STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060147	A. BUILDING: _____ B. WING _____	03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANSON RIDGE AT THE VILLAGES OF MECKL	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 an annual survey 03/05/19-03/06/19.	D 000		
D 354	10A NCAC 13F .1003 (c) Medication Labels 10A NCAC 13F .1003 Medication Labels (c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medication was correctly labeled, as prescribed by the physician, for 1 of 5 sampled residents (Resident #6), related to Senna Plus. The findings are: Review of Resident #6's current FL2 dated 01/24/19 revealed: -Diagnoses included senile dementia, gastritis	D 354		

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D 354	Continued From page 1	D 354		

and gastroesophageal reflux disease (GERD).
-There was a physician's order for Senna Plus 8.6-50mg take one tablet twice a day for constipation.

Review of Resident #6's physician's order dated 02/27/19 revealed an order for Senna Plus, two tablets daily, discontinue the evening dose.

Observation of Resident #6's medications on hand during the medication pass on 03/06/19 at 8:35am revealed:
-There was one bubble pack labeled Senna Plus 8.6-50mg take one tablet twice a day.
-The medication aide (MA) popped 2 tablets from the bubble pack into the medication cup to be administered to Resident #6.
-There was no change of direction sticker or indication that directions were inaccurate on the bubble pack.
-There were several tablets left in the bubble pack.

Interview with the MA on 03/06/19 at 8:45am revealed:
-The order for Senna Plus changed "a while ago."
-"I go by the eMAR when I pass medications. The eMAR (entry) is for 2 tabs of Senna."
-She always did her three checks before passing medications.
-She had been a MA for several years and "she knew her medications."
-She knew there should be a sticker on the bubble pack indicating direction changes.
"I guess I should get a sticker (for the bubble pack)."
-She did not know where the stickers were kept.
-She would have to check with her supervisor regarding the change in direction stickers and their placement.

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D 354	Continued From page 2 Review of Resident #6's February electronic Medication Administration Record (eMAR) revealed: -There was an entry for Senna Plus, one tablet twice a day, scheduled to be administered at 8:00am and 8:00pm, documented as administered from 02/01/19-02/27/19. -There was an entry for Senna Plus, two tablets daily, scheduled to be administered at 8:00am, documented as administered on 02/28/19. Review of Resident #6's March eMAR revealed there was an entry for Senna Plus, two tablets daily, scheduled to be administered at 8:00am, documented as administered from 03/01/19-03/06/19. Interview with the pharmacist at the facility's contracted pharmacy on 03/06/19 at 12:30pm revealed: -Resident #6's medication profile at the pharmacy listed Senna Plus 8.6-50mg one tablet twice a day, as the only physician order for this medication. -The pharmacist had not received an order from the facility for Senna Plus, two tablets daily, discontinue the evening dose. -The last dispense date for Senna Plus was on 01/15/19, sixty tablets for a 30 day supply. -The facility staff entered the orders on the eMAR. -The facility faxed new orders to the pharmacy staff and the orders were entered on the resident's medication profile in the pharmacy system. -The pharmacy software did not interface with the facility's eMAR system. -The pharmacy staff were not able to see entries on the facility eMAR system.	D 354		

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D 354	Continued From page 3 Interview with the Resident Care Director (RCD) on 03/06/18 at 3:15pm revealed: -The MAs were responsible for performing the three check system for medication administration. -The MAs were to check the medication label for the name of the resident, the name of the medication, the dosage, the scheduled time and any parameters, against the order entry on the eMAR, for verification. -If there were any discrepancies, the MAs should alert the Supervisor, the Resident Care Coordinator (RCC) or herself. -The Mediction Skill checklist, evaluated by the contract Registered Nurse (RN) upon hire, covered all the aspects of medication administration. -She and the RCC reviewed the procedure regarding expired medications, discontinued medications and medications whose directions had changed, periodically with the MAs. -She did not know why the Senna Plus was on the cart for a week without a direction change sticker applied to the bubble pack. -She did not know why the MA did not have direction change stickers on the cart. -She thought the MAs were not reading the entire medication label when administering medications. Interview with the Administrator on 03/06/19 at 3:40pm revealed: -The RCD was responsible for the clinical aspects of the facility. -The RCC and the RCD were responsible for the ongoing training of the MAs. -He expected the MAs to follow the process and procedures for medication administration.	D 354		

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D 358	Continued From page 4	D 358		
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 medication was correctly administered, as prescribed by the physician, for 1 of 5 sampled residents (Resident #7), related to Metoprolol Succinate extended release (ER). The findings are: The medication error rate was 8.8% as evidenced by the observation of 3 errors out of 34 opportunities during the 11:00am medication pass on 03/05/19 and the 8:00am medication pass on 03/06/19. Review of Resident #7's current FL2 dated 04/26/18 revealed:	D 358		

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D 358	Continued From page 5	D 358		

-Diagnoses included hypertension, valvular heart disease and chronic kidney disease stage 3.
-There was a physician's order for Metoprolol Succinate ER 25 mg tablet, one tablet every morning, hold if the heart rate (HR) is less than 60 or the systolic blood pressure (SBP) is less than 110.

Observation of Resident #7's medications on hand during the medication pass on 03/06/19 at 9:10am revealed:
-The medication aide (MA) removed a bubble card of Metoprolol Succinate ER 50mg from the medication cart to be administered to Resident #7.
-There were 27 tablets in the bubble card.
-The medication was filled on 02/13/19 with 30 tablets in the bubble card.
-There were no other bubble cards of Metoprolol Succinate on the medication cart for Resident #7.
-There were no bubble cards of Metoprolol Succinate in the medication room at the nurses station for Resident #7.
-The MA reported the discrepancy between the medication on hand and the electronic medication administration record (eMAR) to the supervisor.

Interview with the first shift MA on 03/06/19 at 9:30am revealed:
-"I always do my checks (medication label to eMAR order)." "That is how I saw this today."
-She had worked on the '200 Hall' medication cart several times over the past months.
-She did not know how she missed the incorrect label.
-She thought the incorrect medication had been sent only on this bubble card, dispensed on 02/13/19.

Review of Resident #7's record revealed:

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D 358	Continued From page 6	D 358		

-There was a subsequent physician's order summary dated 02/07/19 with an entry for Metoprolol Succinate ER 25mg, one tablet daily in the morning, hold for HR less than 60 or SBP less than 110.
-There were no orders for Metoprolol Succinate ER 50 mg.

Review of Resident #7's April 2018-March 2019 eMARs revealed the physician's order entered for Metoprolol Succinate ER was 25mg one tablet every morning, hold if the HR is less than 60 or the SBP is less than 110.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 03/06/19 at 12:30pm revealed:
-Resident #7's medication profile at the pharmacy listed Metoprolol Succinate ER as 50 mg, one tablet daily in the morning, hold for HR less than 60 or SBP less than 110.
-The physician's order for Metoprolol Succinate 50 mg was dated 01/04/18.
-There had been no additional orders received from the facility, or Resident #7's physician, regarding Metoprolol Succinate, until today.
-A physician's order dated 03/01/18 for Metoprolol Succinate 25 mg was faxed from the facility today.
-Metoprolol Succinate ER 50 mg tablets had been dispensed monthly to the facility from 01/04/18-02/13/19.
-The facility staff entered the physician orders on the Resident's eMAR.
-The pharmacy computer software does not interface with the facility's eMAR system. The pharmacy staff were not able to see entries on the facility eMAR system.

Interview with the Resident Care Coordinator

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D 358	Continued From page 7 (RCC) on 03/06/19 at 2:25pm revealed: -The RCD, the Supervisor or he would fax new physician orders to the pharmacy. -He and the RCD entered orders on the residents' eMARs. -The MAs should be checking the orders with the labels on the medication bubble cards as part of their 3 check system for medication administration. -The facility contracted pharmacist also completes rolling cart audits monthly. -It was the responsibility of the weekend nurse supervisor to complete cart audits on all three carts each weekend. -The Resident Care Director (RCD) trained the supervisors regarding the process for completing a cart audit. -MAs were not checking the labels against the orders and the cart audits were not done properly. -The date and results of the cart audits were not documented. Interview with another first shift MA on 03/06/19 at 3:00pm revealed: -She had worked on the '200 Hall' medication cart several times in the past months. -She had administered morning medications to Resident #7. -She knew her medications and always checked the medication label with the eMAR order. -She never administered 50 mg of Metoprolol Succinate to Resident #7. -"The medication came in half tabs (from the pharmacy). I only administered half tabs." Review of the pharmacy manifest of medications delivered to the facility from 12/16/18-02/13/19 revealed Metoprolol Succinate ER in 50 mg tablets, a bubble card of 30 tablets, were delivered each month.	D 358		

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D 358	Continued From page 8 Interview with the RCD on 03/06/19 at 3:20pm revealed: - "I cannot believe the medication (Metoprolol Succinate 50 mg) was not identified as incorrect for a year!" -The MAs had been trained to check the medication label against the eMAR order, affix direction change labels on medications that can continue to be used, and remove expired medications from the medication cart. -The MAs were initially trained by the contract registered nurse (RN) upon hire. -She and the RCC conducted period trainings through out the year as refresher courses for the MAs. -Two nurses were hired as weekend Supervisors, whose responsibility was to complete a full cart audit on each of the 3 medication carts, every weekend. -She trained the weekend Supervisors in the process of completing a cart audit. -She did not require them to complete any documentation regarding the date or outcome of the cart audit. -She would ask the MAs if the supervisors completed a cart audit on their cart. -The electronic fax was used to transmit orders to the pharmacy. -She was not sure all orders sent to the pharmacy were received. -She and the RCC entered the orders onto the eMAR before the order was faxed to the pharmacy. -She conducted random cart audits at times, but did not document the dates or results. Interview with the Administrator on 03/06/19 at 3:40pm revealed: -He expected the MAs to follow the process and	D 358		

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D 358	Continued From page 9 procedures of medication administration. -He was very concerned this error could take place with all the checks and balances they have implemented. -The RCD was responsible for the training and supervision of the clinical staff. -He questioned the accuracy of the electronic fax transmissions, possibly not transmitting documentation in its entirety.	D 358		