STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086001	A. BUILDING: _____ B. WING _____	R-C 01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(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 conducted a follow-up survey and complaint investigation from 01/15/20 to 01/17/20. The complaint investigation was initiated by the Surry County Department of Social Services on 11/21/19.	D 000	Filing the Plan of Correction does not constitute an admission that the deficiencies alleged, did, in fact exist. This Plan of Correction is filed as evidence of the facilities desire to comply with the requirements and to continue to provide high quality resident care.	
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, record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing preaction for 1 of 5 sampled residents (Resident #5) including errors with two medications used to treat liver disease and hepatic encephalopathy (#5). The findings are: Review of Resident #5's current FL2 dated 10/25/19 revealed diagnoses included altered mental status, hepatic encephalopathy (a disease that causes worsening of brain function in people with liver disease), liver cirrhosis, portal hypertension, diabetes mellitus type 2, schizoaffective disorder, bipolar disorder, and	D 358	a) The administrator will put in place a policy on following up on medications with prior authorizations to ensure resident receives medications as prescribed by the PCP.	03/02/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandi Robertson | TITLE: Administrator | (X6) DATE: 2/24/20

Reviewed and acknowledged
02/24/20 Maggi Chmura

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D 358	Continued From page 1 thrombocytopenia. a. Review of Resident #5's FL2 dated 10/25/19 revealed there was an order for Xifaxan (an antibiotic used to prevent hepatic encephalopathy) 550mg twice daily. Review of a Resident #5's hospital discharge summary dated 10/25/19 revealed: -Resident #5 was treated for acute encephalopathy and hepatic encephalopathy. -Resident #5's ammonia level was 104umol/L dated 10/21/19 (normal reference range was from 18-54umol/L). -Resident #5's ammonia level was 58umol/L dated 10/25/19 (normal reference range was from 18-54umol/L). Review of Resident #5's November 2019, December 2019, and January 2020 electronic Medication Administration Records (eMARs) revealed: -There was an entry for Xifaxan 550mg twice a day scheduled for administration at 6:00am and 7:00pm. -There were directions on the eMARs that prior authorization was required and "waiting for approval from insurance". Observation of the medications on hand for Resident #5 on 01/17/20 revealed Xifaxan was not available for administration. Review of Resident #5's Pharmacy Request for Prior Approval Standard Drug Request Form revealed: -The drug requested was Xifaxan 550mg. -The prescriber signed the form and was dated 11/03/19.	D 358		

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D 358	Continued From page 2 Review of Resident #5's laboratory (lab) results dated 11/14/19 revealed Resident #5's ammonia level was 43ug/dL (normal reference range was from 22-87ug/dL). Telephone interview with a representative from the contracted pharmacy on 01/17/20 at 12:00pm revealed: -Resident #5 was ordered Xifaxan 550mg on 10/25/19. -Resident #5's Xifaxan needed prior authorization by the primary care provider (PCP) in order to be filled. -The pharmacy notified the facility regarding prior authorization for Resident #5's Xifaxan (date unknown). -The Pharmacy Request for Prior Approval Standard Drug Request Form was sent to the provider for prior authorization (date unknown). -The provider was responsible for completing the prior authorization form in order to have Xifaxan approved by the insurance company and filled for Resident #5. -If the medication was approved, the pharmacy would be notified and Xifaxan would be filled for Resident #5. -Xifaxan was not filled for Resident #5 in November 2019, December 2019, or January 2020. Telephone interview with the Pharmacist from the contracted pharmacy on 01/17/20 at 1:35pm revealed: -Xifaxan was used to prevent and treat encephalopathy. -Xifaxan was expensive and was not always covered by insurance, therefore, Resident #5 needed prior authorization in order to have the medication filled. -Resident #5 was not ordered another medication	D 358		

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D 358	Continued From page 3 that would have the same treatment effect as Xifaxan. -If Xifaxan was not administered as ordered, Resident #5 may have an increased ammonia level and was at risk for encephalopathy and liver damage. Telephone interview with Resident #5's PCP on 01/17/20 at 2:00pm revealed: -Resident #5 was prescribed Xifaxan for liver disease, to lower ammonia levels, and for hepatic encephalopathy. -If Resident #5 was not administered Xifaxan as ordered, Resident #5 was at risk for hepatic encephalopathy, liver failure, psychiatric encephalopathy, and increased agitation. -She had been Resident #5's PCP since January 2020, and she did not know if the facility notified the previous PCP about Xifaxan not being administered to Resident #5 in November 2019, December 2019, and January 2020. -She considered Resident #5's ammonia level of 43ug/dL as "good" and a resident that needed Xifaxan would normally have a baseline ammonia level between 50-60ug/dL; behavioral changes would occur with an ammonia level between 80-90ug/dL. -Since Resident #5's Xifaxan was not administered as ordered, Resident #5's ammonia level would vary depending on the severity of Resident #5's liver disease. -If Resident #5 had severe liver disease, she would expect the ammonia level to increase in 48 hours. -She expected the facility to administer medications to Resident #5 as ordered. Interview with the Supervisor on 01/17/19 at 2:32pm revealed: -She was responsible for processing residents	D 358		

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D 358	Continued From page 4 medication orders. -She knew Resident #5's was ordered Xifaxan on 10/25/19. -Resident #5's Xifaxan was not filled by the contracted pharmacy and was waiting on prior authorization. -Residents #5's prior authorization form for Xifaxan was completed by the PCP in November 2019. -She did not follow up with Resident #5's PCP about prior authorization for Resident #5's Xifaxan because she knew the prior authorization form was completed. -Resident #5 was not administered the Xifaxan that was ordered on 10/25/19. -The PCP was not notified that Resident #5's Xifaxan was not administered in November 2019, December 2019, and January 2020 because she knew he completed the prior authorization form and were waiting on approval. Interview with the Administrator on 01/17/19 at 2:32pm revealed: -The facility did not have a policy on following up with medications needing prior authorization. -She did not know Resident #5's Xifaxan was not administered as ordered on 10/25/19 from November 2019 to January 2020. -There was no process for medications needing prior authorization because "usually the medication was approved" and administered as ordered. -She did not know the PCP was not notified that Xifaxan was not administered as ordered from November 2019 to January 2020. Telephone interview with Resident #5's Gastroenterologist on 01/17/20 at 3:52pm revealed: -Xifaxan was ordered for Resident #5 for hepatic	D 358		

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D 358	Continued From page 5 encephalopathy. -The 11/22/19 appointment, he noted that Resident #5 was "supposed to be taking Xifaxan, but this had not been approved by her [pharmacy benefit manager]." -He did not order Xifaxan for Resident #5. -If Resident #5 was not administered Xifaxan, it could cause encephalopathy. Attempted telephone interview with Resident #5 on 01/17/20 at 3:00pm was unsuccessful. Refer to the interview with the Administrator on 01/17/20 at 2:35pm. Refer to the telephone interview with Resident #5's Gastroenterologist on 01/17/20 at 3:52pm. b. Review of Resident #5's physician's order dated 11/22/19 revealed lactulose (used to treat and prevent complications of liver disease) 30cc three times a day. Review of a Resident #5's hospital discharge summary report dated 10/25/19 revealed: -Resident #5 was treated for acute encephalopathy and hepatic encephalopathy. -Resident #5's ammonia level was 104umol/L dated 10/21/19 (normal reference range was from 18-54umol/L). -Resident #5's ammonia level was 58umol/L dated 10/25/19 (normal reference range was from 18-54umol/L). Review of Resident #5's November 2019, December 2019, and January 2020 electronic Medication Administration Records (eMARs) revealed there was no entry for lactulose 30cc three times a day.	D 358	b) Medication Aides will be in-serviced on the process of receiving orders from the PCP and how to carry out those orders. c) RN consultant from pharmacy will conduct chart audits to ensure orders are carried out as ordered by the PCP. d) The Administrator and/or designee will conduct random chart audits weekly for one month, bi-weekly for one month the quarterly thereafter.	03/02/2020 01/29/2020 03/02/2020 and ongoing

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D 358	Continued From page 6 Observation of the medications on hand for Resident #5 on 01/17/20 revealed lactulose was not available for administration. Review of Resident #5's laboratory (lab) results dated 11/14/19 revealed Resident #5's ammonia result was 43ug/dL (normal reference range was 22-87ug/dL). Telephone interview with a representative from the contracted pharmacy on 01/17/20 at 12:00pm revealed: -The pharmacy did not have the order for Resident #5's lactulose dated 11/22/19 on file. -Resident orders were usually faxed from the facility to the pharmacy. Telephone interview with Resident #5's Primary Care Provider (PCP) on 01/17/20 at 2:00pm revealed: -Resident #5 was ordered lactulose for liver disease, to lower ammonia levels, and for hepatic encephalopathy. -If Resident #5 was not administered lactulose as ordered, she was at risk for hepatic encephalopathy, liver failure, psychiatric encephalopathy, and increased agitation. -She considered Resident #5's ammonia level of 43ug/dL as "good" and a resident that needed lactulose would normally have a baseline ammonia level between 50-60ug/dL; behavioral changes would occur between 80-90ug/dL. -Since lactulose was not administered as ordered on 11/22/19, Resident #5's ammonia level would depend on the severity of Resident #5's liver disease. -If Resident #5 had severe liver disease, she would expect the ammonia level to increase in 48 hours. -She expected the facility to fax the orders to the	D 358		

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D 358	Continued From page 7 pharmacy and administered medications to Resident #5 as ordered. Interview with the Supervisor on 01/17/20 at 2:32pm revealed: -She was responsible for processing residents medication orders. -She did not know Resident #5's was ordered lactulose three times a day on 11/22/19. -She was not working on 11/22/19 and the MA working the day the order was written was responsible for faxing the order to the pharmacy. -She did not know why the order for Resident #5's lactulose was not sent to the pharmacy. -There was no process in place for double checking orders to make sure they were sent to the pharmacy. Interview with the Administrator on 01/17/20 at 2:32pm revealed: -She did not know Resident #5's lactulose was ordered on 11/22/19. -The MA working the day the order was written was responsible for processing orders. -She did not know why the order for Resident #5's lactulose was not sent to the pharmacy. -She expected MAs to send orders to the pharmacy and administer medications as ordered. -The PCP was not notified that lactulose was not administered as ordered. Telephone interview with Resident #5's Gastroenterologist on 01/17/20 at 3:52pm revealed: -Lactulose was ordered for Resident #5 for hepatic encephalopathy. -On the 11/22/19 appointment, he noted that Resident #5 should be taking lactulose. -He did not order lactulose for Resident #5 on	D 358		

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D 358	Continued From page 8 11/22/19. -If Resident #5 was not administered lactulose as ordered by her PCP, it could cause worsening hepatic encephalopathy. Attempted telephone interview with Resident #5 on 01/17/20 at 3:00pm was unsuccessful. Refer to the interview with the Administrator on 01/17/20 at 2:35pm. Refer to the telephone interview with Resident #5's Gastroenterologist on 01/17/20 at 3:52pm. _____ Interview with the Administrator on 01/17/20 at 2:35pm revealed: -The RCC (Resident Care Coordinator) was responsible for auditing residents' records and the RCC was no longer employed at the facility since October 2019. -The Supervisor was training to be the RCC and the Administrator was currently responsible for auditing resident records and orders. -Resident #5's record had not been audited since before October 2019. Telephone interview with Resident #5's Gastroenterologist on 01/17/20 at 3:52pm revealed: -Resident #5's last appointment was 11/22/19. -Ammonia and hepatic encephalopathy could "go together", but that was "not always the case"; If ammonia levels were normal, but the resident clinically looked like they had hepatic encephalopathy, then he diagnosed the resident with hepatic encephalopathy. -On 11/23/19, Resident #5 had an ammonia level of 54, which was "technically high", but he considered Resident #5's ammonia level on 11/23/19 to be "normal".	D 358		

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D 358	Continued From page 9 The facility failed to administer medications as ordered to Resident #5, who had diagnoses including hepatic encephalopathy, resulting in the resident not receiving two medications prescribed to lower the ammonia level in her bloodstream, which causes encephalopathy, and placed the resident at risk for liver damage, behavioral changes, and increased ammonia levels. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/17/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2020.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents received care and services which are adequate,	D912	See Plan of Correction D358 b, c and d	

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D912	Continued From page 10 appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration. The findings are: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing preaction for 1 of 5 sampled residents (Resident #5) including errors with two medications used to treat liver disease and hepatic encephalopathy (#5). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		