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YANCEY HOUSE	4 COOPER LANE BURNSVILLE, NC 28714

(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 Yancey County Department of Social Services comducted an annual and follow up survey on 01/24/19 to 01/25/19.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 5 of 6 sampled residents (Residents #2, #3, #4, #5, and #7) related to gentamicin eye drops and quetiapine (#2), vitamin B12 and Zanaflex (#3), amlodipine (#4), and Lasix (#5 and #7). The findings are:	D 358		

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D 358	Continued From page 1 1. Review of Resident #2's current FL2 dated 10/05/18 revealed diagnoses included dementia and hypertension. a. Review of a physician's order dated 12/27/18 revealed gentamicin (antibiotic) 0.3% eye drops, give two drops into right eye three times daily and discontinue on 01/04/19. Review of Resident #2's December 2018 and January 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for gentamicin eye drops. Telephone interview on 01/25/19 with a representative from the facility's contracted pharmacy revealed: -The pharmacy entered faxed medication orders for Resident #2 into the eMAR system. -Resident #2's medications were dispensed by another local pharmacy. -The pharmacy had not received a faxed order for gentamicin eye drops to enter into the eMAR system. Telephone interview on 01/25/19 with a pharmacist at the local pharmacy revealed: -The pharmacy had dispensed a 5ml bottle of gentamicin eye drops on 12/31/18 for Resident #2. -Staff from the facility had picked up the eye drops on 12/31/18. Observation on 01/25/19 at 9:39am of Resident #2's medications on hand revealed: -There was a 5ml opened bottle of gentamicin 0.3% eye drops. -There was a label with instructions to instill two drops into the right eye three times daily.	D 358		

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-There was a dispense date of 12/27/18.
-There was no stop date.

Interview on 01/25/19 at 9:40am with a first shift Medication Aide (MA) revealed:
-The MA had administered one drop of gentamicin eye drops into Resident #2's right eye at 8:00am on 01/25/19.
-Sometimes the eye drops could not be administered because the Resident would not open her eyes.
-The MA did not know that the eye drops were not listed on the eMAR.
-She did not know why the eye drops were not showing up on the eMAR.

Interview on 01/25/19 at 10:00am with the physician's Nurse Practitioner (NP) revealed:
-The gentamicin eye drops were ordered for an eye infection.
-It was "not really good" for Resident #2's eye to continue to receive the eye drops but it would not "damage" anything.

Interview on 01/25/19 at 10:23am with a second first shift MA revealed:
-The MA had administered the eye drops to Resident #2 on 01/20/19 at 8:00am.
-The MA thought she had documented on the eMAR that she had administered the eye drops, but sometimes it was "hard to remember".
-The MA did not know why the gentamicin eye drops were not listed on the eMAR.

Interview on 01/25/19 at 10:40am with the Special Care Coordinator (SCC) revealed:
-She knew Resident #2 was on eye drops because she had heard staff talking about it.
-She had administered medications on 01/24/19 at 8:00am and had not administered the eye

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drops because it was not listed on the eMAR.
-She was responsible for faxing new orders to the facility's contracted pharmacy to be entered into the eMAR system.
-She conducted audits on new orders daily and compared them with the eMAR and ensured the medications were in the facility.
-She conducted routine medication carts audits weekly.
-She did not know why the gentamicin eye drops had not been faxed to the pharmacy for processing.
-She did not know why the MAs were administering the eye drops when it was not listed on the eMAR.

Interview on 01/25/19 at 11:00am with the Director of Nursing (DON) revealed:
-She did not know Resident #2 was receiving gentamicin eye drops.
-The DON and the SCC were responsible for faxing new orders to the facility's contracted pharmacy for entering into the eMAR system.
-The DON and the SCC were responsible for auditing new orders and the eMAR on Wednesdays.
-She did not know why the eye drops had not been faxed.
-She did not know why the MAs were administering the eye drops when it was not listed on the eMAR.

Telephone interview on 01/25/19 at 11:20am with a second shift MA revealed:
-She did not know Resident #2 had an order for gentamicin eye drops in December 2018.
-She had not administered the gentamicin eye drops to Resident #2.

Based on observations, interviews, and record

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reviews it was determined Resident #2 was not interviewable.

Attempted telephone interview on 01/25/19 at 10:30am with Resident #2's Power of Attorney was unsuccessful.

Request for the facility's Medication Administration Policy and Procedure was not provided.

Refer to interview on 01/25/19 at 10:08am with a first shift Medication Aide (MA).

Refer to the interview on 01/25/19 at 11:32am with the Administrator.

b. Review of a physician's order on Resident #2's current FL2 dated 10/05/18 revealed quetiapine (anti psychotic) 50mg, give one tablet every day at bedtime.

Review of Resident #2's electronic Medication Administration Record (eMAR) for December 2018 revealed:
-There was an entry for quetiapine 50mg take one tablet at bedtime, with an administration time of 8:00pm.
-There was documentation the quetiapine had been administered 12/01/18 -12/16/18 and 12/23/18 - 12/31/18 at 8:00pm.
-There was documentation the quetiapine had not been administered 12/17/18 - 12/22/18 due to being on hold.

Review of Resident #2's physician orders revealed there was no order to hold the quetiapine.

Telephone interview on 01/25/19 at 11:20am with

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a second shift Medication Aide (MA) revealed.
-She had been instructed by administration to document "on hold" when a medication was not in the facility to administer.
-Resident #2 had not had any quetiapine 50mg in the facility from 12/17/18 - 12/22/18.
-She had not requested a refill because she did not have time.
-She would write a note and report to the next shift that the medication needed to be refilled.

Interview on 01/25/19 at 10:00am with the Nurse Practitioner (NP) from Resident #2's primary care provider's office revealed:
-Resident #2 was receiving the quetiapine for sleep and behaviors.
-She had not ordered the medication to be held between 12/17/18 - 12/22/18.
-Resident #2 had not had any adverse behaviors during that time.

Interview on 01/25/19 at 10:40am with the Special Care Coordinator (SCC) revealed:
-The MAs were to reorder medications or notify the SCC.
-She had not been notified there had been no quetiapine to administer.
-She conducted weekly medication cart audits to ensure medications were in the facility.

Interview on 01/25/19 at 11:00am with the Director of Nursing (DON) revealed:
-The Medication Aides (MA) should call the local pharmacy when they were getting "low" on medications.
-The MAs should have notified the DON the medication was not in the facility.
-The DON did not know the medication was not in the facility.

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Telephone interview on 01/25/19 at 11:10am with the pharmacist from the local pharmacy revealed:
-They had an original order for quetiapine 50mg one tablet at bedtime.
-A total of fourteen tablets were dispensed on 11/06/18 and on 11/20/18.
-There had been no requests to refill the quetiapine 50mg from the facility staff until 12/27/18.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Attempted telephone interview on 01/25/19 at 10:30am with Resident #2's Power of Attorney was unsuccessful.

Request for the facility's Medication Administration Policy and Procedure was not provided.

Refer to interview on 01/25/19 at 10:08am with a first shift Medication Aide (MA).

Refer to the interview on 01/25/19 at 11:32am with the Administrator.

2. Review of Resident #3's current FL2 dated 08/10/18 revealed diagnoses included dementia, hypertension, asthma, and hyperlipidemia.

Review of Resident #3's Resident Register revealed an admission date of 09/12/17 to the Special Care Unit (SCU).

a. Review of Resident #3's physician's order dated 11/02/18 revealed a physician's order for vitamin B12 500mcg take one tablet daily (vitamin supplement used to treat vitamin B12 deficiency).

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D 358	Continued From page 7 Review of Resident #3's December 2018 and January 2019 electronic Medication Administration Record (eMAR) revealed no computer generated entry for vitamin B12. Observation of Resident #3's medication on hand on 01/25/19 at 10:35am revealed no vitamin B12 was available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/25/19 at 11:25am revealed: -The pharmacy only filled prescriptions for Resident #3 when the facility was not able to obtain the medication from Resident #3's pharmacy. -The pharmacy did not have an order for vitamin B12 for Resident #3. -The facility was responsible for faxing all orders to the pharmacy for Resident #3 for the medication order to be added to the eMAR. Telephone interview with the pharmacist from Resident #3's pharmacy on 01/25/19 at 11:30am revealed the pharmacy did not have an order for vitamin B12 for Resident #3. Interview with a medication aide (MA) from the SCU on 01/25/19 at 10:39am revealed: -She usually worked first shift in the SCU. -She did not know Resident #3 had a physician's order for vitamin B12. Interview with the Special Care Coordinator (SCC) on 01/25/19 at 11:58am revealed: -She did not know Resident #3 had an order for vitamin B12. -She did not know why Resident #3's order for vitamin B12 was not processed.	D 358		

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-She was responsible for faxing new medication orders to the facility's contracted pharmacy to be entered on the eMAR.
-She was responsible for approving medication orders entered by the pharmacy for the order to appear on the eMAR.
-She was responsible for faxing medication orders for Resident #3 to her selected pharmacy to be filled.
-Resident #3's family was responsible for picking up and delivering medications to the facility.

Interview with the Director of Nursing (DON) on 01/25/19 at 10:45am revealed:
-She was responsible for processing medication orders beginning in December 2018.
-She did not know Resident #3 had an order for vitamin B12.
-She and the SCC were responsible for processing medication orders for the assisted living and SCU.
-She did not know why Resident #3's vitamin B12 order was not processed.

Interview with the Nurse Practitioner (NP) from Resident #3's primary care provider's office on 01/25/19 at 10:00am revealed:
-She did not know Resident #3 was not receiving vitamin B12.
-The facility staff were responsible for following the physician's orders as written.
-Resident #3 was at risk of vitamin B12 deficiency if she was not receiving her vitamin B12.
-Resident #3 was at risk for muscle weakness and fatigue, decrease in thought process, and anxiety.

Attempted telephone interview with Resident #3's Power of Attorney on 01/25/19 at 10:53am was unsuccessful.

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D 358	Continued From page 9 Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Request for the facility's Medication Administration Policy and Procedure was not provided. Refer to interview on 01/25/19 at 10:08am with a first shift MA. Refer to interview with the Administrator on 01/25/19 at 11:32am. b. Review of Resident #3's physician's order revealed a physician's order dated 08/17/18 revealed a physician's order for Zanaflex 2mg one tablet every eight hours as needed for chest wall pain (used to treat muscle spasms). Review of Resident #3's hospital discharge summary dated 09/20/18 revealed Zanaflex 2mg one tablet every eight hours as needed for chest wall pain should be continued after hospital discharge. Review of Resident #3's December 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for Zanaflex take one tablet every eight hours as needed for chest wall pain. -There were no doses of Zanaflex documented as administered. Review of Resident #3's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for	D 358		

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Zanaflex take one tablet every eight hours as needed for chest wall pain.
-There were no doses of Zanaflex documented as administered.

Observation of Resident #3's medication on hand on 01/25/19 at 10:35am revealed there was no Zanaflex available to be administered.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/25/19 at 11:25am revealed:
-The pharmacy only filled prescriptions for Resident #3 when the facility was not able to obtain the medication from Resident #3's pharmacy.
-The pharmacy did not have an order for Zanaflex for Resident #3.
-The facility staff were responsible for faxing all orders to the pharmacy for Resident #3 for the medication order to be added to the eMAR.

Telephone interview with the pharmacist from Resident #3's pharmacy on 01/25/19 at 11:30am revealed the pharmacy dispensed a five day supply of Zanaflex to Resident #3 on 08/14/18 to take one tablet every eight hours for three days then to continue one tablet every eight hours as needed for chest wall pain.

Interview with a medication aid (MA) from the SCU on 01/25/19 at 10:39am revealed:
-She usually worked first shift in the SCU.
-She did not know Resident #3 had a physician's order for Zanaflex.
-She did not remember administering Zanaflex to Resident #3.

Interview with the Special Care Coordinator (SCC) on 01/25/19 at 11:58am revealed:

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-She was responsible for faxing new medication orders to the facility's contracted pharmacy to be entered on the eMAR.
-She was responsible for approving medication orders entered by the pharmacy for the order to appear on the eMAR.
-She was responsible for faxing medication orders for Resident #3 to her selected pharmacy to be filled.
-Resident #3's family was responsible for picking up and delivering medications to the facility.

Interview with the Director of Nursing (DON) on 01/25/19 at 10:45am revealed:
-She was responsible for processing medication orders beginning in December 2018 when she was named the DON.
-She and the SCC were responsible for processing medication orders for the assisted living and SCU.
-She and the SCC were responsible for reviewing hospital discharge summaries for new medication orders.

Interview with the Nurse Practitioner (NP) from Resident #3's primary care provider's office on 01/25/19 at 10:00am revealed:
-Resident #3 complained of bilateral knee and back pain.
-The facility staff was responsible for following physician's orders as written.
-The facility staff was responsible for processing new orders from a hospital discharge summary.

Attempted telephone interview with Resident #3's Power of Attorney on 01/25/19 at 10:53am was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not

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D 358	Continued From page 12 interviewable. Request for the facility's Medication Administration Policy and Procedure was not provided. Refer to interview on 01/25/19 at 10:08am with a first shift MA. Refer to interview with the Administrator on 01/25/19 at 11:32am. 3. Review of Resident #7's current FL2 dated 01/04/19 revealed: -Diagnoses included chronic obstructive pulmonary disorder (COPD), hypertension, and osteoarthritis. -There was a physician's order for Lasix 20mg take one tablet daily for ankle swelling (used to treat high blood pressure and swelling). Review of Resident #7's Resident Register revealed an admission date of 10/31/18. Review of Resident #7's physician's order revealed a physician's order dated 01/11/19 to add Lasix 20mg take one tablet daily at lunch for edema, weeping. Review of Resident #7's physician's order revealed a physician's order dated 01/18/19 to discontinue Lasix 20mg and give Lasix 40mg one tablet daily. Review of Resident #7's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for Lasix 20mg take one tablet daily for ankle swelling scheduled to be administered at 8:00am.	D 358		

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D 358	Continued From page 13 -Lasix 20mg was documented as administered at 8:00am from 01/01/19 to 01/12/19 with a discontinued date of 01/17/19. -There was a computer generated entry for Lasix 20mg take one tablet daily at lunch with a scheduled administration time of "other." -Lasix 20mg was documented as administered from 01/21/19 to 01/24/19 with no time of administration documented. -There was a computer generated entry for Lasix 40mg take one tablet daily scheduled to be administered at 8:00am. -Lasix 40mg was documented as administered on 01/21/19, 01/22/19, and 01/24/19 at 8:00am. -Resident #7 refused Lasix 40mg on 01/23/19. -Resident #7 was out of the facility from 01/13/19 to 01/20/19. Observation of a medication pass on 01/24/19 at 11:25am revealed Resident #7 was administered Lasix 20mg. Observation of Resident #7's medication on hand on 01/25/19 at 10:08am revealed: -A medication card containing twenty-one tablets of Lasix 20mg dispensed on 01/08/19 was available to be administered. -A medication card containing twenty-five tablets of Lasix 40mg dispensed on 01/17/19 was available to be administered. Telephone Interview with a pharmacy technician from the facility's contracted pharmacy on 01/25/19 at 10:12am revealed: -A 30 day supply of Lasix 40mg take one tablet daily was dispensed to Resident #7 on 01/17/19. -A 30 day supply of Lasix 20mg take one tablet daily was dispensed to Resident #7 on 01/08/19 and 12/01/18. -The facility staff were responsible for approving	D 358		

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the medication orders entered by the pharmacy before the order appeared on the eMAR.
-A discontinued medication order had to be approved by the facility staff before the medication was removed from the eMAR.
-The facility was responsible for approving a discontinued medication order before the order was removed from the eMAR.

Interview with the Medication Aide (MA) on 01/25/19 at 10:08am revealed:
-She administered medications during first shift.
-She administered Lasix 20mg to Resident #7 on 01/23/19 and 01/24/19.

Interview with the Director of Nursing (DON) on 01/25/19 at 10:45am and at 11:51am revealed:
-She was responsible for processing medication orders starting in December 2018.
-She and the SCC were responsible for processing discontinued medication orders and making sure they were removed from the eMAR on 01/17/19.
-She knew Resident #7 had a physician's order to discontinue Lasix 20mg.
-She had discontinued Lasix 20mg and removed the physician's order from the eMAR.
-She did not know why the order for Lasix 20mg was still showing up on the eMAR.
-The third shift MA was responsible for removing discontinued medications from the medication cart.

Interview with the Nurse Practitioner (NP) from Resident #3's primary care provider's office on 01/25/19 at 10:00am revealed:
-Resident #7 was supposed to be taking only Lasix 40mg daily.
-Resident #7 was recently discharged from the hospital with a diagnosis of congestive heart

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failure and was admitted to hospice services.
-Resident #7 was at risk for dehydration, low blood pressure, and confusion if she received too much Lasix.

Telephone interview with a nurse from Resident #7's hospice service provider on 01/25/19 at 11:05am revealed:
-Resident #7 was admitted to hospice services on 01/22/18.
-Resident #7's current order for Lasix was 40mg take one tablet daily.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to interview on 01/25/19 at 10:08am with a first shift MA.

Refer to interview with the Administrator on 01/25/19 at 11:32am.

4. Review of Resident #4's current FL2 dated 01/24/19 revealed:
-Diagnoses included blood clots, hyperlipidemia, anemia, congestive heart failure, and hypertension.
-There was documentation Resident #4 was intermittently disoriented.

Review of physician order's for Resident #4 dated 10/16/18 revealed a medication order for amlodipine (treats high blood pressure) 5mg daily at bedtime.

Review of Resident #4's electronic Medication Administration Record for January 2019 revealed:
-There was an entry to give amlodipine 5mg at bedtime with an administration time of 8:00pm.

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-There was documentation the amlodipine had been administered 01/01/19 - 01/12/19, 01/18/19, 01/19/19, 01/20/19, 01/22/19, and 01/23/19 at 8:00pm.
-There was documentation the amlodipine was "on hold" from 01/13/19 - 01/17/19.

Observation on 01/24/19 at 3:00pm of Resident #4's medications on hand revealed there was no amlodipine available for administration.

Interview on 01/24/19 at 3:00pm with a Medication Aide (MA) revealed:
-The facility did not have any amlodipine in the medication cart for Resident #4.
-The facility did not have any amlodipine for Resident #4 in medication storage.

Telephone interview on 01/25/19 at 10:00am with a representative from the facility's contracted pharmacy revealed:
-The pharmacy had dispensed amlodipine 5mg for Resident #4 on 12/22/18 and 01/24/19.
-The pharmacy dispensed a thirty day supply on 12/22/18 and 01/24/19.

Interview on 01/25/19 at 12:22pm with a second MA revealed:
-The MAs documented "on hold" on the eMAR when a medication was not available.
-There had been "a lot of problems" with the pharmacy.
-The pharmacy delivered medications daily no earlier than 11:30pm.
-A local pharmacy was used as backup pharmacy for medications.
-She did not know why the back up pharmacy was not contacted about the amlodipine.

Review of Resident #4's documented blood

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pressures (BP) for January 2019 revealed BPs ranged from 118/52 to 153/70.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

Refer to interview on 01/25/19 at 10:08am with a first shift MA.

Refer to the interview on 01/25/19 at 11:32am with the Administrator.

5. Review of Resident #5's current FL2 dated 01/04/19 revealed:
-Diagnoses included bradycardia, status post pacemaker, coronary artery disease, and hypertension.
-There was a physician's order for Lasix (used to treat high blood pressure and swelling) 20mg one tablet daily.
-There was a physician's order for Lasix 20mg take two tablets (40mg) on Saturday and Sunday.

Review of Resident #5's Resident Register revealed an admission date of 12/16/15.

Review of Resident #5's January 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lasix 20mg take one tablet daily at 8:00am.
-Lasix 20mg was documented as administered at 8:00am from 01/01/19 to 01/24/19.
-There was an entry for Lasix 20mg take two tablets (40mg) once daily by mouth on Saturday and Sunday.
-Lasix 20mg take two tablets (40mg) on Saturday and Sunday was documented as administered

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D 358	Continued From page 18 every day at 8:00am from 01/01/19 to 01/24/19. Record review of a signed physician order for Resident #5 revealed an order dated 11/09/18 for Lasix 20mg take two tablets on Saturday (11/10/18) and Sunday (11/10/18), then Lasix 20mg daily. Review of Resident #5's December 2018 eMAR revealed: -There was an entry for Lasix 20mg take one tablet daily at 8:00am. -Lasix 20mg was documented as administered at 8:00am from 12/01/18 to 12/31/18. -There was an entry for Lasix 20mg take two tablets (40mg) once daily by mouth on Saturday and Sunday. -Lasix 20mg take two tablets 940mg) on Saturday and Sunday, was documented as administered on the weekdays at 8:00am on 12/05/18, 12/06/18, 12/10/18 to 12/13/18, 12/17/18 to 12/21/18, 12/24/18 to 12/28/18, and on 12/31/18. Observation on 01/25/19 at 9:30am of Resident #5's medications on hand revealed: -There was a medication card containing four tablets of Lasix 40mg, take one tablet every morning, dispensed on 09/29/18 was available to be administered. -There was no Lasix 20mg on the medication cart. Interview on 01/25/19 at 9:30am with the Medication Aide (MA) revealed: -There was not a card of Lasix 20mg on the medication cart. -There was a medication card containing thirty tablets of Lasix 20mg, take one tablet every day, dispensed on 01/11/19 that was in the overstock medication cabinet.	D 358		

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-She administered medications to assisted living residents during first shift.
-She administered Lasix 40mg to Resident #5 at 8:00am on 01/25/19 because "that is what the card said" and did not reference the orders in the eMAR system.
-"I guess I should go by what the eMARs have on them."
-She could not find a medication card for Lasix 40mg on Saturday and Sunday.

Telephone interview on 01/25/19 at 10:25am with a pharmacy technician from the facility's contracted pharmacy revealed:
-A thirty day supply of Lasix 20mg take one tablet daily was dispensed to Resident #5 on 01/11/19 due to a refill request from the facility.
-The most current order received for Resident #5 was a signed physician's order sheet dated 01/04/19 for Lasix 20mg take one tablet daily.
-The facility was responsible for approving the medication orders entered by the pharmacy before the order appeared on the eMAR.

Interview on 01/25/19 at 10:35am and 11:02am with the Director of Nursing (DON) revealed:
-The current orders for Resident #5 on the eMAR for Lasix were dated 11/12/18 and 11/18/18 and were not in the resident's record.
-The first shift MA working today had been administering 20mg Monday through Friday, and 40mg on Saturdays and Sundays.

Interview on 01/25/19 at 10:40am with the facility's contracted NP revealed:
-Resident #5 was supposed to be taking Lasix 20mg daily on Monday through Friday, and 40mg daily on Saturday and Sunday.
-She had written an order on 11/09/18 for Lasix 20mg take two tablets on Saturday (11/10/18) and

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Sunday (11/10/18), then Lasix 20mg daily.
-She did not specify which days to administer the 20mg daily.
-The facility had not contacted her to clarify the order until 01/25/19.

Interview on 01/25/19 at 11:02am with the DON and the Corporate Nurse revealed:
-The NP had written an order on 11/09/18 and "wanted" Lasix 20mg to be administerd on Monday - Friday only, and 40mg on Saturday and Sunday only.
-On 01/25/19 the NP added "M-F" for the 20mg dose, that was not originally written on the 11/09/18 order.
-The facility had not contacted the NP prior to 01/25/19 to clarify the order.

Further record review on 1/25/19 at 1:01pm of a signed physician order for Resident #5 revealed:
-An order dated 01/25/19 for Lasix 40mg on Saturdays and Sundays.
-An order dated 01/25/19 for Lasix 20mg on Monday, Tuesday, Wednesday, Thursday and Friday.

Interview on 01/24/19 at 9:45am with Resident #5 revealed he received his medications as ordered.

Attempted telephone interview on 01/25/19 at 11:30am with Resident #5's POA was unsuccessful.

Request for the facility's Medication Administration Policy and Procedure was not provided.

Refer to interview on 01/25/19 at 10:08am with a first shift MA.

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D 358	Continued From page 21 Refer to interview on 01/25/19 at 11:00am with the DON. Refer to the interview on 01/25/19 at 11:32am with the Administrator. Interview on 01/25/19 at 10:08am with a first shift MA revealed: -The pharmacy was responsible for entering new medication orders. -The Director of Nursing (DON) was responsible for approving the medication orders from the pharmacy for the orders to appear on the eMAR. -She and other MAs were responsible for completing weekly random medication cart audits during each shift. -She and other MAs were responsible for comparing the medications on the medication cart to the eMAR during the cart audits. -She was not responsible for comparing the eMAR to new physician's orders. -She was responsible for administering medications to the residents based on the eMAR. Interview on 01/25/19 at 10:40am with the Special Care Coordinator (SCC) revealed: -She had been in the position since the middle of December 2018. -She was responsible for faxing new orders to the facility's contracted pharmacy to be entered into the eMAR system. -She conducted audits on new orders daily and compared them with the eMAR and ensured the medications were in the facility. -The SCC conducted routine medication cart audits weekly. Interview on 01/25/19 at 11:32am with the Administrator revealed: -All medication orders were to be faxed to the	D 358		

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facility's contracted pharmacy for entering into the electronic Medication Administration Record.
-All new medications were to be in the facility within twenty-four hours.
-The Director of Nursing and the Special Care Coordinator conduct medication cart audits once per week to check for expired medications and to compare orders with the medications and electronic Medication Administration Records.
-The MAs were to request refills when there was a seven day supply left.

Interview on 01/25/19 at 11:00am with the Director of Nursing (DON) revealed:
-The DON and SCC were responsible for faxing new orders to the facility's contracted pharmacy for profiling into the eMAR system.
-The DON and SCC were responsible for for auditing new orders and the eMAR on Wednesdays.

The facility failed to administer medications as ordered, including antibiotic eye drops and quetiapine to Resident #2, vitamin B12 and Zanaflex to Resident #3, amlodipine to Resident #4, and Lasix to Resident #5 and #7. This failure increased the risk of continued eye infection and adverse behaviors to (#2), vitamin B12 deficiency and pain to (#3), high blood pressure (#4), and dehydration and low blood pressure (#5 and #7). The facility's failure to administer medications as ordered was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/25/19 for this violation.

CORRECTION FOR THE TYPE B VIOLATION

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D 358	Continued From page 23 SHALL NOT EXCEED MARCH 11, 2019.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 5 of 6 sampled residents (Residents #2, #3, #4, #5, and #7) related to gentamicin eye drops and quetiapine (#2), vitamin B12 and Zanaflex (#3), amlodipine (#4), and Lasix (#5 and #7). [Refer to Tag 0358, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation).]	D912		