STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060014	A. BUILDING: _____ B. WING _____	11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER VILLAGE	111 S CHURCH STREET HUNTERSVILLE, NC 28070

(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 an annual survey on 11/19/18 and 11/20/18.	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 for 1 of 5 residents sampled, related to aspirin (ASA) 81mg, used as a blood thinner, for 15 days. The findings are: Review of Resident #2's current FL2 dated 03/11/18 revealed: -Diagnoses included atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD), diabetes, seizures, schizophrenia. -Medication orders included Aspirin 81mg, take	D 358		

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D 358	Continued From page 1 two tablets once a day. Review of Resident #2's hospital discharge summary on 11/05/18 revealed: -Diagnoses included acute exacerbation of COPD, interstitial edema, atrial fibrillation and rhinovirus. -Medications included Xarelto 20mg tablet daily (a medication used as a blood thinner), ASA 81mg one tablet daily, and Cardizem 300mg tablet daily (a medication used to treat used hypertension and atrial fibrillation to increase blood flow). Review of Resident #2's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for ASA 81mg two tablets daily at 8:00am from 11/01/18-11/20/18. -ASA 81mg two tablets was documented as administered at 8:00am from 11/05/18-11/20/18. Observation of Resident #2's medications on hand on 11/19/18 at 3:35pm revealed: -There was a bubble pack of ASA 81mg, two tablets per sealed casing, on the medication cart. -The pharmacy label on the bubble pack documented 60 tablets of ASA 81mg were dispensed on 11/01/18. -There were 15 doses (30 tablets) that had been removed from the bubble pack, and 15 remaining doses (30 tablets). Interview with the first shift medication aide (MA) on 11/20/18 at 10:05am revealed: -She administered Resident #2's medications in the morning. -Resident #2 had recently been discharged from the hospital. -The medications on the hospital discharge summary were sent to the pharmacy by the	D 358		

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D 358	Continued From page 2	D 358		

supervisor.
-The pharmacist entered the medication changes on the eMAR.
-There had been no change to Resident #2's ASA order.

Interview with the pharmacist from the facility's contracted pharmacy on 11/20/18 at 9:05am revealed:
-She had received the hospital discharge orders for Resident #2 on 11/05/18.
-She did not enter the correct ASA order.
-She overlooked the order change for the ASA 81mg from two tablets every day to one tablet every day.
-It was the pharmacy technician's responsibility to enter the orders sent from the facility.

Interview with the Supervisor on 11/20/18 at 10:40am revealed:
-When a resident was discharged from the hospital she was to send the medications ordered to the pharmacy.
-The pharmacy would make any changes needed on the eMAR.
-She would review the eMAR with the discharge orders to verify accuracy.
-Resident #2 was discharged late in the afternoon and she did not reconcile the new discharge orders with the eMAR.
-The new orders and discharge summary were not sent to the primary care physician (PCP).
-It was the facility policy to discuss any medication changes that resulted from a hospitalization with their PCP at the follow up appointment.
-The follow up appointments would be scheduled by the transportation staff.
-They would attempt to schedule the appointment within a week or two of discharge.

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D 358	Continued From page 3 -Resident #2 was not scheduled to see his PCP until next week and she did not have the exact date. Interview with the Administrator on 11/20/18 at 11:00am revealed: -She did not know Resident #2 had received the wrong dosage of ASA. -It was the Supervisor's responsibility to send new orders to the pharmacy and verify the orders have been entered on the eMAR correctly. -It was not the policy of the facility to send a copy of the hospital discharge orders to the PCP. Interview with the PCP's nurse on 11/20/18 at 4:30pm revealed: -The PCP did not know Resident #2 had been admitted to the hospital or had medication changes. -The PCP expected the facility would notify him of hospitalizations and medication changes. -If he knew that Xarelto 20mg daily and Cardizem 300mg daily had been added to Resident #2's medication profile, he would have discontinued the ASA 81mg daily. -He did not want to wait until an appointment could be scheduled at his office to be informed of medication changes he did not initiate.	D 358		