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
	HAL044042	A. BUILDING: _____ B. WING _____	C 01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD HOUSE	27 NORTH MAIN STREET CANTON, NC 28716

(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 completed a complaint investigation on 01/14/19 to 01/15/19.	D 000	D 273 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law. Physician will be notified of missed medications/med errors. Facility will implement an ordering Processing System (Bucket System) to ensure medication are received in Community as ordered and in a timely matter. SIC's / Supervisor's In Charge will process orders per instructions of the bucket system. SIC's will relay all missed medications daily to Memory Care Manager or Executive Director and what steps they have taken to get correct medicine in Community timely. Memory Care Manager or ED will then call pharmacy directly to identify problem and get issue resolved. Unavailable Medication report will be reviewed daily by Memory Care Manager, ED or Weekend Manager. Medication Management and Physician Notification will be monitored during month QA meetings for at least 3 months or will extend if needed. Cart Audit will be preformed weekly by Memory Care Manager and designee. Cart audit will consist of making sure the	03/01/19
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, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled residents (Resident #1's) physician was notified of missed doses of valproic acid and magnesium due to the medication being unavailable for administration. The findings are: Review of Resident #1's current FL2 dated 09/27/18 revealed: -Diagnoses included Alzheimer's Disease, frontotemporal dementia, Type II Diabetes, benign prostatic hyperplasia, and gastroesophageal reflux disease. -There was an order for valproic acid (widely used to treat behavioral disturbance in patients with dementia) 250mg/5ml 5ml every morning and evening. -There was an order for valproic acid 250mg/5ml 10ml daily at bedtime. -There was an order for magnesium (used as a	D 273		

Reviewed and accepted 02/18/19 RP

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D 273	Continued From page 1 supplement to prevent magnesium deficiency) 250mg two times a day. Review of Resident #1's Resident Register revealed an admission date of 09/28/18. a. Observation of Resident #1 on 01/14/19 at 10:00am revealed: -The resident was standing in the reception area of the facility. -The resident walked up to a surveyor and forcefully took the pen the surveyor was holding out of her hand. -The resident placed the pen in his front pocket and walked away. Interview with the Activity Director on 01/14/19 at 10:01am revealed: -Resident #1 collected pens throughout the day and then would turn them in at the end of the day to staff. -He had never hurt himself or others with the pens he collected. Observation of Resident #1 on 01/14/19 at 10:35am revealed: -The resident standing at front reception area with a can of shaving cream in his hand. -The resident was holding the can away from the grasp of the staff member standing beside him. -The resident lifted the can with the cap still in place to his mouth as if to try to drink the shaving cream. -The staff member calmly spoke to the resident and told the resident the shaving cream was not a drink and to give them the shaving cream. -The resident then threw the shaving cream can across the floor. Review of Resident #1's Care Notes dated	D 273	sure the MARS match what is on the medication cart and that all medications are reordered timely. Cart audit finding will be giving to the Executive Director. Results of Cart Audit will be monitored during month QA meetings for at least 3 months or will extend if needed.	

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D 273	Continued From page 2 11/06/18 to 01/03/19 revealed: -An entry on 01/01/19, "Resident seems very agitated and combative at times, even after prn [as needed] medications are administered." -An entry on 01/03/19, "Very agitated today." Review of Resident #1's September 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for valproic acid 250mg/5ml take 5mls scheduled daily at 8:00am and at 2:00pm. -The valproic acid scheduled at 8:00am and 2:00pm was documented as administered 3 occurrences out of 4 opportunities (on 09/29/18 at 2:00pm the medication was documented as "Not administered: Other order error.") -There was an entry for valproic acid 250mg/5ml take 10mls scheduled daily at 9:00pm. -The valproic acid scheduled at 9:00pm was documented as administered 1 occurrence out of 3 opportunities (on 09/29/18 and 09/30/18 at 9:00pm the medication was documented as "Not administered: Drug/Item Unavailable.") Review of Resident #1's October 2018 eMAR revealed: -There was an entry for valproic acid 250mg/5ml take 5mls scheduled daily at 8:00am and at 2:00pm. -The valproic acid scheduled at 8:00am and 2:00pm was documented as administered 60 occurrences out of 62 opportunities (on 10/12/18 at 8:00am the medication was documented as "Not administered: Resident Unavailable" and on 10/22/18 at 8:00am the medication was documented as "Not administered: Refused.") -There was an entry for valproic acid 250mg/5ml take 10mls scheduled daily at 9:00pm. -The valproic acid scheduled at 9:00pm was	D 273		

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D 273	Continued From page 3 documented as administered 3 occurrences out of 31 opportunities (on 10/01/18 and 10/05/18 at 9:00pm the medication was documented as "Not administered: Drug/Item Unavailable.") Review of Resident #1's November 2018 eMAR revealed: -There was an entry for valproic acid 250mg/5ml take 5mls scheduled daily at 8:00am and at 2:00pm. -The valproic acid scheduled at 8:00am and 2:00pm was documented as administered 59 occurrences out of 60 opportunities (on 11/13/18 at 2:00pm the medication was documented as "Not administered: other with comment: wouldn't wake up to take.") -There was an entry for valproic acid 250mg/5ml take 10mls scheduled daily at 9:00pm. -The valproic acid scheduled at 9:00pm was documented as administered 30 occurrences out of 30 opportunities from 11/01/18 to 11/30/18. Review of Resident #1's December 2018 eMAR revealed: -There was an entry for valproic acid 250mg/5ml take 5mls scheduled daily at 8:00am and at 2:00pm. -The valproic acid scheduled at 8:00am and 2:00pm was documented as administered 31 occurrences out of 62 opportunities from 12/01/18 to 12/31/18 (there were 15 occurrences when the medication was not administered due to "drug/item unavailable" and 14 occurrences when the medication was not administered due to "order error.") -There was an entry for valproic acid 250mg/5ml take 10mls scheduled daily at 9:00pm. -The valproic acid scheduled at 9:00pm was documented as administered 18 occurrences out of 31 opportunities from 12/01/18 to 12/31/18	D 273		

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D 273	Continued From page 4 (there were 13 occurrences when the medication was not administered due to "drug/item unavailable.") Review of Resident #1's Nurse Practitioner's Encounter Note dated 01/11/19 revealed: -The chief complaint was agitation. -"This visit is at the request of facility staff concerned about ongoing agitation despite the use of antipsychotic medication as well as Depakote..." (Depakote is the name brand for valproic acid). -An order to decrease the valproic acid from 500mg at bedtime to 250mg daily at bedtime. Review of Resident #1's January 2019 eMAR revealed: -There was an entry for valproic acid 250mg/5ml take 5mls scheduled daily at 8:00am and at 2:00pm. -The valproic acid scheduled at 8:00am and 2:00pm was documented as administered 0 occurrences out of 22 opportunities from 01/01/19 to 01/11/19 (there were 11 occurrences when the medication was not administered due to "drug/item unavailable" and 11 occurrences when the medication was not administered due to "order error.") -There was an entry for valproic acid 250mg/5ml take 10mls scheduled daily at 9:00pm. -The valproic acid scheduled at 9:00pm was documented as administered 3 occurrences out of 10 opportunities from 01/01/19 to 01/11/19 (there were 7 occurrences when the medication was not administered due to "drug/item unavailable.") -There was an entry for valproic acid 250mg/5ml 5ml three times a day scheduled at 8:00am, 12:00pm, and 8:00pm. -The valproic acid scheduled at 8:00am,	D 273		

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D 273	Continued From page 5 12:00pm, and 8:00pm was documented as administered 0 occurrences out of 8 opportunities from 01/11/19 to 01/14/19 (there were 7 occurrences when the medication was not administered due to "drug/item unavailable" and 1 occurrences when the medication was not administered due to "order error.") Telephone interview with Resident #1's Nurse Practitioner (NP) on 01/14/19 at 2:09pm revealed: -She had ordered valproic acid for Resident #1 to help with behaviors. -She had just seen the resident on 01/11/19 for increased agitation. -Facility staff had reported the resident's increased agitation and behaviors to her, however they had not reported the resident had missed multiple doses of the scheduled valproic acid. -The resident had a lot of problems with behaviors "lately" and the valproic acid would have "helped with that." Telephone interview with the contracted facility pharmacy on 01/14/19 at 2:30pm revealed: -They received an FL2 order for valproic acid 250mg/5ml 5ml every morning and evening and 10ml at bedtime dated 09/29/18. -They dispensed one 473 ml bottle (250mg/5ml strength) of valproic acid (a 23 day supply) to the facility for Resident #1 on 09/29/18. -They had not dispensed any other valproic acid for Resident #1 until they received an electronic prescription on 01/11/19 for valproic acide 250mg/5ml three times a day. -They dispensed one 473 ml bottle (250mg/5ml strength) of valproic acid (a 31 day supply) to the facility for Resident #1 on 01/11/19. Observation of Resident #1's medications available in the facility on 01/15/19 at 9:52am	D 273		

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D 273	Continued From page 6 revealed: -There was one 473 ml bottle of valproic acid 250mg/5ml available on the medication cart for Resident #1. -The dispense date on the bottle was 01/11/19. -The label directions were "Take 5ml by mouth three times a day." Interview with the Special Care Coordinator (SCC) on 01/14/19 at 12:19pm revealed Resident #1's valproic acid had been on "back order with the pharmacy" because it was liquid and "sometimes the pharmacy had trouble getting those." Interview with a medication aide (MA) on 01/14/19 at 1:50pm revealed: -Resident #1 had brought an open bottle of valproic acid with him upon admission to the facility on 09/29/18. -She did not know how much valproic acid was in the bottle on admission. -At some point the valproic acid supply had gotten low and they had contacted the resident's family. -The resident then signed an agreement with the contracted facility pharmacy to start getting his medications from them. -The insurance was taking a long time to "cover" the resident's medications and the family was waiting to buy more because insurance had told them insurance would cover the medications. -A fax had been sent to the NP by the third shift MA to let her know the medications were not in the facility. -The family had also called the NP to let her know the medications were not in the facility. Interview with a second MA on 01/14/19 at 3:25pm revealed when she documented a medication was not administered due to	D 273		

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D 273	Continued From page 7 "drug/item unavailable" that meant the medication had already been ordered, but it had not yet arrived from pharmacy. Interview with the Administrator on 01/15/19 at 8:50am revealed: -The unavailable valproic acid for Resident #1 was not an "insurance problem." -"We just didn't follow through with ordering it and ensuring it made it here." -She was not sure if medications were brought in with the resident on admission and how much was provided by the family on admission. -She did not think medications resident's brought with them on admission were inventoried and recorded in the resident record. Interview on 01/15/19 at 10:00am with the same MA interviewed on 01/14/19 at 1:50pm revealed: -Staff had thought the valproic acid had not come in from the pharmacy, however she had found it in the medication room in a medication storage area. -"It just hadn't been put on the cart." -"It was behind all his other meds." -An order error comment on the eMAR meant, they were waiting on clarification of a new order. -She remembered Resident #1's family had brought in one bottle of valproic acid on admission, however she was not sure how much had been in the bottle. -The SCC was responsible for following up on all the discrepancies discovered during cart audits. Interview with the SCC on 01/15/19 at 10:15am revealed: -Resident #1 had brought in one bottle of valproic acid with him on admission. -An inventory of his admission medications "should" be in the resident record.	D 273		

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D 273	Continued From page 8 -She did not remember how full the valproic acid bottle had been on admission. -"I think the medication aides didn't look" in the drawer in the medication cart to find the valproic acid." -She had noticed Resident #1 had experienced increased agitation recently. -The NP had just been in to see Resident #1 at their request due to increased agitation. -The NP did not always review the eMARs when she came to see the residents. -"She just looks at physician orders." Refer to the interview with the Administrator on 01/14/19 at 3:42pm. b. Observation of Resident #1's medications available in the facility on 01/15/19 at 9:52am revealed there was no magnesium available in the facility for the resident. Review of Resident #1's December 2018 eMAR revealed: -There was an entry for magnesium 250mg twice a day scheduled at 9:00am and 9:00pm. -The medication was documented as administered 14 occurrences out of 62 opportunities from 12/01/18 to 12/31/18 due to "drug/item unavailable." Review of Resident #1's January 2019 eMAR revealed: -There was an entry for magnesium 250mg twice a day scheduled at 9:00am and 9:00pm. -The medication was documented as administered 22 occurrences out of 27 opportunities from 01/01/19 to 01/14/19 (there were 14 occurrences when the medication was not administered due to "drug/item unavailable" and 9 occurrences when the medication was not	D 273		

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D 273	Continued From page 9 administered due to "order error.") Telephone interview with Resident #1's NP on 01/14/19 at 2:09pm revealed: -She had ordered magnesium for Resident #1 due to a low magnesium level. -Facility staff not reported the resident had missed multiple doses of the magnesium due to unavailability. Telephone interview with the contracted facility pharmacy on 01/14/19 at 2:30pm revealed: -They received an FL2 order for magnesium 250mg twice a day dated 09/29/18. -They had dispensed 60 tablets (a 30 day supply) to the facility for Resident #1 on 09/29/18. -They had not received any additional orders for the magnesium. -The FL2 was good as a prescription for one fill only. -They had not dispensed any more magnesium for Resident #1. Interview with a MA on 01/15/19 at 10:00am revealed: -They were out of Resident #1's magnesium. -"It's been ordered, but it's still pending" with insurance at the contracted facility pharmacy. -The medication was pending with the pharmacy. because it was an over the counter medication. -The resident had been out of the magnesium for "three weeks." -She had informed the SCC and the SCC had said she would call Resident #1's NP to let her know the magnesium was out. -The family was notified they were out of magnesium and they were going to call the pharmacy before they bought the magnesium because they were under the impression insurance would pay for it.	D 273		

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D 273	Continued From page 10 Refer to the interview with the Administrator on 01/14/19 at 3:42pm. _____ Interview with the Administrator on 01/14/19 at 3:42pm revealed: -She would have expected staff to communicate with Resident #1's healthcare provider if they were having trouble getting medications for him. -It was her expectation staff would report to the healthcare provider "within a couple days" after finding out a medication was missing to make them aware they were unable to administer a medication as prescribed. -Medication cart audits were performed every 1 to 2 weeks for all residents. -The audit included matching the medications on the cart to the eMARs to see what medications needed to be ordered and to ensure the medication orders were right and the medications were right. -Any items of concern discovered during a medication cart audit were follow up on by the SCC.	D 273		