STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE LAURELS IN THE VILLAGE AT CAROLINA	13180 DORMAN ROAD PINEVILLE, NC 28134

(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 Mecklenburg County Department of Social Services conducted and annual and follow-up survey on 02/19/19-02/20/19.	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: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents related to Lantus (Resident #3) and Senna laxative (Resident #2). The findings are: 1. Review of Resident #3's current FL-2 dated 03/08/18 revealed:	D 358		

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D 358	Continued From page 1 -Diagnoses of metabolic encephalopathy, diabetes mellitus, acute kidney failure, falls, major depression, hypertension, atrial fibrillation. Review of Resident #3's physician order dated 5/29/18 revealed: -Administer Lantus 10 units (a medication used to regulate blood glucose) subcutaneously every morning. -There was no additional documentation. Review of Resident #3's physician's order dated 06/07/18 revealed: -Check blood glucose every morning before breakfast and every night before bed. -There was no additional documentation. Review of Resident #3's 6-month signed physician's order dated 10/01/18 revealed: -Check blood glucose every morning before breakfast and every night before bed. -Administer Lantus 10 units subcutaneously every morning. Review of Resident #3's January 2019 Medication Administration Record (MAR) revealed: -Inject Lantus 10 units subcutaneous every morning was documented as not administered on 01/04/19, 01/18/19, 01/21/19, and 01/24/19. -Blood glucose level every morning before breakfast was documented as 97 on 01/04/19, 95 on 01/18/19, 97 on 01/21/19, and 94 on 01/24/19. -Blood glucose level every morning before breakfast was documented as 112 on 01/05/19, 110 on 01/19/19, 100 on 01/22/19, and 125 on 01/25/19. -There was no additional documentation of why the Lantus medication was withheld.	D 358		

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Review of Resident #3's February 2019 MAR revealed:
-Inject Lantus 10 units subcutaneous every morning was documented as not administered on 02/11/19.
-Blood glucose level every morning before breakfast was documented as 95 on 02/11/19.
-Blood glucose level every morning before breakfast was documented as 117 on 2/12/19.
-There was no additional documentation of why the Lantus medication was withheld.

Review of facility Medication Management policy revealed:
-All medications provided to a resident were to be administered in accordance with state laws and regulations.
-A valid physician's order must include the date, resident name, name of medication, dose, and direction for use, route, parameters, and duration.

Interview with Resident #3 on 2/20/19 at 11:20am revealed:
-Her blood glucose level was checked every morning before breakfast and every night before bed.
-She was administered an injection of insulin every morning except if her blood glucose level was below 100.
-She did not know if the physician knew that she was not administered her insulin if her blood glucose level was below 100.
-She did not feel lethargic, nauseous, or any different on days she had not received her insulin injection.

Interview with Resident #3's physician on 02/20/19 at 10:10am revealed:
-He wrote an order for Resident #3 to have her blood glucose level checked every morning

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before breakfast and every evening before bed.
-He wrote an order for Resident #3 to be administered 10 units of Lantus every morning before breakfast to help regulate Resident #3's blood glucose levels during the day.
-He had not written an order to withhold Resident #3's scheduled Lantus subcutaneous injection.
-He expected staff to administer Resident #3's medications as ordered.
-The facility informed him on 02/19/19 regarding Resident #'3's Lantus had not been administered as prescribed on a few days in January and February 2019.
-Resident #3's blood glucose levels were stable.
-Resident #3 "was not at risk of hypoglycemia from missing an occasional dose of insulin".

Interview with a Licensed Practical Nurse (LPN) on 02/20/19 at 10:25am revealed:
-She was responsible for collecting blood glucose levels for Resident #3.
-She was responsible for administering Resident #3's Lantus injection every morning before breakfast.
-She was responsible for contacting Resident #3's physician to clarify medication and treatment orders.
-She had not administered Resident #3's Lantus in January and February 2019 if Resident #3's blood glucose level before breakfast was below 100.
-She had learned in nursing school to hold insulin if a blood sugar reading was less than 100.
-There was no physician's order to withhold administration of Resident #3's Lantus medication.
-She had not contacted Resident #3's physician when she did not administer Resident #3's Lantus medication.

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D 358	Continued From page 4 Interview with the Resident Services Director (RSD) on 02/20/19 at 11:15am revealed: -She supervised the LPN staff. -She expected the LPN staff to perform blood glucose collection and administration of Lantus medication as ordered for Resident #3. -She expected the LPN staff to contact Resident #3's physician to clarify medication and treatment orders. -She learned on 02/19/19 that Resident #3 had not been administered Lantus as ordered on 5 instances in January and February 2019. Interview with the Administrator on 02/20/19 at 11:31am revealed: -Medications were to be administered by medication aides and/or LPN's in accordance with a valid physician's order. -An LPN was responsible for checking Resident #3's blood glucose level as ordered. -An LPN was responsible for administering Resident #3's Lantus medication as prescribed. -He expected an LPN to contact resident's physicians to clarify medication and treatment orders if necessary. -He learned on 02/19/19 that Resident #3's physician had ordered Resident #3 to be administered Lantus subcutaneous injection daily. -He learned on 02/19/19 that an LPN had not administered Resident #3's Lantus as ordered in January and February 2019. -He was not aware if Resident #3's physician had been notified to clarify if Resident #3's Lantus was to be withheld if Resident #3's blood glucose was less than 100. 2. Review of Resident #2's current FL-2 dated 10/16/18 revealed: -Diagnoses included gastroesophageal reflux	D 358		

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disease (GERD), hypertension, and neuropathy.
-There was a medication order for Senna 8.6 mg two tablets at bedtime (a medication used to treat constipation).

Review of Resident #2's hospital discharge summary dated 12/12/18 revealed:
-Diagnoses included chronic constipation, GERD admitted with abdominal distension and pain.
-There was no order to discontinue Senna 8.6mg.

Review of Resident #2's December 2018 Medication Administration Record (MAR) revealed:
-There was an entry for Senna 8.6mg two tablets to be administered daily at 8:00pm.
-There was documentation Senna 8.6mg was not administered for 20 out of 31 opportunities from 12/12/19-12/31/19.
-There was a handwritten note that listed "d/c 12/12/18".

Review of a subsequent physician order for Resident #2 dated 01/07/19 for Senna 8.6mg two tablets at bedtime.

Review of Resident #2's January 2019 eMAR revealed:
-There was an entry for Senna 8.6mg two tablets to be administered daily at 8:00pm.
-There was a line drawn through the entry for Senna 8.6mg with a note "d/c 12/12/18".
-There was another entry dated 01/08/19 for Senna 8.6mg to be administered daily at 8:00pm.
-Senna 8.6mg was not administered 7 out of 31 opportunities from 01/01/19-01/07/19.

Observation of Resident #2's medications on hand on 02/19/19 at 3:15pm revealed Senna 8.6mg was available for administration.

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D 358	Continued From page 6 Telephone interview with a representative from the facility's contracted pharmacy on 02/20/19 at 8:49am revealed: -The facility was responsible for requesting refills from the pharmacy. -The pharmacy had dispensed 60 tablets of Senna 8.6mg for Resident #2 on 11/09/18, 01/09/19, and 02/05/19. -The pharmacy did not fill Senna 8.6mg in December 2018. -The pharmacy did not know why the medication was not filled in December 2018. -The pharmacy did not have a discontinue order from the physician for Senna 8.6mg. Interview with Resident #2 on 02/19/19 at 9:55am revealed: -She was prescribed Senna to help with constipation. -The medication had stopped "for a while" in December and she had to request for it to restart in January 2019. -She feels better and not constipated when taking Senna. Interview with a medication aide (MA) on 02/20/19 at 3:50pm revealed: -She administered medications as listed on the MAR. -She did not administer the Senna 8.6mg to Resident #2 from 12/12/19-01/07/19 because it was listed at discontinued on the MAR. -She thought someone received a discontinue order for the medication because it was listed as discontinued on the MAR. -The Licensed Practical Nurses (LPNs) were responsible for processing orders and notifying the MAs if a medication was discontinued.	D 358		

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D 358	Continued From page 7 Interview with the Resident Services Director (RSD) on 02/20/19 at 10:39am revealed she did not know Resident #2 had missed any doses of Senna. Interview with the LPN on 02/20/19 at 2:30pm revealed: -There was no discontinue order received for Senna 8.6mg. -She discontinued the Senna on Resident #2's MAR effective 12/12/18 because it was not listed on the hospital discharge summary. -Resident #2 requested the Senna 8.6mg to restart and the physician signed an order to continue restart the medication on 01/07/19. Telephone interview Resident #2's primary care physician (PCP) on 02/20/19 at 9:49am revealed: -Resident #2 was prescribed Senna 8.6mg to treat constipation. -He did not know Resident #2 had missed 26 doses of Senna. -He had not discontinued Senna medication for Resident #2. -Resident #2 missing Senna could cause her to be more constipated. Interview with the Administrator on 02/20/19 at 3:13pm revealed: -He did not know Resident #2 had missed any doses of Senna. -He expected orders to be followed as written and the physician to be contacted if the orders are not clear. -He expected a discontinue order to be received from the physician before the medication was stopped.	D 358		

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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 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: Based on observations, record reviews and interviews, the facility failed to assure the medication administration records (MARs) were accurate and complete for 2 of 5 sampled residents (Resident #1 and #2). The findings are:	D 367		

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D 367	Continued From page 9 1. Review of Resident #1's current FL-2 dated 02/19/19 revealed: -Diagnoses included Non-Insulin Dependent Diabetes Mellitus, anxiety, depression and occipital lobe cerebrovascular accident. -There was an order to clean bilateral inguinal (groin) folds, perineal area, and abdominal folds with soap and water, pat dry, then apply nystatin powder 100000units/gm three times daily (an antifungal powder used to treat fungal infections). Review of Resident #1's signed physician's orders dated 10/18/18 and 01/08/19 revealed an order to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water and pat dry three times daily, then apply nystatin powder 100000units/gm. Review of Resident #1's physician's visit note dated 11/20/18 revealed Resident #1 was at risk for cutaneous candidiasis (an infection of the skin caused by candida fungus) and would be on nystatin powder on a daily basis. Review of Resident #1's December 2018 Medication Administration Record (MAR) revealed: -There was an entry to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water, pat dry and apply nystatin powder three times daily scheduled for 8:00am, 2:00pm and 8:00pm. -There was an entry for nystatin powder 100000units/gm apply to inguinal folds, perineal area, lower abdominal folds three times daily scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation nystatin powder had been applied 76 of 93 opportunities. -There was documentation Resident #1 refused	D 367		

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the nystatin powder on 12/27/18 at 9:00am.
-There was no documentation of administration or reason nystatin powder was not applied 16 of 93 opportunities.

Review of Resident #1's January 2019 MAR revealed:
-There was an entry to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water, pat dry and apply nystatin powder three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was an entry for nystatin powder 100000units/gm apply to inguinal folds, perineal area, lower abdominal folds three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was documentation nystatin powder had been applied 82 of 90 opportunities.
-There was documentation Resident #1 refused the nystatin powder on 01/13/19 (no time was noted).
-There was no documentation of administration or reason nystatin powder was not applied 7 of 90 opportunities.

Review of Resident #1's February 2019 MAR revealed:
-There was an entry to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water, pat dry and apply nystatin powder three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was an entry for nystatin powder 100000units/gm apply to inguinal folds, perineal area, lower abdominal folds three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was documentation nystatin powder had been applied 48 of 55 opportunities.
-There was no documentation of administration or reason nystatin powder was not applied 7 of 55

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D 367	Continued From page 11 opportunities. Observation of Resident #1's private room on 02/20/19 at 10:20am revealed there were two 15g bottles of nystatin beside her bathroom sink. Interview with Resident #1 on 02/20/19 at 10:20am revealed: -She was ordered nystatin powder because she had "a rash." -The rash had improved some but was still present. "I think I will always have it." -The medication aides (MA) "sometimes" applied the nystatin powder, usually three times daily. -The MAs had allowed her to keep the nystatin powder in her room per her request so she could apply it at her convenience. -Resident #1 applied the nystatin powder to her groin folds every time she urinated, at least six to seven times each day. Observation of Resident #1's medications available for administration on 02/20/19 at 10:27am revealed there were two 15g bottles of nystatin powder on the medication cart available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 02/20/19 at 2:33pm revealed: -Resident #1's nystatin powder was not on a cycle fill so the facility had to order refills as they needed them. -The pharmacy had dispensed 30g of nystatin powder 100000units/gm for Resident #1 on 10/23/18, 11/24/18, 12/22/18, 01/01/19, 01/07/19 and 02/04/19. -It was difficult to determine how long the powder would last because it depended on how much was used during each administration.	D 367		

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D 367	Continued From page 12 Interview with a morning shift MA on 02/20/19 at 10:27am revealed: -She assisted Resident #1 in applying nystatin powder every time it was scheduled to be administered on her shift. -She always documented the administration of the nystatin powder on Resident #1's MAR. -Resident #1 would often refuse to allow other MAs on other shifts to apply the nystatin powder. -If a resident had a physician's order to self-administer medications, the words "self-administration" would be written on the resident's MAR. -If a resident had an order to self-administer their medications, the MAs were not responsible for documenting administration on the resident's MAR. -"Self-administration" was not written on Resident #1's MAR. Interview with a second morning shift MA on 02/20/19 at 2:00pm revealed: -If she worked on the medication cart on Resident #1's hall, it was typically on the evening shift. -She could remember only one time when she did not administer nystatin powder to Resident #1 and that was because she refused it. -If a resident refused a medication, the MAs were to initial the MAR, circle their initial, and write the reason the medication was not administered on the back of the MAR. -She thought she had documented on the MAR every time she had administered the nystatin powder. "I may have forgotten to document it last night, but I will go check." Interview with an evening shift MA on 02/20/19 at 2:22pm revealed: -She could not recall a time when she had not	D 367		

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administered nystatin powder to Resident #1 when it was scheduled.
-She thought she had documented on the MAR every time she had administered the nystatin powder.

Refer to interview with the Licensed Practical Nurse on 02/20/19 at 11:50am.

Refer to interview with the Resident Services Director on 02/20/19 at 10:39am.

Refer to interview with the Administrator on 02/20/19 at 3:21pm.

2. Review of Resident #2's current FL2 dated 10/16/18 revealed:
-Diagnoses included glaucoma, hypertension, and anxiety.
-There was a medication order for Refresh dry eye therapy, instill one drop in both eyes six times daily.

Review of Resident #2's December 2018 Medication Administration Record (MAR) revealed:
-There was an entry for Refresh dry eye therapy 0.4mL instill one drop in both eyes six times daily, to be administered at 6:00am, 9:00am, 12:00pm, 3:00pm, 6:00pm, and 9:00pm.
-On 12/10/18 at 9:00am, 12:00pm, 6:00pm, and 9:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR.
-On 12/11/18 at 6:00am, there were initials circled but no documentation on the back of the MAR, indicating if the dosage was missed or refused.
-On 12/11/18 at 9:00am, 3:00pm, 6:00pm, and 9:00pm, there was no documentation of administration, and no explanation documented

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D 367	Continued From page 14 on the back of the MAR. -On 12/12/18 at 6:00am, there were initials circled but no documentation on the back of the MAR, indicating if the dosage was missed or refused. -On 12/12/18 at 9:00am, 12:00pm, 6:00pm, and 9:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR. Review of Resident #2's January 2019 MAR revealed: -There was an entry for Refresh dry eye therapy 0.4mL instill one drop in both eyes six times daily, to be administered at 6:00am, 9:00am, 12:00pm, 3:00pm, 6:00pm, and 9:00pm. -On 01/10/18 at 12:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR. -On 01/22/19 at 9:00am and 12:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR. -On 01/24/19 at 6:00pm and 9:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR. -On 01/27/19 at 12:00pm, 3:00pm, 6:00pm and 9:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR. Review of Resident #2's February 2019 MAR revealed: -There was an entry for Refresh dry eye therapy 0.4mL instill one drop in both eyes six times daily to be administered at 6:00am, 9:00am, 12:00pm, 3:00pm, 6:00pm, and 9:00pm. On 02/01/19 at 9:00am and 12:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR. -On 02/04/19 at 12:00pm, there was no documentation of administration, and no	D 367		

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explanation documented on the back of the MAR.
-On 02/13/19 at 6:00pm and 9:00pm, there was no documentation of administration, and no explanation documented on the back of the MAR.

Observation of Resident #2's medications available for administration on 02/19/19 at 3:15pm revealed there was Refresh dry eye therapy on the medication cart available for administration.

Interview with Resident #2 on 02/19/19 at 9:55am revealed:
-She received her eye drops "most of the time".
-There were times when staff ran out of eye drops.
-Staff did not always administer correctly, the drops would run down her face and would need to be administered again.
-She never refused her eye drops.

Interview with a medication aide (MA) on 02/20/19 at 3:50pm revealed:
-When a medication was not administered she was trained to write in the entry why the medication was not administered.
-She was instructed to write on the back of the MAR a reason, if the medication was "as needed or refused".
-She was trained by one of the Licensed Practical Nurses (LPNs) when she was first hired.
-She did not know that she needed to record a reason on the back of the MAR when a medication was not administered.
-She did not know why there were missed entries on the MAR.
-MAs are supposed to review the MAR each shift for accuracy, "I am not sure what happened".

Refer to interview with the Licensed Practical

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D 367	Continued From page 16 Nurse on 02/20/19 at 11:50am. Refer to interview with the Resident Services Director on 02/20/19 at 10:39am. Refer to interview with the Administrator on 02/20/19 at 3:21pm. _____ Interview with the Licensed Practical Nurse (LPN) on 02/20/19 at 11:50am revealed: -LPNs were responsible for checking the MARs monthly for missed entries "I don't know how the holes were missed". -MAs were responsible for checking the MARs when changing shifts to ensure documentation was complete. -The last review of MARs was "a couple of weeks ago". -She did not know there were missed entries in the MARs, "it would have been addressed with the MAs working the cart. Interview with the Resident Services Director (RSD) on 02/20/19 at 10:39am revealed: -She was responsible for providing oversight to the LPNs working in the facility. -LPNs were responsible for reviewing the MARs every two weeks for missed entries in the MAR. -She would expect the MAs to check behind each other when changing shifts to ensure that there are no missed entries. Interview with the Administrator on 02/20/19 at 3:21pm revealed: -It was his expectation that MAs document every medication administered to a resident immediately after administration and prior to moving on to the next resident. -It was the responsibility of the LPNs and the	D 367		

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D 367	Continued From page 17 RSD to audit the eMARs for accuracy at least one time per month.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 3 of 3 sampled residents (Resident #1, #4, and #2) who were permitted to self-administer their medications met requirements to do so related to having a physician's order and an assessment to determine if they were competetent and physically able to self-administer their medications. The findings are: Review of the facility's self-administration policy and procedure revealed: - If a resident wishes to self-administer his/her	D 375		

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medications, the Resident Service Director (RSD) or designee will assess the resident's ability to participate, by completing a Self-Administration of Medication Assessment. The assessment must be completed upon move-in or resident's request.
-The RSD will interview the resident to determine their ability to identify, prepare and administer medications/treatments.
-Based on the assessment, a decision is made as to whether or not the resident is a candidate for self-administration." "This will be recorded on the assessment tool.
-A valid written physician's order must be obtained for each resident conducting self-administration of medications/treatments.
-The RSD will assess accuracy and compliance of self-administration by periodic observation and counting of doses.
-Storage of self-administered medications/treatments will comply with state/federal and community requirements for medication storage.
- If the RSD determines that a resident is unwilling/unable to take medications as prescribed, he/she will meet with the resident concerning the need for possible assistance with medications. The RSD/Wellness Director will contact the resident's healthcare provider regarding questions, concerns, and observations related to the resident's medications.
-Document the self-administration of medications on the resident's service plan.
-An updated list of the resident's medications will be maintained in the resident record/file. If the resident is not self-administering all of his/her medications, mark the medication administration record (MAR) to identify individual medications that are self-administered by the resident.
-The RSD (or designee) will document all communication with the resident and his/her

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healthcare provider in the resident's record/file.

1. Review of Resident #1's current FL-2 dated 02/19/19 revealed:
-Diagnoses included Non-Insulin Dependent Diabetes Mellitus, anxiety, depression and occipital lobe cerebrovascular accident.
-There was documentation Resident #1 was non-ambulatory and used a wheelchair.
-There was an order to clean bilateral inguinal (groin) folds, perineal area, and abdominal folds with soap and water, pat dry, then apply nystatin powder 100000units/gm three times daily (an antifungal powder used to treat fungal infections).
-There was no physician's order Resident #1 could self-administer medications.

Review of Resident #1's signed physician's orders dated 10/18/18 and 01/08/19 revealed an order to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water and pat dry three times daily, then apply nystatin powder 100000units/gm.

Review of Resident #1's physician's visit note dated 11/20/18 revealed Resident #1 was at risk for cutaneous candidiasis (an infection of the skin caused by candida fungus) and would be on nystatin powder on a daily basis.

Review of Resident #1's record revealed no documentation of a "Self-Administration of Medication Assessment" and no physician's order to self administer medications.

Review of Resident #1's December 2018 medication administration record (MAR) revealed:
-There was an entry to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water, pat dry and apply nystatin

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powder three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was an entry for nystatin powder 100000units/gm apply to inguinal folds, perineal area, lower abdominal folds three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was documentation nystatin powder had been applied 76 of 93 opportunities.
-There was documentation Resident #1 refused the nystatin powder on 12/27/18 at 9:00am.
-There was no documentation of administration or reason nystatin powder was not applied 16 of 93 opportunities.

Review of Resident #1's January 2019 MAR revealed:
-There was an entry to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water, pat dry and apply nystatin powder three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was an entry for nystatin powder 100000units/gm apply to inguinal folds, perineal area, lower abdominal folds three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was documentation nystatin powder had been applied 82 of 90 opportunities.
-There was documentation Resident #1 refused the nystatin powder on 01/13/19 (no time was noted).
-There was no documentation of administration or reason nystatin powder was not applied 7 of 90 opportunities.

Review of Resident #1's February 2019 MAR revealed:
-There was an entry to clean bilateral inguinal folds, perineal area, and abdominal folds with soap and water, pat dry and apply nystatin powder three times daily scheduled for 8:00am,

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2:00pm and 8:00pm.
-There was an entry for nystatin powder 100000units/gm apply to inguinal folds, perineal area, lower abdominal folds three times daily scheduled for 8:00am, 2:00pm and 8:00pm.
-There was documentation nystatin powder had been applied 48 of 55 opportunities.
-There was no documentation of administration or reason nystatin powder was not applied 7 of 55 opportunities.

Observation of Resident #1's private room on 02/20/19 at 10:20am revealed there were two 15g bottles of nystatin beside her bathroom sink.

Interview with Resident #1 on 02/20/19 at 10:20am revealed:
-She was ordered nystatin powder because she had "a rash."
-The rash had improved some but was still present. "I think I will always have it."
-The medication aides (MA) "sometimes" applied the nystatin powder, usually three times daily.
-The MAs had allowed her to keep the nystatin powder in her room, per her request, so she could apply it at her convenience.
-Resident #1 applied the nystatin powder to her groin folds every time she urinated, at least six to seven times each day.

Observation of Resident #1's medications available for administration on 02/20/19 at 10:27am revealed there were two 15g bottles of nystatin powder on the medication cart available for administration.

Interview with a MA on 02/20/19 at 10:27am revealed:
-She assisted Resident #1 in applying nystatin powder every time it was scheduled to be

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administered on her shift.
-Resident #1 would often refuse to allow other MAs on other shifts to apply the nystatin powder.
-She knew Resident #1 had nystatin powder in her room, and she knew Resident #1 applied it several times each day in addition to the times the MAs applied it.
-If a resident had a physician's order to self-administer medications, the words "self-administration" would be written on the resident's eMAR.
-"Self-administration" was not written on Resident #1's eMAR.
-She thought it was okay for Resident #1 to keep the nystatin powder in her room and self-administer it as long as she (the MA) continued to do her job and follow the order to administer the powder three times daily.
-She had never thought to discuss Resident #1's desire to self-administer the nystatin powder with her physician.

Interview with a Licensed Practical Nurse (LPN) on 02/20/19 at 11:00am revealed:
-She knew Resident #1 kept nystatin powder in her room and self-administered it.
-Resident #1 had expressed to her she would like the nystatin order to be changed from a powder to a cream because the cream would be easier for her to apply.
-She assumed since the resident was talking about having the nystatin powder in her room and applying it herself, she had a physician's order to do so.
-She did not double check to see if Resident #1 had a physician's order to self-administer medications and had not completed any type of assessment on Resident #1 to evaluate her physical ability to self-administer the nystatin powder.

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D 375	Continued From page 23 Telephone interview with Resident #1's Primary Care Physician (PCP) on 02/20/19 at 12:40pm revealed: -He had not given an order for Resident #1 to self-administer nystatin powder and, he did not know Resident #1 was self-administering the medication. -He did not think she was capable of self-administering the nystatin powder due to her physical limitations. -Allowing Resident #1 to self-administer the nystatin powder was "a safety concern" due to the risk of her falling while trying to apply the powder since she was non-ambulatory. -Because Resident #1 was being administered the nystatin powder more than the ordered three times daily, she was at risk for her skin becoming resistant to the effects of the powder and having a future skin infection. Refer to interview with the LPN on 02/20/19 at 11:00am. Refer to interview with the Resident Services Director (RSD) on 02/20/19 at 10:35am. Refer to interview with the Administrator on 02/20/19 at 3:21pm. 2. Review of Resident #4's current FL-2 dated 01/18/19 revealed: -Diagnoses included hypertension, diabetes, hypokalemia, anxiety, and unspecified injury of head. -The resident was orientated and required limited assistance with activities of daily living. a. Review of Resident #4's physician's orders dated 01/18/19 revealed an order for nystatin	D 375		

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D 375	Continued From page 24 100,000 units/1gm powder (to treat fungal rash) apply three times daily under breasts as needed for rash. Review of Resident #4's record revealed no subsequent physician's order for self-administration of nystatin powder, and no documentation of a "Self-Administration of Medication Assessment." Observation on 02/19/19 at 3:15pm of Resident #4's room revealed: -Resident #4 did not have a roommate. -A partial container of nystatin powder was on a shelf above the wash basin in her bathroom. -The container of nystatin powder was uncapped, not in a box or bag, and was not labeled with instructions for use. Review of Resident #4's January 2019 and February 2019 medication administration records (MARs) revealed: -There was an entry on each MAR for nystatin powder apply 3 times daily under breasts as needed for rash. -There was no documentation on either MAR indicating the nystatin powder was administered. Interview with Resident #4 on 02/19/19 at 3:15pm revealed: -She applied the nystatin powder herself under her breasts. -She had applied it at least every morning. -The nystatin powder had been given to her by the medication aide (MA) to put on herself. -She did not know which MA had given it to her. -She did not want anyone to put it on her because she could do it herself. Interview with a second shift MA on 02/19/19 at	D 375		

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D 375	Continued From page 25 3:20pm revealed: -She did not know Resident #4 had nystatin in her room. -She had not left the medications in Resident #4's room. -Resident #4 was not supposed to self-administer her medications because she did not have an order. -Residents who have an order to self-administer their medications have written instructions on the MAR for them to self-administer a medication. Interview with a first shift MA on 02/20/19 at 12:00pm revealed: -She did not know Resident #4 had nystatin powder in her room. -She had not been instructed to check for medications left in Resident #4's room, so she had not checked. -She had not left the medications in Resident #4's room. -She did know Resident #4 had self-administered the nystatin powder found on the MAR. Refer to interview with a Licensed Practical Nurse (LPN) on 02/20/19 at 11:00am. Refer to interview with the Resident Service Director (RSD) on 02/20/19 at 10:35am. Refer to interview the Administrator on 02/20/19 at 3:21pm. b. Review of Resident #4's physician's orders dated 01/18/19 revealed an order for vitamin A&D ointment (to treat a rash) apply one application to affected area 3 times a day. Review of Resident #4's record revealed no subsequent physician's order for	D 375		

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self-administration of vitamin A&D ointment, and no documentation of a "Self-Administration of Medication Assessment."

Observation on 02/19/19 at 3:15pm of medications on hand for administration kept in Resident #4's room revealed:
-Resident #4 did not have a roommate.
-A partial container of A&D ointment was on a shelf above the wash basin in her bathroom.

Review of Resident #4's January 2019 and February 2019 medication administration records (MARs) revealed:
-There was an entry on each MAR for vitamin A&D ointment apply one application to affected area 3 times a day.
-There was no documentation on either MARs indicating the vitamin A&D ointment was self-administered.
-There was documentation on the MARs the vitamin A&D ointment had been administered 3 times a day with the last administration on 02/19/19 at 8:00am.

Interview with Resident #4 on 02/19/19 at 3:15pm revealed:
-She applied the vitamin A & D ointment to her buttocks.
-She had applied it at least every morning.
-The vitamin A&D ointment had been given to her by the medication aide (MA) to put on herself.
-She did not know which MA had given it to her.
-She could not remember when the MA had given it to her.
-She did not want anyone to put it on her because she could do it herself.

Interview with a second shift MA on 02/19/19 at 3:20pm revealed:

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-She did not know Resident #4 had vitamin A & D ointment in her room.
-She had not left the medications in Resident #4's room.
-Resident #4 was not supposed to self-administer her medications because she did not have an order.
-Residents who have an order to self-administer their medications have written instructions on the MAR for them to self-administer a medication.

Interview with a first shift MA on 02/20/19 at 12:00pm revealed:
-She did not know Resident #4 had vitamin A & D ointment in her room.
-She had not been instructed to check for medications left in Resident #4's room, so she had not checked.
-She had not left the medications in Resident #4's room.
-She did not know Resident #4 had self-administered the vitamin A & D ointment found on the MAR.

Refer to interview with a licensed practical nurse (LPN) on 02/20/19 at 11:00am.

Refer to interview with the Resident Service Director (RSD) on 02/20/19 at 10:35am.

Refer to interview the Administrator on 02/20/19 at 3:21pm.

c. Review of Resident #4's physician's orders dated 01/18/19 revealed there was no order for antacid tablets

Review of Resident #4's record revealed no subsequent physician's order for self-administration of antacid tablets, and no

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documentation of a "Self-Administration of Medication Assessment."

Observation on 02/19/19 at 3:15pm of Resident #4's room revealed:
-Resident #4 did not have a roommate.
-A partial bottle of antacid tablets on her bedside table.

Review of Resident #4's January 2019 and February 2019 medication administration records (MARs) revealed there was no entry of a physician's order for antacid tablets on either MAR.

Interview with Resident #4 on 01/19/19 at 3:15pm revealed:
-She had purchased the antacid tablets herself, and took them for upset stomach.
-She did not want anyone to take them because they belonged to her.
-She wanted to be able to take them when she needed them.

Interview with a second shift MA on 02/19/19 at 3:20pm revealed:
-She did not know Resident #4 had antacid tablets in her room.
-The antacid tablets were not on Resident #4's MAR.
-She did not know Resident #4 was taking the antacid tablets.
-Resident #4 was not supposed to self-administer her medications because she did not have an order.
-Residents who have an order to self-administer their medications have written instructions on the MAR for them to self-administer a medication.

Interview with a first shift MA on 02/20/19 at

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12:00pm revealed:
-She did not know Resident #4 had antacid tablets in her room.
-She had not been instructed to check for medications left in Resident #4's room, so she had not checked.
-Resident #4 did not have a physician's order to take antacid tablets.

Attempted telephone interview with Resident #4's primary care physician on 02/20/19 at 2:00pm was unsuccessful.

Refer to interview with a Licensed Practical Nurse (LPN) on 02/20/19 at 11:00am.

Refer to interview with the Resident Service Director (RSD) on 02/20/19 at 10:35am.

Refer to interview the Administrator on 02/20/19 at 3:21pm.

3. Review of Resident #2's current FL-2 dated 10/16/18 revealed:
-Diagnoses included hypertension, osteoarthritis, atrial fibrillation, neuropathy and vertigo.
-There was not inormation included for orientation status.

Review of a subsequent physician's order dated 10/23/18 for Resident #2 revealed:
-There was an order for nystatin powder 100000units/gm (used to treat fungal infection) apply to right and left breast folds and lower abdomen folds and ingenuinal folds after shower.
-There was no order to self-administer the nystatin powder 100000units/gm.

Review of Resident #2's record revealed no documentation of a "Self-Administration of

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D 375	Continued From page 30 Medication Assessment." Review of Resident #2's December 2018 Medication Administration Record (MAR) revealed: -There was an entry for nystatin powder 100000units/gm apply to right and left breast folds and lower abdomen folds and ingenuinal folds after shower scheduled for 8:00pm. -There were no documented administrations of the nystatin powder. -There was a handwritten note next to the entry which listed "resident administers". Review of Resident #2's January 2019 MAR revealed: -There was an entry for nystatin powder 100000units/gm apply to right and left breast folds and lower abdomen folds and ingenuinal folds after shower scheduled for 8:00pm. -There were no documented administrations of the nystatin powder. -There was a handwritten note next to the entry which listed "resident administers". Review of Resident #2's February 2019 MAR revealed: -There was an entry for nystatin powder 100000units/gm apply to right and left breast folds and lower abdomen folds and ingenuinal folds after shower scheduled for 8:00pm. -There were no documented administrations of the nystatin powder. -There was a handwritten note next to the entry which listed "resident admin [sic]". Observation of Resident #2's private room on 02/20/19 at 3:55pm revealed: -There were one 15gm bottle of nystatin powder on her bathroom counter.	D 375		

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D 375	Continued From page 31 -The bottle was labeled with Resident #2's name and included instructions. -The fill date listed on the bottle was 10/23/18. Interview with Resident #2 on 02/20/19 at 3:55pm revealed: -She was ordered nystatin powder because she "sweats and gets bumps under her breast". -She applied the nystatin powder when she felt that she needed it. -The medication aides (MA) never applied the nystatin powder. -She was told by one of the Licensed Practical Nurses (LPNs) that she could keep the medication in her room. -There had never been an assessment completed to ensure that she knew how to administer the nystatin powder. Observation of Resident #2's medications available for administration on 02/19/19 at 3:15pm revealed there was no nystatin powder on the medication cart available for administration. Interview with a MA on 02/20/19 at 3:50pm revealed: -She never assisted Resident #2 with applying nystatin powder, because on the MAR it lists "resident administers". -She knew Resident #2 had nystatin powder in her room. -She thought Resident #2 had a physician's order to self-administer the nystatin powder as listed on the MAR. -The LPNs were responsible for getting a physician's order for Resident #2 to self-administer her medications. Interview with a Licensed Practical Nurse (LPN) on 02/20/19 at 10:39am revealed:	D 375		

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D 375	Continued From page 32 -She knew Resident #2 kept nystatin powder in her room and self-administered it. -She wrote "resident self-administers" on the MAR so that MAs knew that the resident administered the nystatin. -She requested an order in January 2019 to self-administer nystatin powder and thought the physician wrote that Resident #2 could self-administer. Telephone interview with Resident #2's Primary Care Physician (PCP) on 02/20/19 at 12:40pm revealed: -He had not given an order for Resident #2 to self-administer nystatin powder and did not know she was self-administering the medication. -He would be "ok", with Resident #2 administering the powder after instructions for how and when to apply was provided by staff. -He would expect the resident to receive oversight periodically to ensure that medication was being applied properly. Refer to interview with the LPN on 02/20/19 at 11:00am. Refer to interview with the Resident Services Director (RSD) on 02/20/19 at 10:35am. Refer to interview with the Administrator on 02/20/19 at 3:21pm. _____ Interview with the LPN on 02/20/19 at 11:00am revealed: -She was responsible for assessing residents' ability to self-administer their medications. -She completed assessments on residents who self-administered all their medications. -She did not complete assessments on residents who self-administered only some of their	D 375		

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medications, but had planned to do so in the future when she had more time.
-It was the LPN or RSD's (Resident Services Director) responsibility to write "self-administer" on the MARs whenever they received a physician's order for a resident to self-administer a medication.
-Writing "self-administer" on the MAR was a way of alerting MAs the residents were able to administer the medication themselves.
-If the MA found medications in a resident's room who did not have "self-administer" written on their MAR, they should remove the medications and report it to either an LPN or the RSD.

Interview with the Resident Service Director (RSD) on 01/20/19 at 10:35am revealed:
-She expected the LPN designated to complete an assessment for self-administration to be aware of all the residents capable of self-administration of medications.
-She did not know residents were self-administering medications without a physician's order or appropriate assessment.
-She was responsible for overseeing the LPN who obtained the physician's orders and perform the assessments.
-She had not monitored the residents who were not self-administering all of their prescribed medications.

Interview with the Administrator on 02/20/19 at 3:21pm revealed:
-If a resident requested to self-administer medications, it was his expectation either one of the LPNs or the RSD would complete an assessment to evaluate the resident's competency to do so.
-If the resident was determined to be competent, it was the LPN's or the RSD's responsibility to

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D 375	Continued From page 34 obtain a physician's order prior to the resident being allowed to self-administer any medications. -How often the assessments should be done would depend on the resident and whether the resident had a significant change such as a hospital admission. -If staff discovered medications in a resident's room, who did not have a physician's order to self-administer, it was his expectation the staff would remove the medications from the resident's room and report it immediately to one of the LPNs or the RSD.	D 375		