

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL090033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/28/2018
NAME OF PROVIDER OR SUPPLIER MONROE MANOR ASSISTED LIVING BUILDING II		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BAUCOM ROAD MONROE, NC 28110		
(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 Union County Department of Social Services conducted an annual survey on 11/28/18.	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: Based on observations, interviews and record reviews, the facility failed to administer a medication as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #2) who was prescribed atorvastatin (used to treat high cholesterol, and to lower the risk of stroke, heart attack, or other heart complications in people with type 2 diabetes). The findings are: Review of Resident #2's current FL2 dated 07/01/18 revealed diagnoses included diabetes, hyperglycemia, cachexia and anxiety.	D 358		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 358	Continued From page 1 Review of Resident #2's record revealed a signed order from his primary care provider (PCP) dated 10/23/18 for atorvastatin 10mg, one tab per day. Review of Resident #2's October and November 2018 electronic Medication Administration Record (eMAR) revealed there was no entries for atorvastatin 10mg, one tab per day. Observation of Resident #2's medications on hand on 11/28/18 at 11:00am revealed there was no atorvastatin 10mg available for administration. Interview with a Supervisor-in-Charge/medication aide (SIC) on 11/28/18 at 11:30am revealed: -She administered Resident #2's medications. -She would take new medications orders to the Resident Care Coordinator (RCC). -The RCC would review the orders and fax them to the pharmacy. -The pharmacy representative entered the medication changes on the eMAR. -The next morning she would collect the medications from the RCC's office, compare the medication with what was listed on the eMAR and then place the medication on the cart. -She had not reviewed the 10/23/18 order from Resident #2's PCP. -She was not aware Resident #2 had been prescribed atorvastatin. Interview with the RCC on 11/28/18 at 11:15am revealed: -She or the SIC faxed new medication orders to the pharmacy. -The pharmacy representative entered the medication changes on the eMAR. -She or the SIC were to check the eMAR and medication orders for accuracy.	D 358		

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D 358	Continued From page 2 -She had not checked the 10/23/18 medication order for Resident #2. -She did not know why Resident #2's atorvastatin was not on the medication cart or on the eMAR. -She would follow-up with Resident #2's PCP. Interview with a pharmacist from the facility's contracted pharmacy on 11/28/18 at 11:45am revealed: -They had received the 10/23/18 atorvastatin order for Resident #2. -He did not know the reason the medication was not entered on the eMAR. -He did not know the reason the medication was not delivered to the facility. -This was a "pharmacy error". Interview with the Administrator on 11/28/18 at 12:08pm revealed: -She did not know Resident #2 had not received the atorvastatin as ordered by his PCP on 10/23/18. -It was the SIC's responsibility to assure new medications are entered on the eMAR. -It was the SIC's responsibility to verify a new medication with the orders from the PCP. -Either the RCC or the SIC were responsible to follow-up with the pharmacy when a medication wasn't delivered or entered on the eMAR. Attempted interviews with Resident #2's PCP's on 11/28/18 at 11:53am and 2:45pm were unsuccessful.	D 358		