The following is the Plan of Correction for Community name Elmcroft of Little Avenue. This Plan of Correction is regarding the Statement of Deficiency from the Annual Survey completed on October 24, 2018 This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

10A NCAC 13F .0902(b) Health Care:

- The Resident Services Director/and designee will ensure that the Executive Director, Resident's Physician and family member is notified of any missing medications immediately.

- The Resident Services Director/and designee will ensure that the DID NOT administer report is generated and reviewed daily Monday through Friday and will ensure that action is taken for missing medications.

- An In-service will be held by November 2018 with all Medication Aides to review facility and pharmacy policies and procedures for submitting refill requests, following up on the status of refills with 7 doses of a resident's medication remaining, and communicating with the RSD/designee as necessary.

10A NCAC 13F .1004 (a) Medication Administration:

MD was notified on 10/24/18 regarding medication not administered for resident #2. Family has been aware of the non-availability of the medication due to staff calling family for refill.

- The Resident Services Director/and designee will conduct random New Order/Medication Administration Record and random Medication Cart audits 3 times per week and as needed for one month starting October 25th thru Jan 31st, 2019. At the end of one-month, weekly random audits will continue.

- The Executive Director will follow up weekly regarding completion and results of the audits. The Resident Services Director/and designee will pull DID NOT administer record Monday through Friday to review and identify medications not administered due to non-availability.

- MA training conducted on 11/14/18 to re-educate regarding medications supplied by family members and the refill process. Staff to document the date and name of family member contacted regarding refill. Pharmacy to supply 15 day supply until medication is available from the family. Facility will take responsibility to make sure that the residents medications are available for administration.

- Residents that prefer not to use the facility contracted pharmacy services will have all medication orders, refills and new medication scripts tracked by the RSD/designee using the Outside Pharmacy Tracking Tool by December 2018.

- The Resident Service Director and Pharmacy Representative will conduct retraining by Jan 31 2019 with all current Medication Aides. Medication Technicians Training to include but not limited to: Transcription of new orders and the process for following up of new orders, the review of the medication administration procedures related to time/ documentation. Documentation of the trainings will be maintained on file in the community. Retraining will be on an ongoing basis.

10A NCAC 13F .1004 (g) Medication Administration:

- The times for Medication Administration for residents were evaluated and adjusted to suit preferences and ability to ensure medication administration guidelines are followed by 11-30-18.

- The Executive Director /Resident Services Director/and designee will conduct random Medication Administration observations 3 times per week and as needed thru 1/31/19. At the end of one-month observations will be monthly. Observation focus will be to observe for timeliness in medication administration. The Executive Director will follow up weekly regarding completion and results of the audits.

- Medication Technicians Training to include the review of the medication administration procedures related to time/ documentation by Jan 31, 2019.

10A NCAC 13F .1004 (j) Medication Administration

- The Resident Services Director/and designee will ensure and will continually assess and improve the new medication verification process and educate staff on ensuring all orders are verified on MAR for accuracy and ensure that all medications are available.

- The Resident Services Director/and designee will ensure that discontinued medications are taken out of the Medication cart the same day as the order to discontinue to medication is received. The Resident Services Director/and designee will ensure that temporary orders entered by community staff is replaced by permanent order by Pharmacy the following calendar day.

- A cart audit was completed by 10/25/18 to remove any discontinued medications.

- A cart audit will be conducted by the RSD/ and or designee monthly and randomly by Jan 31, 2019 to assure compliance with the facility's medication administration policies specific to access of discontinued medications.

- A cart audit will be conducted by the RSD monthly and randomly by Jan 31, 2019 to assure medication bubble pack/storage containers with dosage, frequency, or other parameters changes are label correctly. This will include the RSD checking EMAR and physician's orders to the medication on-hand.

Signature of Executive Director/Date: Tara Benson 12-3-18

Name of Executive Director and title. TARA BENSON

Reviewed and Accepted by CD on 12/14/18

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ELMCROFT OF LITTLE AVENUE	7745 LITTLE AVENUE CHARLOTTE, NC 28226

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey on 10/23/18-10/24/18.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to notify the physician medication was not administered for eight consecutive days for 1 of 5 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 06/20/18 revealed: -Diagnoses included unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and hypertension (high blood pressure). -Medication orders included pravastatin 40mg one tablet daily (used to treat high cholesterol and triglyceride levels). Review of Resident #2's September 2018 electronic Medication Administration Record (eMAR) revealed:	D 273		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tara Brown TITLE Executive Dir (X6) DATE 12-3-18
Reviewed and Accepted by CD on 12/14/18

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D 273	Continued From page 1 -There was an electronic entry for pravastatin 40mg one tablet daily at 8:00pm. -There was documentation pravastatin 40mg had been administered from 09/01/18 through 09/23/18 and again on 09/25/18. -There was documentation pravastatin was not administered for six of thirty opportunities. -There was documentation pravastatin was not administered on 09/24/18 due to "Med not here, Family orders." -There was documentation pravastatin was not administered on 09/26/18, 09/27/18, 09/29/18 and 09/30/18 due to "Patient unable to take medication." -There was documentation pravastatin was not administered on 09/28/18 due to "Med not here, Nurse aware." Review of Resident #2's October 2018 eMAR revealed: -There was an electronic entry for pravastatin 40mg one tablet to be administered daily at 8:00pm. -There was documentation pravastatin 40mg had been administered from 10/02/18 through 10/22/18. -There was documentation pravastatin was not administered for one of twenty-two opportunities on 10/01/18 due to "Med not here." Observation of Resident #2's medications available for administration on 10/24/18 at 10:34am revealed pravastatin 40mg was available for administration. Interview with a medication aide (MA) on 10/24/18 at 10:34am revealed: -She knew Resident #2 was not administered pravastatin for eight consecutive doses and had notified the Resident Services Director (RSD) that	D 273		

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D 273	Continued From page 2	D 273		

the medication was not on the medication cart.
-It was the RSD's responsibility to notify the physician when a resident missed a medication.
-She did not know if Resident #2's physician had been notified about her missing the pravastatin.

Interview with the RSD on 10/24/18 at 11:20am revealed:
-Resident #2 had missed eight doses of pravastatin from 09/24/18 through 10/01/18 because the medication was not in the facility.
-She was responsible for notifying physicians when a resident missed a medication.
-She printed a "did not administer" computer generated report every day Monday through Friday that documented if residents had missed a medication.
-She would notify the resident's physician after one dose was missed.
-She could not recall contacting Resident #2's physician about her missing eight consecutive doses of pravastatin, and she could not locate any documentation showing she had done so.
-She could not explain why she did not contact Resident #2's physician.

Telephone interview with the Registered Nurse (RN) at Resident #2's primary care physician's (PCP) office on 10/24/18 at 2:02pm revealed:
-Resident #2's PCP did not know the resident had missed eight doses of pravastatin.
-The PCP expected the facility to notify her once a resident had missed seven doses of a medication.

Interview with the Administrator on 10/24/18 at 11:48am revealed:
-Failure to administer a medication was considered a "medication error" and should have been reported to both her and the resident's

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D 273	Continued From page 3 physician "immediately" after the first dose was missed. -The RSD was responsible for notifying both the Administrator and the resident's physician when a medication was missed. -She was not notified Resident #2 had missed eight doses of pravastatin. -She did not know Resident #2's physician had not been notified about the missed doses.	D 273		
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: This rule area is still out of compliance. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents sampled, Resident #2 did not receive their medication to control cholesterol and Resident #3 did not receive the correct dose of thyroid	D 358		

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D 358	Continued From page 4 medication. The findings are: 1. Review of Resident #3 current FL2 dated 10/10/18 revealed diagnoses included hypertension, dementia, mild cognitive impairment, and hypothyroidism. Review of physician orders for Resident#3 dated 10/15/18 revealed a medication order for Levothyroxine (used to manage hypothyroidism) 25mcg 1 tablet daily at 8:00am. Review of Resident#3's October electronic Medication Administration Record (eMAR) on 10/23/18 at 11:00am revealed: -There was an entry for Levothyroxine 25mcg ½ tablet(12.5mcg) daily that had been discontinued on 10/15/18. -There was an entry for Levothyroxine 25mcg 1 tablet daily at 8:00am that had expired on 10/19/18. -There was no documentation of these medications having been administered on 10/23/18. Observation of the medication pass of Resident#3 on 10/23/18 at 10:20am revealed the medication aide (MA) administered Levothyroxine 25mcg ½ tablet (12.5mcg) to Resident #3. Observation of Resident #3's medication on hand on 10/23/18 at 12:00pm revealed: -There were 13 tablets of levothyroxine 25mcg ½ tablet(12.5mcg) filled 10/01/18 for a total of 30 (1/2 tablets). -There were 30 tablets of levothyroxine 25mcg tablets filled 10/16/18 for a total of 30 tablets.	D 358		

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D 358	Continued From page 5 Interview on 10/23/18 at 12:00pm with the Wellness Nurse revealed: -The MA had not administered Levothyroxine 25mcg on 10/23/18 because it was not documented on the eMAR. -According to the eMAR the resident had not received Levothyroxine 25mcg since 10/19/18. -She had entered a temporary physician's order that required the pharmacy verification onto the eMAR on 10/16/18 and the order expired on 10/19/18. -She had not told the pharmacy about the temporary order for Levothyroxine 25mcg and when the pharmacy did not receive follow up communication, temporary orders expired. -Resident #3's previous order for Levothyroxine 25mcg 1/2 tablet (12.5mcg) was discontinued on 10/15/18 and the medication had not been returned to the pharmacy. -She was aware the MA gave the incorrect dose when the MA pulled all the medications and had not compared the labels to the eMAR. Interview on 10/24/18 at 10:00am with the Resident Service Director (RSD) revealed: -She was aware the facility had a policy for administration of medications according the eMAR, and documenting the medications given at the time they had been given. -The MA told her she had removed all of the resident's medications from the cards and she had not compared them to the eMAR because she was running late on giving them. -When she removed the resident's medication cards, the Levothyroxine 25mcg 1/2 tablet(12.5mcg) was still there yesterday (10/23/18). -The MA gave the Levothyroxine 25mcg 1/2 tablet(12.5mcg) on 10/23/18 and had not documented it on the eMAR because the order	D 358		

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D 358	Continued From page 6 had been discontinued on 10/15/18. Interview with Resident #3's physician on 10/24/18 at 2:00pm revealed: -He did not know the resident had not been getting her levothyroxine until his office was notified on 10/23/18 by the facility when an error was found. -He had given them another order to restart the Levothyroxine, and he would recheck Resident #3's thyroid hormone levels next month. Review of the facility Medication Administration policy revealed medications were to be administered according to the physician's orders entered on the eMAR and documented at the time administered. Interview with the Administrator on 02/16/17 at 1:30 pm revealed: -The facility's medication policy was for residents to receive their medications according the physician's order on the eMAR and documented at the time mediations was given to the resident. -The MA told her she had given the medications late, and she documented medications administered to Resident#3 prior to giving them on 10/23/18. -The MA had failed to follow the facility medication policy and made a medication error. -The RSD should have followed up with communication to the pharmacy about the temporary medication order to prevent it from expiring and Resident #3 missing medication doses. -The facility's medication policy did not address the management of temporary orders placed on the eMAR.	D 358		

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D 358	Continued From page 7 2. Review of Resident #2's current FL-2 dated 06/20/18 revealed: -Diagnoses included unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and hypertension (high blood pressure). -Medication orders included pravastatin 40mg take one tablet daily (a medication used to treat high cholesterol and triglyceride levels). Review of Resident #2's September 2018 electronic Medication Administration Record (eMAR) revealed: -There was an electronic entry for pravastatin 40mg one tablet daily at 8:00pm. -There was documentation pravastatin was not administered for six of thirty opportunities. -There was documentation pravastatin 40mg had been administered from 09/01/18 through 09/23/18 and again on 09/25/18. -There was documentation pravastatin was not administered on 09/24/18 due to "Med not here. Family orders." -There was documentation pravastatin was not administered on 09/26/18, 09/27/18, 09/29/18 and 09/30/18 due to "Patient unable to take medication." -There was documentation pravastatin was not administered on 09/28/18 due to "Med not here. Nurse aware." Review of Resident #2's October 2018 eMAR revealed: -There was an electronic entry for pravastatin 40mg one tablet to be administered daily at 8:00pm. -There was documentation pravastatin 40mg had been administered from 10/02/18 through 10/22/18. -There was documentation pravastatin was not	D 358		

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D 358	Continued From page 8 administered for one of twenty-two opportunities on 10/01/18 due to "Med not here." Observation of Resident #2's medications available for administration on 10/24/18 at 10:34am revealed pravastatin 40mg was available for administration. Interview with Resident #2 on 10/23/18 at 10:25am revealed: -She preferred not to use the facility's contracted pharmacy for her medications. -Her responsible party (RP) ordered her medications from a different pharmacy and delivered them to the facility. -She had "no issues with her medications" and could not recall a time when she had ever ran out. Interview with the morning shift medication aide (MA) on 10/24/18 at 10:34am revealed: -Resident #2 did not use the facility's contracted pharmacy for her medications. -Resident #2's RP ordered her medications from her preferred pharmacy and personally delivered them to the facility. -The MAs were responsible for contacting Resident #2's RP when there were "about twenty pills" remaining. -She remembered contacting Resident #2's RP in September 2018 to request she have the pravastatin refilled, but had not documented the contact. -After "a few days," she alerted the Resident Services Director (RSD) the facility had still not received Resident #2's pravastatin. -Resident #2's RP delivered the pravastatin to the facility on 10/02/18. Interview with the Resident Services Director	D 358		

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D 358	Continued From page 9 (RSD) on 10/24/18 at 11: 20am revealed: -Resident #2 had missed eight doses of pravastatin from 09/24/18 through 10/01/18 because the medication was not in the facility and available for administration. -The MAs were responsible for contacting Resident #2's RP when she had about twenty doses left of any medication so the RP could order it from her preferred pharmacy and bring it into the facility. -The MAs would notify her if they noticed a medication had not arrived at the facility after their contact with the RP, and she would also contact the RP. -Both she and the MAs had contacted Resident #2's RP about getting the pravastatin refilled in September 2018, but they had not documented the contacts. -The RP had agreed to bring in the pravastatin, but it had taken her until 10/02/18 to do so. -The RSD and the Administrator had several care plan meetings with Resident #2's RP to discuss obtaining her medications. -During the care plan meetings, the RP refused to allow the facility to order Resident #2's medications from the facility's contracted pharmacy because she did not want to be charged for the additional expense. -The RSD could not locate documentation of these discussions. -She knew the facility was responsible for ensuring residents had medications available for administration and thought she had done everything allowed to obtain Resident #2's pravastatin. She did not know she could order medications and have the facility pay for them. Attempted telephone interview with Resident #2's preferred pharmacy on 10/24/18 at 12:32pm was unsuccessful.	D 358		

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D 358	Continued From page 10 Telephone interview with the Registered Nurse (RN) at Resident #2's primary care physician's (PCP) office on 10/24/18 at 2:02pm revealed: -Resident #2's PCP did not know she had missed eight doses of pravastatin. -The PCP expected the facility to administer medications as ordered. Attempted telephone interview with Resident #2's RP on 10/24/18 at 2:24pm was unsuccessful. Interview with the Administrator on 10/24/18 at 11:48am revealed: -Resident #2's RP ordered her medications from her preferred pharmacy and delivered the medications to the facility. -The facility had "issues in the past" with getting the RP to deliver Resident #2's medications in a timely manner. -It was the responsibility of the MAs and the RSD to notify the RP when the resident had ten doses remaining. -Failure to administer a medication was considered a "medication error" and should have been reported to her by the RSD. -She did not know Resident #2 had missed eight doses of pravastatin. -Had she known Resident #2 did not have pravastatin available for administration, she would have ordered the medication from the facility's contracted pharmacy, and the facility would have paid for the medication if the RP refused to do so.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 364		

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D 364	Continued From page 11 (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: This rule area is still out of compliance. Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered within one hour before or one hour after the scheduled times as ordered by a licensed prescribing practitioner for 2 of 2 (Resident #3 and #6) sampled residents. The findings are: 1. Observation on 10/23/18 between 10:00am and 10:15am of a medication pass revealed: -There was one Medication Aide (MA) administering medications in the Memory Care Unit(MCU). -The MA started the administration of medications to Resident #6 at 10:04am from the medication cart located in activity room of the MCU. -The MA administered the following medications to Resident#6 which included Memantine 5mg 1 tablet, Aspirin 81mg 1 tablet, Lisinopril 20mg 1 tablet, Amlodipine 5mg 1 tablet with a cup of water at 10:15am. Review of Resident #6's current FL2 dated 06/15/18 revealed diagnoses included dementia with behavioral disturbances, hypertension, arthritis, hypertension, hypothyroidism and scoliosis. Review of Resident #6's Physician's orders dated 07/11/18 revealed: -There was an order for Memantine(used to	D 364		

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D 364	Continued From page 12 manage dementia) 5mg take 1 tablet by mouth twice a day at 8:00am and 8:00pm. -There was an order for Aspirin(used to manage heart disease) 81mg take 1 tablet by mouth daily at 8:00am. -There was an order for Lisinopril(used to manage blood pressure) 20mg take 1 tablet by mouth once a day at 8:00am. -There was an order for Amlodipine(used to manage blood pressure)5mg take 1 tablet daily at 8:00am. Review of Resident #6's October 2018 electronic medication administration record (eMAR) revealed: -There was an entry for Memantine 5mg take 1 tablet by mouth twice a day at 8:00am and 8:00pm. -There was an entry for Aspirin 81mg take 1 tablet by mouth daily at 8:00am. -There was an entry for Lisinopril 20mg take 1 tablet by mouth once a day at 8:00am. -There was an entry for Amlodipine 5mg take 1 tablet daily at 8:00am. Review of the facility order administration report on 10/24/18 at 10:00am revealed Resident #6's scheduled 8:00am medications included: Memantine, Lisinopril, Amlodipine, Aspirin were documented as administered on 10/23/18 at 10:04am. Attempted telephone interview on 10/24/18 at 2:00pm with Resident #6's physician was unsuccessful. Refer to the interview on 10/23/18 at 10:45am with the MA in the Memory Care Unit (MCU). Refer to the interview on 10/23/18 at 12:00pm	D 364		

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D 364	Continued From page 13 with the Wellness Nurse. Refer to the interview on 10/24/18 at 10:00am with the Resident Service Director. Refer to review of the facility medication administration policy. Refer to interview on 10/24/18 at 2:45pm with the Administrator. 2. Observation on 10/23/18 between 10:15am and 10:45am of a medication pass revealed: -There was one Medication Aide (MA) administering medications in the Memory Care Unit(MCU). -The MA started the administration of medications to Resident #3 at 10:20am from the medication cart located in activity room of the MCU. - The MA administered the following medications to Resident#3 Lorazepam 1mg/ml gel, Hydrocodone/APAP 10mg/325mg 1 tablet, Amlodipine 5mg 1 tablet, Aspirin 81mg 1 tablet, Prednisone 5mg 1 tablet, Potassium 10meq ER 1 tablet, Vitamin D3 2,000iu 1 tablet, Risperidone 0.5mg 1 tablet, Restasis 0.05% solution 1 drop in each eye, Levothyroxine 25mg ½ tablet(12.5mg), Divalproex 125mg 1 capsule, Gabapentin 300mg 1 capsule, Daily Multivitamin 1 tablet, Amlodipine Besylate 5mg 1 tablet, and Calcium/Vitamin D 600/400 1 tablet with water at 10:30am all medications were time for 8:00am. Review of Resident #3 current FL2 dated 10/10/18 revealed diagnoses included hypertension, dementia, mild cognitive impairment, and hypothyroidism. Review of Resident #3's signed Physician orders	D 364		

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D 364	Continued From page 14 dated 10/10/18 revealed: -There was an order for Lorazepam (used to treat anxiety) 1mg/ml gel spread 1ml (1mg) topically to inner wrist 3 times a day at 8:00am, 2:00pm, and 8:00pm. -There was an order for Hydrocodone/APAP (used to treat pain) 10mg/325mg 1 tablet every 8 hours at 8:00am, 2:00pm, 8:00pm and 2:00am. -There was an order for Amlodipine (used to treat pain) 5mg 1 tablet daily at 8:00am. -There was an order for Aspirin (use to treat heart disease) 81mg 1 tablet daily at 8:00am. -There was an order for Prednisone (to treat inflammation) 5mg 1 tablet daily at 8:00am. -There was an order for Potassium (used to treat potassium deficiency) 10meq ER 1 tablet daily at 8:00am. -There was an order for Vitamin D3 (to treat vitamin D deficiency) 2,000iu 1 tablet daily at 8:00am. -There was an order for Risperidone (used to treat agitation) 0.5mg 1 tablet 3 times daily at 8:00am, 2:00pm, and 8:00pm. -There was an order for Restasis (use to treat dry eyes)0.05% solution 1 drop in each eye daily at 8:00am. -There was an order for Divalproex (use to treat agitation) 125mg 1 capsule twice daily at 8:00am and 8:00pm. -There was an order for Gabapentin (used to treat pain) 300mg 1 capsule, 3 times daily at 8:00am, 2:00pm, and 8:00pm. -There was an order for Multivitamin (a supplement) 1 tablet daily at 8:00am. -There was an order for Amlodipine Besylate (used to treat blood pressure) 5mg 1 tablet daily at 8:00am -There was an order for Calcium/Vitamin D (used to treat calcium and vitamin D deficiency) 600/400 1 tablet daily at 8:00am.	D 364		

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D 364	Continued From page 15 Review of Resident#3's record revealed a physician order dated 10/15/18 for Levothyroxine (used to treat hypothyroidism) 25mcg 1 tablet daily at 8:00am. Review of Resident#3's October Electronic Medication Administration Record (eMAR) revealed: -There was an entry for a physician's order entry for Lorazepam1mg/ml gel spread 1ml (1mg) topically to inner wrist 3 times a day at 8:00am, 2:00pm, and 8:00pm. -There was an entry for a physician's order entry for Hydrocodone/APAP 10mg/325mg 1 tablet every 8 hours at 8:00am, 2:00pm, 8:00pm and 2:00am. -There was an entry for a physician's order entry for Amlodipine 5mg 1 tablet daily at 8:00am. -There was an entry for a physician's order entry for Aspirin 81mg 1 tablet daily at 8:00am. -There was an entry for a physician's order entry for Prednisone 5mg 1 tablet daily at 8:00am. -There was an entry for a physician's order entry for Potassium10meq ER 1 tablet daily at 8:00am. -There was an entry for a physician's order entry for Vitamin D3 2,000iu 1 tablet daily at 8:00am. -There was an entry for a physician's order entry for Risperidone 0.5mg 1 tablet 3 times daily at 8:00am, 2:00pm, and 8:00pm. -There was an entry for a physician's order entry for Restasis 0.05% solution 1 drop in each eye daily at 8:00am. -There was an entry for a physician's order entry for Divalproex 125 mg 1 capsule twice daily at 8:00am and 8:00pm. -There was an entry for a physician's order entry for Gabapentin 300mg 1 capsule, 3 times daily at 8:00am, 2:00pm, and 8:00pm. -There was an entry for a physician's order entry	D 364		

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D 364	Continued From page 16 for Multivitamin 1 tablet, Amlodipine Besylate 5mg 1 tablet -There was an entry for a physician's order entry for Calcium/Vitamin D 600/400 1 tablet daily at 8:00am. -There was an entry for a physician's order entry for Levothyroxine 25mcg 1 tablet daily at 8:00am. Interview with the Resident #3's physician on 10/24/18 at 2:00pm revealed: -The administration of the medications too close between scheduled times could result in possible complications of the effects of the medications administered. -The facility had not reported medications administered too close between scheduled times for Resident #3. Interview on 10/24/18 at 2:45pm with the Administrator revealed: -The facility had appropriate staff to assist the MA's with the medication pass this morning. -The MA failed to communicate the delay, and documented medications administered to Resident#3 prior to giving them. Refer to the interview on 10/23/18 at 10:45am with the MA in the MCU. Refer to the interview on 10/23/18 at 12:00pm with the Wellness Nurse. Refer to the interview on 10/24/18 at 10:00am with the Resident Service Director. Refer to the review of the facility medication administration policy. Interview on 10/23/28 at 10:45am with the MA in the MCU revealed:	D 364		

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D 364	Continued From page 17 -She was the only MA administering medications for 25 residents on the MCU. -She was delayed from starting the medication pass at 7:00am because a resident had been agitated, physically attacking another resident, and continuously wandering the unit. -She was aware of the facility policy for administration of medication one hour before and one hour after the scheduled time. -She had not asked the Wellness Nurse or the Resident Service Director to assist with the morning medication pass. Interview on 10/23/18 at 12:00pm with the Wellness Nurse revealed: -She was aware the MCU had a heavy medication pass in the mornings. -There was a resident on the MCU during the morning medication pass this morning who was very agitated, and additional staff had assisted with management of his behavior. -There was a policy for administration of medications one hour before and one hour after the scheduled times. -She was able to assist the MAs on the MCU. -The MA had not requested assistance with the medication pass this morning. -She was not aware the MA was delayed with the medication pass this morning. -She had not routinely asked the MA if she needed assistance with the 7:00am medication pass. Interview on 10/24/18 at 10:00am with the Resident Services Director (RSD) revealed: -She was aware the facility had a policy for administration of medications to residents one hour before and one hour after the scheduled times. -She was available to assist with the medication	D 364		

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D 364	Continued From page 18 pass to prevent delay, but the MA had not requested assistance. -She was not aware the MA was delayed with the medication pass this morning because she had not asked for assistance. -She had not routinely asked the MA if she needed assistance with the 7:00am medication pass. Review of the facility Medication Administration policy revealed administration of medications were to be administered one hour before and one hour after the scheduled times. Interview with the Administrator on 02/16/17 at 1:30 pm revealed: -The facility's medication policy was for residents to receive their medications one hour before or one hour after the scheduled times. -The facility had appropriate staff to assist the MA's with the medication pass this morning. -The Wellness Nurse and Resident Service Director had not asked the MA if she needed assistance with 7:00am medication pass.	D 364		
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	D 367		

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D 367	Continued From page 19 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: This rule area is still out of compliance. Based on observation, record reviews, and interviews, the facility failed to assure the electronic medication administration record (eMARs) were accurate for 1 of 5 sampled residents (#3) related to documentation of levothyroxine. The findings are: Review of Resident #3 current FL2 dated 10/10/18 revealed diagnoses included hypertension, dementia, mild cognitive impairment, and hypothyroidism. Review Resident #3's physician's order dated 10/15/18 revealed a medication order for levothyroxine 25mcg 1 tablet daily. Review of Resident #3's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 10/15/18 to discontinue levothyroxine 25mcg take ½ tablet	D 367		

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D 367	Continued From page 20 (12.5mcg) once daily at 8am. -There was an entry dated 10/15/18 to begin levothyroxine 25mcg take 1 tablet once daily at 8am. -There was documentation of administration of levothyroxine 25mcg take 1 tablet once daily at 8am on 10/16/18, 10/17/18, 10/18/18. -There was documentation of levothyroxine 25mcg take 1 tablet once daily at 8am on 10/19/18 with the initials "EXP" which indicated according to the eMAR legend of abbreviations the order expired. -There was no additional documentation of the administration of levothyroxine 25mcg take 1 tablet by mouth once daily at 8am for 10/19 through 10/23/18. Observation of the medication pass by the medication aide (MA) on 10/23/18 at 10:30am revealed, the MA administered a half of a 25mcg tablet of Levothyroxine (12.5mcg) to Resident #3. Interview with the pharmacy on 10/24/18 at 10:40am revealed: -An order for levothyroxine 25mcg take 1 tablet by mouth once daily had been received by fax for Resident #3 on 10/15/18. -The facility had put a temporary order on the eMAR on 10/15/18 that expired after 3 days. -The order had not been accepted by the pharmacy after their review for correctness and had expired no longer allowing the medication to be documented. -When the order had expired there was a message on the eMAR for further communication from the facility to the pharmacy to clarify the order. -The facility had not clarified the medication order with them.	D 367		

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D 367	Continued From page 21 Interview with the Wellness Nurse on 10/24/18 at 12:00pm revealed: -She had faxed the order for Resident #3 on 10/15/18 for levothyroxine 25mcg take 1 tablet once daily at 8am to the pharmacy. -She had put in a temporary order after the pharmacy had closed for the new dosage on the eMAR on 10/15/18 and discontinue the other order on the eMAR. -The temporary medication had allowed the administration of medication until it was clarified with the pharmacy. -Resident #3 had not received her levothyroxine since 10/19/18 according to the documentation on the eMAR. -She did not know the order had expired on eMAR. -She failed to clarify the order before it expired on 10/19/18 with the pharmacy. Interview with the Resident Service Director on 10/24/18 at 9:30am revealed: -The eMAR was not accurate because the new order for Resident #3 on 10/15/18 had not been followed through completely by the Wellness Nurse. -The Wellness Nurse had not notified the pharmacy of the temporary order on 10/15/18 when she entered it onto the eMAR. -The MA should not have administered medications not on the eMAR. -The MA had gave the medication without reviewing the order on the eMAR because there was no order on the eMAR. Interview with the Resident 3#'s physician on 10/24/18 at 2:00pm revealed: -He did not know the resident had not been getting her levothyroxine 25mcg take 1 tablet once daily ordered on 10/15/18 until his office	D 367		

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D 367	Continued From page 22 was notified on 10/23/18 by the facility when an error was found. -He had given them another order to restart levothyroxine 25mcg take 1 tablet once daily today, and he would recheck Resident #3's thyroid hormone levels next month. Interview with the Administrator on 10/24/18 at 2:45pm revealed: -The MAs were responsible for ensuring eMAR accuracy and administering only the medications on hand that are on the eMAR. -The inaccuracy of the eMAR was a result of the Wellness Nurse not following through with the pharmacy on the temporary order she put on the eMAR for Resident #3 before it expired on the third day.	D 367		