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D 000	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted an annual and follow-up survey from 07/17/19 - 07/18/19.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to assure physician's orders were followed to follow up on completed lab work for 1 of 6 residents (#5). The findings are: Review of Resident #5's current FL2 dated 04/02/19 revealed a diagnosis of disoriented schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Review of physician's orders for a lab (blood) draw dated 05/15/19 revealed: -VPA (Valproic Acid - used to treat manic depression) -Ammonia Level (a high ammonia develops in the body when there is probable kidney or liver disease).	D 273		

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D 273	Continued From page 1 Review of Resident #5's laboratory results dated 06/13/19 revealed: -VPA level was low at 16 (normal range of 50-100). -Ammonia level was high at 90 (normal range of 6-47). -On the lab sheet for the ammonia level was the word "redraw" with the initials of PL (the Physician Assistant) and no date. Interview with the Facility Manager on 07/18/19 at 10:00 am revealed: -The physician visited the facility every other week. -Labs were done within a 2-week period of being ordered. -She was not sure why the ammonia level had not been redrawn. -She was not sure why the VPA level was not followed-up on. Interview with the Supervisor on 07/18/19 at 10:28 am revealed: -The order for the VPA and ammonia levels were faxed to the company that provided laboratory services on 05/15/19. -The normal schedule for lab draws were taken on the Tuesday after the Physician's Assistant (PA) came to the facility. -She was unsure why there had not been a redraw of Resident #5's ammonia level. -When the PA or Family Nurse Practitioner (FNP) writes an order for labs, she called the manager at the laboratory to request they send someone to complete the lab draw. -She thought the copy of the lab results had been misplaced and that was how the lab redraw for the elevated ammonia was missed. -Resident #5 has had no change in condition in	D 273		

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D 273	Continued From page 2 the past 2 months. Interview with the FNP on 07/18/19 at 11:58 am revealed: -She ordered the labs for the VPA and ammonia level on 05/15/19. -She came to the facility monthly and was last present on 06/17/19 and no lab results for Resident #5 were available to her. -With the VPA and ammonia level being out of normal range she would have expected the facility to contact her. -A recheck does need to be completed because Resident #5's ammonia level was too high. Interview with the PA on 07/18/19 at 12:24 pm revealed: -He would have expected the ammonia level to have been drawn if he had put a date requesting it to be completed on the order. -He considered this his error because he did not specify a draw by date for the ammonia level recheck. -The ammonia level is concerning to him due to the elevation and he thinks it was a false result. -Resident #5 had no recent mental changes that would concern him that she had developed encephalopathy (abnormal brain functioning due to metabolic upset that could be related to medication).	D 273		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be	D 306		

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D 306	Continued From page 3 served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure water was served to each resident during the lunch and breakfast meal, in addition to other beverages. The findings are: Interview with the Supervisor on 07/17/19 revealed the current census was 45. Observation on 07/17/19 from 12:00pm to 12:35pm of the lunch meal service revealed: -Pre-poured beverages were on the dining tables prior to residents entering the dining room. -No residents were asked what they wanted to drink. -Beverages served to all residents included an eight-ounce glass of tea. -There were 8 residents in the dining room that were served water. Observation on 07/18/19 from 8:00am to 8:40am of the breakfast meal service revealed: -All beverages were pre-poured and on the dining tables prior to residents entering the dining room. -Beverages served to all residents only included juice and coffee. -All residents in the dining room were not served water. Review of the facility's Week 4 dietary menu revealed water was to be provided at all meals as allowed. Interview on 07/18/19 at 8:45am with the cook and dietary aide revealed:	D 306		

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-The cook and dietary aides were responsible for serving beverages during meals.
-Beverages were pre-poured prior to residents entering the dining room.
-They did not automatically serve water to every resident.
-They were aware of which residents would drink water at each meal, so it was only given to them.
-Water was available to the other residents at each meal if they wanted it.
-They had an adequate supply of cups for each resident to have 2-3 cold beverages at each meal.

Interview on 07/18/19 at 10:50am with a resident revealed:
-He was not served water during the lunch meal on 07/17/19 and during the breakfast meal on 07/18/19.
-Water was not served with each meal.
-Water was available if he wanted it.
-He would like to have water at every meal.

Observation on 07/18/19 at 11:50am in the dining room, prior to the lunch meal revealed a dietary aide was pre-pouring water for each resident.

Interview on 07/18/19 at 2:15pm with a second resident revealed:
-She was not served water with every meal.
-She was not offered water at meals, but instead was given a glass of tea.
-She did not like tea.

Interview on 07/18/19 at 3:00pm with a third resident revealed:
-"We do not get water with our meals."
-She had never been served water with any meal.
-The kitchen staff provided the beverages.
-She had never asked for water.

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D 306	Continued From page 5 Interview with the Administrator on 07/18/19 at 4:30pm revealed: -She was not aware that water was not served to each resident during the lunch meal on 07/17/18 and the breakfast meal on 07/18/19. -She knew water should be served to each resident at each meal, in addition to other beverages.	D 306		
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 assure the preparation and administration of medications by staff were in accordance with orders by a	D 358		

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licensed prescribing practitioner for 2 of 6 sampled residents (Resident #3 and #6) related to the administration of warfarin (#3), and potassium chloride (#6).

The findings are:

1. Review of Resident #3's current FL2 dated 08/16/18 revealed diagnoses included Alzheimer's dementia, failure to thrive, and extreme weight loss.

Review of Resident #3's record revealed:
-A physician's order dated 05/17/19 to hold warfarin (used to treat deep vein thrombosis) on 05/17/19 and 05/18/19, and then to begin warfarin 5mg on Mondays, Wednesdays and Fridays, and 2.5mg all other days.
-A physician's order dated 06/05/19 to hold warfarin for three days, then begin warfarin 2.5mg daily, and to recheck the International Normalized Ratio (INR) in 7 days.
-There was no documentation of any warfarin orders received after 06/05/19.

Review of Resident #3's physician visit note dated 02/07/19 revealed a diagnosis of deep vein thrombosis of the upper extremity following a peripherally inserted central catheter (PICC) line placement during a recent hospitalization.

Review of Resident #3's Medication Administration Records (MAR) for the month of June 2019 revealed:
-There was an entry on page one for warfarin 5mg, take one tablet on Monday, Wednesday and Friday.
-There was an entry on page one for warfarin 5mg, take one-half tablet (2.5mg) on Tuesday, Thursday, Saturday, and Sunday.

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-On page one of the MAR, warfarin 5mg was documented as administered on 06/26/19.
-There was a handwritten note on page one to hold warfarin 5mg and 2.5mg for 3 days (from 06/06/19 to 06/08/19).
-There was a handwritten entry on page one to change warfarin to 2.5mg daily for 7 days to begin on 06/09/19 and to end on 06/15/19.
-There was a handwritten entry on page two of the MAR for warfarin 5mg, take one tablet on Monday, Wednesday and Friday, with a note to hold from 06/06/19 to 06/15/19, and on 06/21/19 and 06/22/19.
-On page two of the MAR, warfarin 5mg was documented as administered on 06/17/19, 06/19/19, 06/24/19, 06/26/19, and 06/28/19.
-There was a handwritten entry on page two for warfarin 5mg, take one-half tablet (2.5mg) on Tuesday, Thursday, Saturday, and Sunday, with a note to hold from 06/06/19 to 06/08/19, and to hold on 06/21/19 and 06/22/19.
-There was not an entry for warfarin 2.5mg daily beginning on 06/09/19.
-From 06/16/19 to 06/30/19 warfarin 5mg was documented as administered 5 days out of 15, when 2.5mg was ordered.

Review of Resident #3's MAR for the month of July 2019 revealed:
-There was an entry for warfarin 5mg, take one tablet on Monday, Wednesday and Friday.
-There was an entry for warfarin 5mg, take one-half tablet (2.5mg) on Tuesday, Thursday, Saturday, and Sunday.
-Warfarin 5mg was documented as administered on 07/01/19, 07/03/19, 07/05/19, 07/08/19, 07/10/19, 07/12/19, 07/15/19 and 07/17/19.
-There was not an entry on the MAR for warfarin 2.5mg daily.
-From 07/01/19 to 07/17/19 warfarin 5mg was

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documented as administered 8 days out of 17, when 2.5mg was ordered.

Review of the Home Health Nurse's notes for Resident #3 revealed:
-Resident #3 had seen the primary care provider (PCP) on 06/05/19 and an order to hold warfarin until 06/09/19 was written.
-The INR for the 06/07/19 home health visit was 5.5 and was called to the PCP.
-Resident #3 was to restart warfarin 2.5mg daily on 06/09/19.
-The INR was 2.0 on 06/14/19.
-The INR was 3.4 on 06/21/19.
-On 06/27/19 facility had requested the INR be checked due to a dose being held, with a result of 1.3.
-The INR was 1.9 on 07/01/19.
-The INR was 2.7 on 07/10/19.
-There was no documentation of any warfarin orders received after 06/05/19.

Interview on 07/18/19 at 10:15am and 11:40am with the Supervisor revealed:
-It was her responsibility to transcribe orders to the MAR and to verify they were accurate.
-She had transcribed the 06/05/19 physician's order for warfarin on the June 2019 MAR incorrectly.
-She had received a clarification order over the phone with the PCP that Resident #3 was to return to the previous dose of warfarin after the 06/15/19 dose was administered.
-She was unable to find the signed clarification order and was unable to provide the date it was obtained.

Interview on 07/18/19 at 10:20am with the Facility Manager revealed she expected the medication aides (MAs) to administer medications as ordered

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D 358	Continued From page 9 by the medical provider. Telephone interview on 07/18/19 at 2:10pm with Resident #3's PCP's medical assistant revealed: -Resident #3 was prescribed warfarin due to deep vein thrombosis. -The current order was for warfarin 2.5mg daily. -There had been no order changes since 06/05/19. -They were not aware that Resident #3 had been receiving 5mg on Monday, Wednesday and Friday and 2.5mg all other days. -There were no orders to hold warfarin on 06/21/19 and 06/22/19, when the INR was 3.4. Telephone interview on 07/18/19 at 2:31pm with the contract pharmacy representative revealed: -The pharmacy was responsible for dispensing Resident #3's medications. -The last prescription received for Resident #3 was dated 05/20/19 for warfarin 5mg on Monday, Wednesday, and Friday, and warfarin 2.5mg all other days. -They did not receive a physician's order dated 06/05/19 to hold warfarin for 3 days, and then resume 2.5mg daily. -A fourteen-day supply was dispensed to the facility. -Warfarin 5mg, take one tablet on Monday, Wednesday, and Friday, and warfarin 2.5mg, take one tablet all other days was last dispensed on 07/11/19 with a 07/12/19 start date. Interview on 07/18/19 at 3:15pm with the Administrator and the Facility Manager revealed: -They were not aware that Resident #3 had received the incorrect dose of warfarin since 06/05/19. -The manager was responsible for completing chart audits each month.	D 358		

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D 358	Continued From page 10 -The Supervisor was responsible for INR results, processing new warfarin orders and updating the MAR for Resident #3. -The 06/05/19 order was never sent to the pharmacy, because it was not stamped with the "faxed" to pharmacy stamp. Interview on 07/18/19 at 3:15pm with the second shift MA revealed: -The MAs were responsible for reviewing the MARs for each resident at the end of each month. -She and the Supervisor reviewed all the resident's records "so they get a double check." -She would review one medication cart and MAR book and the Supervisor would review the other cart and MAR book, then they would switch. -After she and the Supervisor had completed the review of the carts and MAR, the MAR would go to the Facility Manager for a 3rd review. Observation on 07/18/19 at 3:20pm of Resident #3's medication on hand revealed: -A cassette with 6 tablets of warfarin 5mg, with a fill prescribed date of 05/20/19. -A cassette with 6 half tablets (2.5mg) of warfarin 5mg, with a prescribed date of 05/20/19. -These 2 cassettes were the only medication available for Resident #3. -There was not any warfarin in the overstock room for Resident #3. Interview on 07/18/19 at 3:30pm with the second shift MA revealed: -She administered warfarin to Resident #3 according to the June 2019 MAR. -Warfarin 5mg on Monday, Wednesday and Friday and warfarin 2.5mg all other days on the July 2019 MAR were the current orders for Resident #3.	D 358		

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D 358	Continued From page 11 Interview on 07/18/19 at 3:35pm with the Supervisor revealed: -When a new order was received it was faxed to the pharmacy and stamped "faxed" with date and initials of staff. -The Supervisor or second shift MA were responsible for transcribing new medication orders to the MAR. -The 06/05/19 physician's order for warfarin was written on the June 2019 MAR. -She had faxed the order to the pharmacy, even though it was not stamped "faxed", dated or initialed. -The Facility Manager was responsible to review new orders. -The Facility Manager compared medications on the cart to the new orders for all residents once weekly. Review of a the PCP's current medication list for Resident #3 dated 07/18/19 revealed the current dose of warfarin was 2.5mg daily, with a start date of 07/18/19. Interview on 07/18/19 at 3:00pm with Resident #3 revealed she was unaware of her current medications and stated she did not take warfarin. Attempted telephone interview on 07/18/19 at 3:05pm with Resident #3's Power of Attorney was unsuccessful. Refer to review of the facility's policy and procedures for new physician orders. 2. The medication error rate was 4% based on the observation of 1 errors out of 25 opportunities during the 8:00am medication pass on 07/18/19.	D 358		

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D 358	Continued From page 12 Review of Resident #6's current FL2 dated 12/19/18 revealed: -Diagnoses included chronic obstructive pulmonary disease and depression. -Medication order included potassium (a mineral supplement) ER 20mcg daily. Observation during the 8:00am medication pass on 07/18/19 revealed: -At 7:50am, the medication aide (MA) prepared 5 oral medications for administration to Resident #6. -The MA crushed all 5 medications which included potassium ER 20meq. -The MA mixed the 5 crushed medications with pudding. Observation on 07/18/19 at 7:50am of Resident #6's medication on hand revealed the potassium ER 20meq pharmacy generated label had a yellow sticker on the medication dispenser "Do not crush." Interview on 07/18/19 at 7:50am with the MA administering medications to Resident #6 revealed: -She had crushed the potassium ER 20meq every day for a year and a half. -Resident #6 could not swallow the pill whole so she crushed the potassium ER. -She knew the pharmacy had placed a yellow sticker on the potassium ER generated label "do not crush." -She had been trained to crush the potassium by another MA. -She knew she was not to crush the potassium ER. -She was not aware crushing the potassium ER made it a an immediate release potassium. -She had never contacted the pharmacy in regard	D 358		

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to crushing the potassium ER.
-She would immediately contact Resident #6's medical provider and the pharmacy for clarification and instruction prior to administering the potassium ER 20meq on 07/18/19 at 7:50am to Resident #6.

Telephone interview on 07/18/19 at 9:00am with the contract pharmacy representative revealed:
-The pharmacy was responsible for dispensing Resident #6's medications which included potassium ER 20meq.
-The pharmacy placed the yellow sticker on the generated label for the potassium ER "do not crush".
-The potassium was not to be crushed because it was extended release (ER) and if crushed it would be immediate released.
-The facility staff never contacted the pharmacy in regard to crushing the potassium ER for Resident #6 prior to 07/18/19.

Telephone interview on 07/18/19 at 9:30am with Resident #6's medical provider revealed:
-Resident #6 was prescribed the potassium because he was also prescribed a diuretic.
-He prescribed the potassium to supplement the diuretic so Resident #6's potassium level would not be low.
-He remembered writing an order to crush Resident #6's medications but could not recall the date.
-Resident medications can be crushed except for the Potassium ER.
-He did not know the MAs were crushing the Potassium ER.
-"The potassium ER is a extended release and if crushed it would be an immediate release, I would rather [Resident #6] get the potassium crushed than none at all."

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D 358	Continued From page 14 -He thought the pharmacy should label the potassium ER identifying it could not be crushed. -The facility did reach out to him about changing the potassium ER to a liquid several months ago, but he thought Resident #6's insurance would not pay to change the potassium to a liquid formula. Review on 07/18/19 at 10:10am of a laboratory report dated 06/13/19 for Resident #6 revealed a potassium level of 3.7 (normal range 3.3-5.1). Interview on 07/18/19 at 10:35am with Resident #6 revealed; -He did not know all the medications he was taking. -He knew the MAs crushed the pills because he did not like taking the "big pill" whole. -The MAs had crushed his medications for a long time, he could not recall for how long. -He did not have trouble swallowing except for the big pill. Interview on 07/18/19 at 10:20am with the Facility Manager revealed: -She did not know the MAs were crushing Resident #6's potassium ER tablet. -She knew potassium ER could not be crushed. -She relied on her MAs to administer Resident #6's medication as ordered by the medical provider. Refer to review of the facility's policy and procedures for new physician orders. _____ Review of the facility's policy and procedures for new physician orders revealed: -All new orders were given to the secretary and were to be faxed to the pharmacy. -The new order was stamped with the date faxed	D 358		

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and the initials of the person that sent the fax.
-New orders were to be copied and the original was to be filed in the chart.
-The copy of the new order was given to the medication aide on duty.
-The MA on duty was responsible to transcribe the new order to the MAR and sign the copy of the order.
-By signing the copy of the order, the MA was indicating that the order was read, interpreted and transcribed to the MAR properly.
-The copy of the new order was placed behind the resident's tab in the MAR.
-Each MA was to sign the copy of the new order that was placed in the MAR.
-Once all MAs signed the copy of the new order it was removed from the MAR and placed in the "New Orders Book" in numerical order.
-At the end of the month, the orders in the "New Orders Book" were removed and given to the Administrator for review to ensure all orders were signed by all MAs.
-When a new medication was received by the pharmacy, it was the responsibility of the MA to compare the medication to the new physician orders, compare the medication received to the transcribed orders on the MAR.
-If the medications sent by the pharmacy did not match the medications that were ordered, the Manager or the Administrator was to be contacted immediately, and then the pharmacist was to be contacted.

The facility failed to assure the preparation and administration of medications by staff were in accordance with orders by a licensed prescribing practitioner for 2 of 6 sampled residents (Resident #3 and #6) related to the administration of warfarin (#3), and potassium chloride (#6). The

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D 358	Continued From page 16 facility's failure to assure medications were administered and prepared as ordered was detrimental to the health, and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/18/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 1, 2019.	D 358		
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).	D 367		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 1 of 5 sampled residents (Resident #3) related to documenting the administration of warfarin, a medication used to treat deep vein thrombosis (blood clots).

The findings are:

Review of Resident #3's current FL2 dated 08/16/18 revealed diagnoses included Alzheimer's dementia, failure to thrive, and extreme weight loss.

Review of Resident #3's record revealed:
-A physician's order dated 05/17/19 to hold warfarin (used to treat deep vein thrombosis) on 05/17/19 and 05/18/19, and then to begin warfarin 5mg on Mondays, Wednesdays and Fridays, and 2.5mg all other days.
-A physician's order dated 06/05/19 to hold warfarin for three days, then begin warfarin 2.5mg daily, and to recheck the International Normalized Ratio (INR) in 7 days.
-There was no documentation of any warfarin orders received after 06/05/19.

Review of Resident #3's physician visit note dated 02/07/19 revealed a diagnosis of deep vein thrombosis of the upper extremity following a peripherally inserted central catheter (PICC) line

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placement during a recent hospitalization.

Review of Resident #3's June 2019 Medication Administration Record (MAR) revealed:
-There was an entry on page one for warfarin 5mg, take one tablet on Monday, Wednesday and Friday.
-There was an entry on page one for warfarin 5mg, take one-half tablet (2.5mg) on Tuesday, Thursday, Saturday, and Sunday.
-There was a handwritten note on page one to hold warfarin 5mg and 2.5mg for 3 days (from 06/06/19 to 06/08/19).
-There was a handwritten entry on page one to change warfarin to 2.5mg daily for 7 days to begin on 06/09/19 and to end on 06/15/19.
-There was a handwritten entry on page two of the MAR for warfarin 5mg, take one tablet on Monday, Wednesday and Friday, with a note to hold from 06/06/19 to 06/15/19, and on 06/21/19 and 06/22/19.
-There was a handwritten entry on page two for warfarin 5mg, take one-half tablet (2.5mg) on Tuesday, Thursday, Saturday, and Sunday, with a note to hold from 06/06/19 to 06/08/19, and to hold on 06/21/19 and 06/22/19.
-There was not an entry for warfarin 2.5mg daily beginning on 06/09/19.

Review of Resident #3's July 2019 MAR revealed:
-There was an entry for warfarin 5mg, take one tablet on Monday, Wednesday and Friday.
-There was an entry for warfarin 5mg, take one-half tablet (2.5mg) by mouth on Tuesday, Thursday, Saturday, and Sunday.
-There was not an entry on the MAR for warfarin 2.5mg daily.

Interview on 07/18/19 at 10:15am and 11:40am with the Supervisor revealed:

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D 367	Continued From page 19 -It was her responsibility to transcribe orders to the MAR and to verify they were accurate. -She had transcribed the 06/05/19 physician's order for warfarin on the June 2019 MAR incorrectly. -She had received a clarification order over the phone with the PCP that Resident #3 was to return to the previous dose of warfarin after the 06/15/19 dose was administered. -She was unable to find the signed clarification order and was unable to provide the date it was obtained. Interview on 07/18/19 at 3:15pm with the second shift medication aide (MA) revealed: -The MAs were responsible for reviewing the MARs for each resident at the end of each month. -She and the Supervisor reviewed all the resident's records "so they get a double check." -She would review one medication cart and MAR book and the Supervisor would review the other cart and MAR book, then they would switch. -After she and the Supervisor had completed the review of the carts and MAR, the MAR would go to the Facility Manager for a 3rd review. Interview on 07/18/19 at 3:15pm with the Administrator and the Facility Manager revealed: -They were not aware that Resident #3 had received the incorrect dose of warfarin since 06/05/19. -The manager was responsible for completing chart audits each month. -The Supervisor was responsible for INR results, processing new warfarin orders and updating the MAR for Resident #3. -The 06/05/19 order was never sent to the pharmacy, because it was not stamped with the "faxed" to pharmacy stamp.	D 367		

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D 367	Continued From page 20 Further review of Resident #3's record revealed the 06/05/19 order to hold all warfarin for three days, then begin warfarin 2.5mg daily was not stamped with the "faxed" to pharmacy stamp. Interview on 07/18/19 at 3:30pm with the second shift MA revealed: -She administered warfarin to Resident #3 according to the June 2019 MAR. -Warfarin 5mg on Monday, Wednesday and Friday and warfarin 2.5mg all other days on the July 2019 MAR were the current orders for Resident #3. Interview on 07/18/19 at 3:35pm with the Supervisor revealed: -When a new order was received it was faxed to the pharmacy and stamped "faxed" with date and initials of staff. -The Supervisor or second shift MA were responsible for transcribing new medication orders to the MAR. -The 06/05/19 physician's order for warfarin was written on the June 2019 MAR. -She had faxed the order to the pharmacy, even though it was not stamped "faxed", dated or initialed. -The Facility Manager was responsible to review new orders. -The Facility Manager compared medications on the cart to the new orders for all residents once weekly. Review of the PCP's current medication list for Resident #3 dated 07/18/19 revealed the current dose of warfarin was 2.5mg daily, with a start date of 07/18/19. Review of the facility's policy and procedures for	D 367		

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D 367	Continued From page 21 new physician orders revealed: -All new orders were given to the secretary and were to be faxed to the pharmacy. -The new order was stamped with the date faxed and the initials of the person that sent the fax. -New orders were to be copied and the original was to be filed in the chart. -The copy of the new order was given to the medication aide on duty. -The MA on duty was responsible to transcribe the new order to the MAR and sign the copy of the order. -By signing the copy of the order, the MA was indicating that the order was read, interpreted and transcribed to the MAR properly. -The copy of the new order was placed behind the resident's tab in the MAR. -Each MA was to sign the copy of the new order that was placed in the MAR. -Once all MAs signed the copy of the new order it was removed from the MAR and placed in the "New Orders Book" in numerical order. -At the end of the month, the orders in the "New Orders Book" were removed and given to the Administrator for review to ensure all orders were signed by all MAs. -When a new medication was received by the pharmacy, it was the responsibility of the MA to compare the medication to the new physician orders, compare the medication received to the transcribed orders on the MAR. -If the medications sent by the pharmacy did not match the medications that were ordered, the Manager or the Administrator was to be contacted immediately, and then the pharmacist was to be contacted.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 22 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 assure residents received care and services which were 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 assure the preparation and administration of medications by staff were in accordance with orders by a licensed prescribing practitioner for 2 of 6 sampled residents (Resident #3 and #6) related to the administration of warfarin (#3), and potassium chloride (#6). [(Refer to Tag 358 ,10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		