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
	HAL060152	A. BUILDING: _____ B. WING _____	R 09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNI	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 09/25/18-09/26/18.	{D 000}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement orders for blood pressure and pulse prior to administering two medications for 1 of 7 sampled residents (Resident #6). The findings are: 1. Review of Resident #6's current FL2 dated 04/24/18 revealed: -An order for clonidine 0.1mg 1 tablet twice daily. -An order for metoprolol succinate 100mg 1 tablet daily. Review of a subsequent physician's order dated 06/07/18 revealed: -There was an order for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm.	D 276	The medication parameter instructions for Resident #6 and all other residents were clarified with the current physicians. All medications on hand were then compared to the current orders to assure consistency. MAR, chart and cart audits are conducted weekly to assure continued agreement between orders and transcriptions. Those audits will be conducted by nursing administration and/or designee weekly for one month and monthly thereafter to assure continued compliance.	11-6-18

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gale Ann Putnam, E.D. | TITLE: Executive Dir. | (X6) DATE: 11-2-18

STATE FORM 6899 W4KH14 If continuation sheet 1 of 28

Reviewed and Accepted SYR 11/13/18

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D 276	Continued From page 1 -There was an order for metoprolol succinate extended release 100mg take 1 tablet every day at 9:00am. Review of Resident #6's Physician's Visit Summary note dated 07/05/18 revealed: -There was an order to hold clonidine dose or hold metoprolol dose if heart rate was less than 50 and to notify the physician. -The order included instructions to hold "whichever is due as next medicine dose". -There was an order to change the administration time of the metoprolol 100mg to 8:00pm. -The purpose of visit was documented as follow-up for hypertension, venous insufficiency, edema and anticoagulation. Review of Resident #6's After Visit Summary note dated 07/05/18 revealed vital signs were documented as blood pressure 140/70, heart rate 53, and oxygen saturation of 95%. Observation of Resident #6's medications on hand, on 9/26/18 at 9:00am revealed there was a bottle of clonidine 0.1mg take 1 tablet twice daily, hold dose if blood pressure is less than 120 systolic, with a dispensed date of 07/06/18, quantity 180, with 1 refill. a. Review of Resident #6's July 2018 Medication Administration Record (MAR) revealed: -There was a handwritten entry dated 07/05/18 to hold clonidine dose if HR<50 and notify MD, which included the words "Today 7/5/18". -There was an entry for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm. -There was a handwritten entry that was marked out to "hold clonidine HCL dose - next dose". -There was a handwritten entry to hold clonidine dose on 07/05/18 at 8:00pm.	D 276	The results of these audits will be reported to the Quality Assurance Committee monthly to assure continued compliance.	11-6-18

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D 276	Continued From page 2 -There was documentation on the back of the MAR for clonidine dated 07/05/18 at 8:00pm, "medication given HR>50". -Clonidine 0.1mg was documented as administered twice daily from 07/01/18 to 07/31/18 at 8:00am and 8:00pm. -There were no parameter instructions documented on the MAR for blood pressure and heart rate prior to administration of clonidine at 8:00am and 8:00pm. -There were no blood pressures or heart rates documented on the MAR from 07/05/18 to 07/31/18 for clonidine at 8:00am and 8:00pm. Review of Resident #6's August 2018 MAR revealed: -There was an entry for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm. -Clonidine 0.1mg was documented as administered twice daily at 8:00am and 8:00pm from 08/01/18 to 08/31/18. -There were no parameter instructions documented on the MAR for blood pressure and heart rate checks prior to administration of clonidine at 8:00am and 8:00pm. -There were no blood pressures or heart rates documented on the MAR from 08/01/18 to 08/31/18 for clonidine at 8:00am and 8:00pm. Review of Resident #6's September 2018 MAR revealed: -There was an entry for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm. -Clonidine 0.1mg was documented as administered twice daily from 09/01/18 at 8:00am to 09/25/18 at 8:00am. -There were no parameter instructions documented on the MAR for blood pressure and heart rate checks prior to administration of clonidine at 8:00am and 8:00pm.	D 276		

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D 276	Continued From page 3 -There were no heart rates documented on the MAR from 09/01/18 to 09/25/18 for clonidine at 8:00am and 8:00pm. -There were no blood pressures documented on the MAR from 09/01/18 to 09/25/18 for clonidine at 8:00pm. Telephone interview on 09/26/18 at 11:08am with Resident #6's pharmacy provider revealed: -They never received the written order from the facility dated 07/05/18 to hold clonidine if the heart rate was less than 50. -They received an order from the physician's office for clonidine 0.1mg, hold if BP <120 systolic dated 07/05/18, but there were no parameters for heart rate. Interview on 09/26/18 at 11:45am with the Special Care Unit Resident Care Coordinator (SCU/RCC) revealed: -She was the SCU/RCC at the time Resident #6 received the order for clonidine from the physician on 07/05/18. -She faxed the 07/05/08 Physician's Visit Summary order for clonidine to the contract pharmacy, so the MAR could be updated. -She was unsure why the parameters for heart rate, related to clonidine, were not transcribed to the August 2018 and September 2018 MARs. -She did not know the bottle of clonidine had a parameter for blood pressure on the prescription label. Interview on 09/26/18 at 12:15pm with the Executive Director (ED) revealed she did not know Resident #6 had an order for clonidine dated 07/05/18 that needed to be clarified. Interview on 09/26/18 at 1:57pm with the SCU Director revealed:	D 276		

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D 276	Continued From page 4 -She thought the 07/05/18 order to hold clonidine if the heart rate was <50 was a "one time thing". -The handwritten note on Resident #6's July 2018 MAR stated "today 7/5/18". Telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist revealed: -The only order received for clonidine from the facility was from the FL2 dated 04/24/18. -They did not receive the physician's order dated 07/05/18 to hold the clonidine dose if the heart rate was less than 50 and to notify the physician. Telephone interview on 09/28/18 at 8:56am with Resident #6's physician's medical office assistant revealed: -The physician wanted the heart rate and blood pressure checked prior to each administration of clonidine starting on 07/05/18, and was not a one-time order. -Clonidine was to be held if the HR was less than 50 or the systolic BP was less than 120. -The physician did not know that BPs and HRs were not being checked prior to each administration of clonidine. -There was no documentation of the facility contacting the physician's office for clarification of the heart rate and blood pressure parameters related to the administration of clonidine. -The physician had never discontinued the blood pressure or heart rate parameters for clonidine. Refer to interview on 09/26/18 at 9:00am with the medication aide (MA). Refer to interview on 09/26/18 at 11:45am with the SCU/RCC. Refer to interview on 09/26/18 at 12:15pm with the ED.	D 276		

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D 276	Continued From page 5 Refer to telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist. b. Review of Resident #6's July 2018 Medication Administration Record (MAR) revealed: -There was a handwritten entry dated 07/05/18 to hold metoprolol dose if HR<50 and notify MD, which included the words "Today 7/5/18". -There was an entry for metoprolol succinate 100mg take 1 tablet every day at 9:00am, which was documented as administered from 07/01/18 to 07/05/18 at 9:00am. -There was a handwritten entry that the time of administration had changed on 07/05/18. -There was an entry for metoprolol succinate extended release 100mg take 1 tablet every day at 8:00pm, which was documented as administered from 07/06/18 to 07/31/18 at 8:00pm. -Metoprolol 100mg was documented as administered daily from 07/06/18 to 07/31/18 at 8:00pm. -There were no parameters documented on the MAR for heart rate checks prior to administration of metoprolol at 8:00pm. -There were no heart rates documented on the MAR from 07/05/18 to 07/31/18 for metoprolol at 8:00pm. Review of Resident #6's August 2018 MAR revealed: -There was an entry for metoprolol succinate 100mg take 1 tablet every day at 8:00pm. -Metoprolol 100mg was documented as administered daily from 08/01/18 to 08/31/18 at 8:00pm. -There were no parameter instructions documented on the MAR for heart rate checks prior to administration of metoprolol at 8:00pm.	D 276		

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D 276	Continued From page 6 -There were no heart rates documented on the MAR from 08/01/18 to 08/31/18 for metoprolol at 8:00pm. Review of Resident #6's September 2018 MAR revealed: -There was an entry for metoprolol succinate 100mg take 1 tablet every day at 8:00pm. -Metoprolol 100mg was documented as administered daily from 09/01/18 to 09/30/18 at 8:00pm. -There were no parameter instructions documented on the MAR for heart rate checks prior to administration of metoprolol at 8:00pm. -There were no heart rates documented on the MAR from 09/01/18 to 09/30/18 for metoprolol at 8:00pm. Observation of Resident #6's medications on hand, on 9/26/18 at 9:00am revealed: -There was a bubble pack of metoprolol 100mg take 1 tablet daily with a dispensed date of 09/05/18, quantity 30, with 11 refills. -There was a bottle of metoprolol 100mg take 1 tablet daily, with a dispensed date of 09/04/18, quantity 90. -There were no parameter instructions on the prescription label for metoprolol to check a heart rate prior to administration at 8:00pm. Telephone interview on 09/26/18 at 11:08am with Resident #6's pharmacy provider revealed: -They never received the written order from the facility dated 07/05/18 to hold metoprolol if the heart rate was less than 50. -The most recent order received from the physician's office dated 08/31/18 for metoprolol 100mg, instructed to take 1 tablet daily, with no parameters for heart rate.	D 276		

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D 276	Continued From page 7 Telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist revealed: -They did not receive the physician's order dated 07/05/18 to hold the metoprolol dose if the heart rate was less than 50 and to notify the physician. -The contract pharmacy received the signed physician's order sheet dated 06/07/18 for metoprolol on 09/05/18. Interview on 09/26/18 at 11:45am with the Special Care Unit Resident Care Coordinator (SCU/RCC) revealed: -She was the SCU/RCC at the time Resident #6 received the order for metoprolol from the physician on 07/05/18. -She faxed the 07/05/08 Physician's Visit Summary order for metoprolol to the contract pharmacy, so the MAR could be updated. -She was unsure why the parameters for heart rate related to metoprolol were not transcribed to the August 2018 and September 2018 MARs. Interview on 09/26/18 at 12:15pm with the Executive Director (ED) revealed she did not know Resident #6 had an order for metoprolol dated 07/05/18 that needed to be clarified. Interview on 09/26/18 at 1:57pm with the SCU Director revealed: -She thought the 07/05/18 order to hold metoprolol if the heart rate was <50 was a "one time thing". -The handwritten note on Resident #6's July 2018 MAR stated "today 7/5/18". Telephone interview on 09/28/18 at 8:56am with Resident #6's physician's medical office assistant revealed: -The physician wanted the heart rate checked prior to each administration of metoprolol starting	D 276		

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D 276	Continued From page 8 on 07/05/18, and was not a one-time order. -Metoprolol was to be held if the HR was less than 50. -The physician did not know that HRs were not being checked prior to each administration of metoprolol. -There was no documentation of the facility contacting the physician's office for clarification of the heart rate parameters related to the administration of metoprolol. -The physician had never discontinued the heart rate parameters for metoprolol. Refer to interview on 09/26/18 at 9:00am with the MA. Refer to interview on 09/26/18 at 11:45am with the SCU/RCC. Refer to interview on 09/26/18 at 12:15pm with the ED. Refer to telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist. Refer to telephone interview on 09/27/18 at 1:01pm with Resident #6's POA. --- Interview on 09/26/18 at 9:00am with the MA revealed: -She only checked a heart rate on Resident #6 prior to the administration of levothyroxine. -The heart rate was checked a few times per month, as directed by the Wellness Nurse. -Resident #6's blood pressure was checked daily prior to the administration of furosemide. -She did not check a heart rate or blood pressure on Resident #6 related to any other medications.	D 276		

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D 276	Continued From page 9 Interview on 09/26/18 at 11:45am with the SCU/RCC revealed: -Resident #6's family member always brought the Physician's Visit Summary note and any changed or needed medications to the facility after a physician's visit. -Resident #6 did not use the facility's contract pharmacy for medications. -She did not receive any other orders from the physician or the family member on 07/05/18. -The facility's process for processing orders was that when the LPN or RCC received new orders from the receptionist in the facility, they would transcribe new medication orders or medication order changes to the MAR, then fax the order to the contract pharmacy to ensure the resident's profile was updated. -"We should have compared the medications to the physician's orders and requested clarification." -The MARs were checked at the end of each month by the RCC and LPN and compared to the upcoming months MAR. Interview on 09/26/18 at 12:15pm with the Executive Director (ED) revealed the ED and the Wellness Nurse completed bi-weekly MAR audits that focused on documentation issues, which compared the MAR to the medications on hand, but did not include current orders in the chart. Telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist revealed they did not always get orders from the facility for Resident #6 because she used another pharmacy provider for medications.	D 276		
{D 358}	10A NCAC 13F .1004(a) Medication Administration	{D 358}	The order for Resident #2 was clarified with the physician. The MAR was updated to reflect this	

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{D 358}	Continued From page 10 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: Based on observations, interviews and record reviews the facility failed to assure the administration of medications by staff were in accordance with orders by a licensed prescribing practitioner for 1 of 7 sampled residents (Resident #2) with an order for Allegra. The findings are: Review of Resident #2's current FL2 dated 06/26/18 revealed: -Diagnoses included overactive bladder, allergies, hypertension, anemia, neuropathy, glaucoma. -There was an order for Allegra (used for allergies) 180mg one tablet at bedtime. Observation of Resident #2's medications available for administration on 09/25/18 at 4:15pm revealed: -There was one bubble pack of Allegra 180 mg, with one pill remaining. -There were instructions printed on the label for Allegra 180 mg one tablet daily as needed. -There was a label on the bubble pack indicating 30 tablets of Allegra 180 mg was filled on 09/19/17.	{D 358}	clarification. All other resident FL2s and MARs were reviewed for accuracy and clarification obtained as appropriate. Nursing Administration and/or designee will continue to monitor accuracy of FL2 to MAR monthly and assure updates are continously sent to the pharmacy for profile update. Nursing Administration and/or designee will continue the triple check for monthly MAR reconciliation The results of these audits will be reported to the Quality Assurance Committee monthly to assure continued compliance.	11-6-18

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{D 358}	Continued From page 11 -There was no other Allegra available for Resident #2. Review of Resident #2's August 2018 Medication Administration Record (MAR) revealed: -There was an entry for fexofenadine 180mg (equivalent to Allegra), one tablet daily as needed. -The Allegra was not documented as administered from 08/01/18-08/31/18. Review of Resident #2's September 2018 MAR revealed: -There was an entry for fexofenadine 180mg (equivalent to Allegra), one tablet daily as needed. -The Allegra was not documented as administered from 09/01/18-09/25/18. Interview with the second shift medication aide (MA) on 9/26/18 at 3:40pm revealed: -Resident #2 was ordered to receive fexofenadine (equivalent to Allegra) 180 mg as needed according to the MAR. -She only administered Allegra 180mg to Resident #2 as needed as indicated on the MAR. -She did not know Resident #2 had a physician's order for Allegra 180mg, one tablet at bedtime. -She knew about medication changes because they were updated on the MAR. -The Resident Care Coordinator (RCC) was responsible for transcribing medication changes on the MAR. Telephone interview with a pharmacy technician from the contracted pharmacy for Resident #2 on 09/26/18 at 11:09am revealed: -The pharmacy received an order for Allegra 180mg one tablet at bedtime on 09/25/18 "late in the afternoon" -The Allegra 180mg was dispensed on 09/25/18 and delivered to the facility.	{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 12 -There were no requests since 09/19/17 to send additional Allegra 180 mg for Resident #2. -The pharmacy never received the order dated 06/26/18 for Allegra 180 mg. -Prior to dispensing Allegra 180mg on 09/25/18, it was dispensed 09/19/17. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/25/18 at 3:39pm revealed: -The pharmacy was not primary for Resident #2. -Resident #2 was "profile only" for printing of MARs. -The pharmacy had an order for Allegra 180 mg one tablet at bedtime PRN dated 05/25/18. -The pharmacy never received the order dated 06/26/18 for Allegra 180 mg. -The pharmacy had never dispensed Allegra 180mg for Resident #2. Interview with Resident #2's on 09/26/18 at 3:05pm revealed: -Staff administered her medications at the same time daily. -She thought she took a medication every night before bed for allergies. -She could not remember the name of her allergy medication that was given in the evening. -She had no complications with her allergies. Telephone interview with Resident #2's primary care provider (PCP) on 09/26/18 at 1:55pm revealed: -Resident #2 was prescribed Allegra 180 mg to treat seasonal allergies. -She could not remember how often Resident #2 was supposed to be administered Allegra. -She did not remember the facility contacting her about any issues administering Allegra. -She expected the facility to follow orders and	{D 358}		

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	HAL060152	A. BUILDING: _____ B. WING _____	R 09/26/2018

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{D 358}	Continued From page 13 notify her if they had questions or concerns. -If Resident #2 did not receive her Allegra, it would cause her seasonal allergies to "worsen". Interview with the Resident Care Coordinator (RCC) on 09/26/18 at 4:10pm revealed: -She thought Resident #2's physician order for Allegra 180mg was as needed. -She did not review Resident #2's FL2, therefore she was unable to transcribe the change on the MAR. -She was responsible for transcribing medication changes on the MAR, she may have been "on vacation" when the order came into the facility. -She missed the Allegra 180mg change from as need to routine. Interview with the Resident Services Director (RSD) on 09/26/18 at 04:15pm revealed: -The Allegra 180mg once at bedtime was written on the FL2 incorrectly. -She thought the Allegra 180mg was supposed to remain as needed. -The error should have been caught with the MAR audit that is done by the RCC monthly. -The order should have been reviewed with the physician to ensure that it was correct. Interview with the Administrator on 09/26/18 at 4:20pm revealed: -She expected medications to be administered as ordered. -The change with the medication should have been caught during the MAR audit. -The medication should have been discussed with the physician by the RCC, because "it makes more sense as a PRN medication".	{D 358}		

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{D 367}	Continued From page 14	{D 367}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 3 of 7 residents sampled (#2, #4, and #6) with physician orders for Allegra (#2), levothyroxine (#4), clonidine and metoprolol (#6). 1. Review of Resident #2's current FL2 dated 06/26/18 revealed: -Diagnoses included overactive bladder, allergies, hypertension, anemia, neuropathy, glaucoma. -There was an order for Allegra (used for	{D 367}	The MAR was updated for residents #2, #4 and #6 per the physician orders. All other resident orders were reviewed for accuracy. The contracting pharmacy conducted a medical record review audit, MAR to cart and med pass audit on 10-9-18 and 10-10-18. Nursing Administration and/or designee continues to conduct weekly MAR, cart and chart audits for three months and monthly thereafter to assure all orders are transcribed thoroughly and accurately. The results of these audits will be reported to the Quality Assurance Committee monthly to assure continued compliance.	11-6-18

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{D 367}	Continued From page 15 allergies) 180mg one tablet at bedtime. Review of Resident #2's August 2018 Medication Administration Record (MAR) revealed: -There was an entry for fexofenadine 180mg equivalent to Allegra, one tablet daily as needed. -The Allegra was not documented as administered from 08/01/18-08/31/18. Review of Resident #2's September 2018 MAR revealed: -There was an entry for fexofenadine 180mg equivalent to Allegra, one tablet daily as needed. -The Allegra was not documented as administered from 09/01/18-09/25/18. Telephone interview with the facility's contracted pharmacy provider on 09/25/18 at 3:39pm revealed: -The pharmacy was responsible for printing medications on the MAR. -The FL2 was received on 06/26/18 for Allegra 180mg once daily at bedtime. -The pharmacy did not notice the change and did not update the MAR. -The facility was supposed to review the MAR and notify of any changes missed using a carbon copy form. -The facility did not notify them that the Allegra 180mg was printed incorrectly on the MAR. Interview with the Resident Care Coordinator (RCC) on 09/26/18 at 4:10pm revealed: -She did not realize the Allegra 180mg was documented incorrectly on the MAR. -She was responsible for transcribing new orders from the FL2 onto the MAR. -She and the RSD were responsible for checking the previous month MARs and the new MARs, to ensure that the MARs were accurate.	{D 367}		

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{D 367}	Continued From page 16 -She was not sure how Allegra 180mg entry error was missed, "I don't know what happened". Interview with the Resident Services Director (RSD) on 09/26/18 at 4:15pm revealed: -The RCC was responsible updating the MAR for Resident #2 when the FL2 is received 06/26/18. - She and the RCC responsible for reviewing the MAR at the each month to check for discrepancies. -"I don't understand how the Allegra was missed" Interview with the Administrator on 09/26/18 at 04:20pm: -She expected the RCC and RSD to review physician orders, review MARs monthly to prevent medications from being missed. -She does not know how the order change for Allegra was missed. -She expected changes to physician orders to be on the MAR and the pharmacy to be notified so that it would print on the MAR correctly on the next month. -She expected everyone to follow the process in place for reviewing the MAR. 2. Review of Resident #4's current FL-2 dated 06/14/18 revealed: -Diagnoses of chronic obstructive pulmonary disease with exacerbation, acute bronchitis, type 2 diabetes, paroxysmal atrial fibrillation, pulmonary fibrosis, debility, neurogenic bladder, acute hypoxemic respiratory failure. -A medication order dated 06/14/18 for levothyroxine 50mcg, take one tablet my mouth every morning. Review of Resident #4's resident record revealed: -There was a physician's order dated 06/15/18 for	{D 367}		

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{D 367}	Continued From page 17 Resident #4 to self-administer all medications. -There was no documentation to change or discontinue levothyroxine 50mcg 1 tablet my mouth daily. Review of Resident #4's June 2018 Medication Administration Record (MAR) revealed: -There was a computer generated entry: "May self-administer all medications with close supervision." -There was an entry for levothyroxine 50mcg, take once daily. -There were no documented administrations for levothyroxine 50mcg. Review of Resident #4's July 2018 MAR revealed: -There was a computer generated entry: "May self-administer all medications with close supervision." -There was an entry for levothyroxine 50mcg, take once daily. -There were no documented administrations for levothyroxine 50mcg. Review of Resident #4's August 2018 MAR revealed there was no entry for levothyroxine 50mcg. Review of Resident #4's September 2018 MAR revealed there was no entry for levothyroxine 50mcg. Interview with Resident #4 on 9/25/18 at 3:30pm revealed: - He administered all of his medications daily. - He stored all of his medications in his room. - He had a medication named levothyroxine to be administered daily. - He did not maintain documentation of his medication administration.	{D 367}		

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{D 367}	Continued From page 18 - Facility staff "occasionally" asked him questions about his medications. An attempted interview with Resident #4's physician on 09/26/18 at 10:00am was unsuccessful. Interview with a pharmacy consultant on 9/26/18 at 10:30am revealed: -Resident #4 did not use the facility's contracted pharmacy to fill his medications. -The pharmacy was contracted with the facility to maintain medication profiles for all residents. -The pharmacy had received Resident #4's medication order for Levothyroxine 50 mcg, take one tablet daily on 6/15/18 to be added to Resident #4's MAR. -The pharmacy was notified on 09/25/18 that Resident #4's order for levothyroxine 50mcg, was not added to the August and July MAR. Interview with Resident #4's contracted pharmacy on 9/26/18 at 11:05am revealed: -Resident #4 had an order for Levothyroxine 50mcg once daily dated 11/14/2017. -Resident #4's levothyroxine 50mcg was last refilled on 7/9/18 with a quantity of 90 tablets. -There were no orders to change or discontinue Resident #4's levothyroxine 50mcg. Review of the facility's "Self-Administration Documentation" policy revealed: -"An updated list of resident's medications will be maintained in the residents record/file". -"If the resident is not self administering all of his/her medications, mark the MAR to identify individual medications that are self-administered by the resident". Interview with the Resident Services Director	{D 367}		

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{D 367}	Continued From page 19 (RSD) on 9/26/18 at 11:45am revealed: -Resident #4 had a physician's order to self-administer all of his medications. -Resident #4 had an order for levothyroxine 50mcg once daily dated 06/14/18. -Resident #4's medication orders dated 06/14/18 had been sent to the facility's contracted pharmacy on or about 6/15/18 to update Resident #4's MAR for July 2018. -She had transcribed Resident #4's medication order for levothyroxine 50mcg the July 2018 MAR because the pharmacy had not. -She did not know Resident #4's levothyroxine 50mcg was not listed on Resident #4's August or September 2018 MAR. Interview with the Wellness Nurse on 9/26/18 at 11:15am revealed: -She was responsible for completing a quarterly self-administration assessment with Resident #4. -She had last completed a self-administration assessment with Resident #4 on or about 09/21/18. -She had utilized Resident #4's current, September 2018 MAR to compare Resident #4's prescriptions with the facility's medication orders. -She did not recall observing Resident #4's container of levothyroxine 50mcg on 9/21/18. Interview with the Facility Administrator on 9/26/18 at 9:35am revealed she did not know Resident #4's levothyroxine 50mcg was not listed on the August and September MARs. 3. Review of Resident #6's current FL2 dated 04/24/18 revealed: -An order for clonidine 0.1mg 1 tablet twice daily. -An order for metoprolol succinate 100mg 1 tablet daily.	{D 367}		

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{D 367}	Continued From page 20 Review of a subsequent physician's order dated 06/07/18 revealed: -There was an order for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm. -There was an order for metoprolol succinate extended release 100mg take 1 tablet every day at 9:00am. Review of Resident #6's Physician's Visit Summary note dated 07/05/18 revealed: -There was an order to hold clonidine dose or hold metoprolol dose if heart rate was less than 50 and to notify the physician. -The order included instructions to hold "whichever is due as next medicine dose". -There was an order to change the administration time of the metoprolol 100mg to 8:00pm. -The purpose of visit was documented as follow-up for hypertension, venous insufficiency, edema and anticoagulation. a. Review of Resident #6's July 2018 Medication Administration Record (MAR) revealed: -There was a handwritten entry dated 07/05/18 to hold clonidine dose if HR<50 and notify MD, which included the words "Today 7/5/18". -There was an entry for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm. -There was a handwritten entry that was marked out to "hold clonidine HCL dose - next dose". -There was a handwritten entry to hold clonidine dose on 07/05/18 at 8:00pm. -There was documentation on the back of the MAR for clonidine dated 07/05/18 at 8:00pm, "medication given HR>50". -Clonidine 0.1mg was documented as administered twice daily from 07/01/18 to 07/31/18 at 8:00am and 8:00pm. -There were no parameter instructions	{D 367}		

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{D 367}	Continued From page 21 documented on the MAR for blood pressure and heart rate prior to administration of clonidine at 8:00am and 8:00pm. -There were no blood pressures or heart rates documented on the MAR from 07/05/18 to 07/31/18 for clonidine at 8:00am and 8:00pm. Review of Resident #6's August 2018 MAR revealed: -There was an entry for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm. -Clonidine 0.1mg was documented as administered twice daily at 8:00am and 8:00pm from 08/01/18 to 08/31/18. -There were no parameter instructions documented on the MAR for blood pressure and heart rate checks prior to administration of clonidine at 8:00am and 8:00pm. -There were no blood pressures or heart rates documented on the MAR from 08/01/18 to 08/31/18 for clonidine at 8:00am and 8:00pm. Review of Resident #6's September 2018 MAR revealed: -There was an entry for clonidine 0.1mg take 1 tablet twice daily at 8:00am and 8:00pm. -Clonidine 0.1mg was documented as administered twice daily from 09/01/18 at 8:00am to 09/25/18 at 8:00am. -There were no parameter instructions documented on the MAR for blood pressure and heart rate checks prior to administration of clonidine at 8:00am and 8:00pm. -There were no heart rates documented on the MAR from 09/01/18 to 09/25/18 for clonidine at 8:00am and 8:00pm. -There were no blood pressures documented on the MAR from 09/01/18 to 09/25/18 for clonidine at 8:00pm.	{D 367}		

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{D 367}	Continued From page 22 Telephone interview on 09/26/18 at 11:08am with Resident #6's pharmacy provider revealed: -They never received the written order from the facility dated 07/05/18 to hold clonidine if the heart rate was less than 50. -They received an order from the physician's office for clonidine 0.1mg, hold if BP <120 systolic dated 07/05/18, but there were no parameters for heart rate. Telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist revealed: -The pharmacy was responsible for printing medications on the MAR. -The only order received for clonidine from the facility was from the FL2 dated 04/24/18. -They did not receive the physician's order dated 07/05/18 to hold the clonidine dose if the heart rate was less than 50 and to notify the physician. -The facility was supposed to review the MAR and notify of any changes missed using a carbon copy form. Interview on 09/26/18 at 11:45am with the Special Care Unit Resident Care Coordinator (SCU/RCC) revealed: -She was the SCU/RCC at the time Resident #6 received the order for clonidine from the physician on 07/05/18. -She faxed the 07/05/08 Physician's Visit Summary order for clonidine to the contract pharmacy, so the MAR could be updated. -She was unsure why the parameters for heart rate, related to clonidine, were not transcribed to the August 2018 and September 2018 MARs. Interview with the Administrator on 09/26/18 at 4:20pm: -She expected the SCU/RCC and SCU Director to review physician orders, review MARs monthly	{D 367}		

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{D 367}	Continued From page 23 to prevent medications from being missed. -She expected changes to physician orders to be on the MAR and the pharmacy to be notified so that it would print on the MAR correctly on the next month. -She expected everyone to follow the process in place for reviewing the MAR. Interview on 09/26/18 at 1:57pm with the SCU Director revealed: -She thought the 07/05/18 order to hold clonidine if the heart rate was <50 was a "one time thing". -The handwritten note on Resident #6's July 2018 MAR stated "today 7/5/18". -The physician had never discontinued the blood pressure or heart rate parameters for clonidine. Refer to interview on 09/26/18 at 9:00am with the medication aide (MA). Refer to interview on 09/26/18 at 11:45am with the SCU/RCC. Refer to interview on 09/26/18 at 12:15pm with the ED. Refer to telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist. b. Review of Resident #6's July 2018 Medication Administration Record (MAR) revealed: -There was a handwritten entry dated 07/05/18 to hold metoprolol dose if HR<50 and notify MD, which included the words "Today 7/5/18". -There was an entry for metoprolol succinate 100mg take 1 tablet every day at 9:00am, which was documented as administered from 07/01/18 to 07/05/18 at 9:00am. -There was a handwritten entry that the time of administration had changed on 07/05/18.	{D 367}		

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{D 367}	Continued From page 24 -There was an entry for metoprolol succinate extended release 100mg take 1 tablet every day at 8:00pm, which was documented as administered from 07/06/18 to 07/31/18 at 8:00pm. -Metoprolol 100mg was documented as administered daily from 07/06/18 to 07/31/18 at 8:00pm. -There were no parameters documented on the MAR for heart rate checks prior to administration of metoprolol at 8:00pm. -There were no heart rates documented on the MAR from 07/05/18 to 07/31/18 for metoprolol at 8:00pm. Review of Resident #6's August 2018 MAR revealed: -There was an entry for metoprolol succinate 100mg take 1 tablet every day at 8:00pm. -Metoprolol 100mg was documented as administered daily from 08/01/18 to 08/31/18 at 8:00pm. -There were no parameter instructions documented on the MAR for heart rate checks prior to administration of metoprolol at 8:00pm. -There were no heart rates documented on the MAR from 08/01/18 to 08/31/18 for metoprolol at 8:00pm. Review of Resident #6's September 2018 MAR revealed: -There was an entry for metoprolol succinate 100mg take 1 tablet every day at 8:00pm. -Metoprolol 100mg was documented as administered daily from 09/01/18 to 09/25/18 at 8:00pm. -There were no parameter instructions documented on the MAR for heart rate checks prior to administration of metoprolol at 8:00pm. -There were no heart rates documented on the	{D 367}		

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 09/26/2018

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

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{D 367}	Continued From page 25 MAR from 09/01/18 to 09/25/18 for metoprolol at 8:00pm. Telephone interview on 09/26/18 at 11:08am with Resident #6's pharmacy provider revealed: -They never received the written order from the facility dated 07/05/18 to hold metoprolol if the heart rate was less than 50. -The most recent order received from the physician's office dated 08/31/18 for metoprolol 100mg, instructed to take 1 tablet daily, with no parameters for heart rate. Telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist revealed: -They did not receive the physician's order dated 07/05/18 to hold the metoprolol dose if the heart rate was less than 50 and to notify the physician. -The contract pharmacy received the signed physician's order sheet dated 06/07/18 for metoprolol on 09/05/18. Interview on 09/26/18 at 11:45am with the Special Care Unit Resident Care Coordinator (SCU/RCC) revealed: -She was the SCU/RCC at the time Resident #6 received the order for metoprolol from the physician on 07/05/18. -She faxed the 07/05/08 Physician's Visit Summary order for metoprolol to the contract pharmacy, so the MAR could be updated. -She was unsure why the parameters for heart rate related to metoprolol were not transcribed to the August 2018 and September 2018 MARs. Interview with the Administrator on 09/26/18 at 04:20pm: -She expected the SCU/RCC and SCU Director to review physician orders, review MARs monthly to prevent medications from being missed.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 367}	Continued From page 26 -She expected changes to physician orders to be on the MAR and the pharmacy to be notified so that it would print on the MAR correctly on the next month. -She expected everyone to follow the process in place for reviewing the MAR. Interview on 09/26/18 at 1:57pm with the SCU Director revealed: -She thought the 07/05/18 order to hold metoprolol if the heart rate was <50 was a "one time thing". -The handwritten note on Resident #6's July 2018 MAR stated "today 7/5/18". Refer to interview on 09/26/18 at 9:00am with the MA. Refer to interview on 09/26/18 at 11:45am with the SCU/RCC. Refer to interview on 09/26/18 at 12:15pm with the ED. Refer to telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist. Refer to telephone interview on 09/27/18 at 1:01pm with Resident #6's POA. --- Interview on 09/26/18 at 9:00am with the MA revealed: -She only checked a heart rate on Resident #6 prior to the administration of levothyroxine. -The heart rate was checked a few times per month, as directed by the Wellness Nurse. -Resident #6's blood pressure was checked daily prior to the administration of furosemide. -She did not check a heart rate or blood pressure	{D 367}		

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{D 367}	Continued From page 27 on Resident #6 related to any other medications. Interview on 09/26/18 at 11:45am with the SCU/RCC revealed: -Resident #6's family member always brought the Physician's Visit Summary note and any changed or needed medications to the facility after a physician's visit. -Resident #6 did not use the facility's contract pharmacy for medications. -She did not receive any other orders from the physician or the family member on 07/05/18. -The facility's process for processing orders was that when the LPN or RCC received new orders from the receptionist in the facility, they would transcribe new medication orders or medication order changes to the MAR, then fax the order to the contract pharmacy to ensure the resident's profile was updated. -The MARs were checked at the end of each month by the RCC and LPN and compared to the upcoming months MAR. Interview on 09/26/18 at 12:15pm with the Executive Director (ED) revealed the ED and the Wellness Nurse completed bi-weekly MAR audits that focused on documentation issues, which compared the MAR to the medications on hand, but did not include current orders in the chart. Telephone interview on 09/26/18 at 2:30pm with the facility's contract pharmacist revealed they did not always get orders from the facility for Resident #6 because she used another pharmacy provider for medications.	{D 367}		