to 10/03/18. Observation of Resident #1's medications on hand on 10/03/18 at 11:20am revealed:	{D 358}		

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{D 358}	Continued From page 2 -There was one bubble pack of furosemide 20mg tablets available for administration. -There were 29 tablets remaining out of the 32 tablets dispensed on 09/19/18. -The direction label was for furosemide 20mg every day as needed for edema. Interview with Resident #1 on 10/03/18 at 3:36pm revealed: -"My leg is so swollen, I can't get out of the wheelchair to stand to get onto the commode." -She now required staff assistance in standing to transfer to the commode and her bed. -She had just "gotten over" having a lot of fluid in her leg and "now it's back again." -"We got all the fluid off and it was feeling good and now it's swollen again." -She was able to pivot and transfer to the commode and bed without help when the swelling in her leg and "belly" was less. -"My stomach is huge." -She could not lay in bed because she felt "uncomfortable" when her abdomen pressed "on everything." -She attributed the increase in the size of her abdomen to fluid build up. Observation of Resident #1's right lower extremity on 10/03/18 at 3:37pm revealed: -Resident #1's right pant leg was extremely tight around the resident's leg. -The resident pulled on the pant leg to stretch the material to just below her knee to reveal the skin of her lower leg. Interview with the Executive Director on 10/03/18 at 3:20pm and 4:20pm revealed: -The Resident Care Coordinator had discovered "the error" with Resident #1's furosemide "this morning" (10/03/18).	{D 358}		

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{D 358}	Continued From page 3 -The furosemide order was changed to daily in the eMAR system "this morning, " so it was given this morning. -The as needed order had been in place "until this morning." -"She really doesn't have a lot of edema, except in the amputated leg." -The Nurse Practitioner had written the order for the furosemide to be given daily, because of the edema in the amputated leg. -Resident #1 had seen the Nurse Practitioner on 09/21/18, 09/28/18, and on 10/03/18. -Home Health came in twice a week to assess Resident #1 and to perform wound care. Telephone interview with the facility's contracted pharmacy on 10/03/18 at 3:15pm revealed: -A physician's order from the FL2 dated 09/14/18, for furosemide 20mg daily as needed for edema, was faxed on 09/19/18 to the pharmacy from the facility. -The pharmacy dispensed 32 tablets of furosemide 20mg. -The pharmacy had no other furosemide orders. Telephone interview with the NP from Resident #1's primary care physician office on 10/03/18 at 4:36pm revealed: -The furosemide was used to reduce edema. -The resident would have experienced "unchanged edema" as a result of not having had the furosemide daily as it had been ordered. b. Review of Resident #1's prescription dated 09/19/18 revealed an order for levothyroxine 300mcg daily. Review of Resident #1's signed physician order sheet dated 09/21/18 revealed an order for levothyroxine 200mcg daily.	{D 358}		

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{D 358}	Continued From page 4 Review of Resident #1's September 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for levothyroxine 200mcg 1 tablet daily at 8:00am. -The levothyroxine 200mcg was documented as administered 2 times (on 09/20/18 and 09/21/18) from 09/20/18 to 09/30/18. -There was an entry for levothyroxine 300mcg 1 tablet daily at 8:00am. -The levothyroxine 300mcg was documented as administered 9 times from 09/22/18 to 09/30/18. Review of Resident #1's clarification order from the NP dated 10/03/18 revealed: -The resident may continue levothyroxine 300mcg until 10/03/18, then discontinue levothyroxine 300mcg. -On 10/04/18, start levothyroxine 200mcg 1 tablet daily. Review of Resident #1's October 2018 eMAR revealed: -There was an entry for levothyroxine 300mcg daily at 7:00am. -The levothyroxine 300mcg was documented as administered daily from 10/01/18 to 10/03/18. Observation of Resident #1's medications on hand on 10/03/18 at 11:20am revealed: -There was no levothyroxine 200mcg tablets available for Resident #1. -There was one bubble pack of levothyroxine 300mcg tablets available for administration. -There were 21 tablets remaining out of the 28 tablets dispensed on 09/20/18. -The direction label was for levothyroxine 300mcg 1 tablet daily.	{D 358}		

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{D 358}	Continued From page 5 Interview with Resident #1 on 10/03/18 at 3:36pm revealed: -"They had me on 200mcg and then they put me on 300mcg." -"I thought they had changed me back to 200mcg." Interview with the Executive Director on 10/03/18 at 3:15pm revealed: -He had just obtained a clarification order from the NP for the levothyroxine order for Resident #1. -He did not know how the change of orders was overlooked by staff. Telephone interview with the facility's contracted pharmacy on 10/03/18 at 3:15pm revealed: -A physician's order for levothyroxine 200mcg daily dated 09/13/18 was faxed on 09/19/18 to the pharmacy from the facility. -The pharmacy dispensed 32 tablets of levothyroxine 200mcg. -The pharmacy had received an electronic prescription for levothyroxine 300mcg daily on 09/19/18 and dispensed 28 tablets. -The facility returned 28 tablets of levothyroxine 200mcg. -A physician's order for levothyroxine 200mcg daily dated 09/19/18 was faxed on 09/21/18 to the pharmacy from the facility. -The levothyroxine 200mcg dated 09/19/18 had not been dispensed by the pharmacy. -The Pharmacist did not know why the levothyroxine 200mcg dated 09/18/18 had not been dispensed by the pharmacy. -"Maybe the last 200mcg (levothyroxine order dated 09/19/18) was overlooked." Telephone interview with the NP from Resident #1's primary care physician office on 10/03/18 at	{D 358}		

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{D 358}	Continued From page 6 4:36pm revealed: -Resident #1 had severe hypothyroidism due to medication non-compliance and had to be hospitalized before coming to the facility. -Upon discharge from the hospital they had put her on 300mcg daily. -The hospital had intended for her to go back on the 200mcg daily dose after a period of time. -The resident having received the increased dose of levothyroxine from 09/21/18 to 10/03/18 "probably did not hurt her at all." -The NP was going to repeat a Thyroid Stimulating Hormone (TSH) blood test (a test to determine if the thyroid gland is functioning properly and determines how much TSH is in the blood) for the resident on 10/04/18 or 10/05/18 "to make sure." c. Review of Resident #1's NP order dated 09/27/18 revealed potassium chloride 10mEq 1 tablet daily. Review of Resident #1's September 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for potassium chloride 10mEq 1 tablet daily at 8:00am. -The potassium chloride 10mEq was documented as administered 3 of 11 opportunities from 09/20/18 to 09/30/18. Review of Resident #1's October 2018 eMAR revealed: -There was an entry for potassium chloride 10mEq 1 tablet daily at 8:00am. -The potassium chloride 10mEq was documented as administered daily from 10/01/18 to 10/03/18. Observation of Resident #1's medications on hand on 10/03/18 at 11:20am revealed there was	{D 358}		

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{D 358}	Continued From page 7 no potassium chloride available in the facility for the resident. Interview with a medication aide on 10/03/18 at 11:33am revealed: -The potassium chloride for Resident #1 was not on the medication cart or in storage. -The medication had been ordered by a NP, but the order did not get to the pharmacy. -She had administered Resident #1's potassium chloride for the 8:00am dose on 10/03/18. -She had borrowed the potassium chloride 10mEq tablet from another resident to give on 10/03/18. Review of a Borrowing and Replacing Emergency Medication form dated 09/27/18 revealed: -One tablet of potassium chloride was borrowed for Resident #1 from another resident. -The borrowing medication aide, the Care Manager, and the Executive Director had all signed off of knowledge of the borrow of the potassium chloride. Interview with the Executive Director on 10/03/18 at 3:20pm revealed: -"I found out the potassium chloride was not here on Sunday night (09/30/18)." -"I had worked 7am to 11pm on Sunday so I did not work on Monday (10/01/18)." -He had come back to work on Tuesday (10/02/18) and had not yet followed up on getting the potassium chloride for Resident #1. -The dose documented as administered on 10/03/18 had been borrowed from another resident. Telephone interview with the NP from Resident #1's primary care physician office on 10/03/18 at 4:36pm revealed since Resident #1 had not	{D 358}		

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{D 358}	Continued From page 8 received the furosemide as it has been ordered there was no negative affect to the resident not having received the doses of potassium chloride as ordered.	{D 358}		