Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030009	A. BUILDING: ______ B. WING ______	R 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOCKSVILLE SENIOR LIVING & MEMORY CAI	337 HOSPITAL STREET MOCKSVILLE, NC 27028

(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 an annual, follow-up survey and complaint investigation on 5/12/21 and 5/13/21.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report: the Plan of Correction is prepared solely as a matter of compliance with State Law.	
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 administer medications as ordered for 1 of 5 residents sampled residents (Resident #2) regarding a diuretic medication, an antihypertensive medication and a thyroid medication. The findings are: Review of Resident #2's current FL2 dated 05/11/21 revealed: -Diagnoses included hypertension, stroke, seizure and disorder impaired functional mobility. -There was an order for carvedilol 25mg (used to treat hypertension) twice daily. a. Review of Resident #2's previous FL2 dated 09/09/20 revealed an order for carvedilol 12.5mg twice daily.	D 358	10A NCAC 13R .1004 (a) Medication Administration Education provided by DDCS to the Executive Director, Resident Care Manager and Memory Care Manager of the ALG procedure of the Bucket System for processing orders on 05/14/2021. Residents returning from outside appointments, hospital ER visits or hospital stays will have orders reviewed and clarified with the MD. Most current physician orders will be printed and sent with FL2 for MD to review and sign. Audit of FL2's was completed by 5/30/21 to ensure that FL2's and orders are current. Care Managers will review random FL2 and orders monthly to ensure dates are consistent with most current orders and medications on the cart. Cart audits will be completed weekly by Care Managers and/or designee.	06/24/2021

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tracy L Smith
TITLE: Executive Director
(X6) DATE: 6/1/21

reviewed and accepted 06/08/21 Jo Scarlett

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Review of Resident #2's physician's order dated 12/31/20 revealed an order for carvedilol 12.5mg twice daily.

Review of Resident #2's physician's office visit medication list revealed:
-On 03/02/21 Resident #2's current medications included carvedilol 25mg twice daily.
-On 03/12/21 Resident #2's current medications included carvedilol 25mg twice daily.
-On 05/11/21 Resident #2's current medications included carvedilol 25mg twice daily.

Review of Resident #2's March 2021 medication administration record revealed:
-There was an entry for carvedilol 12.5mg twice daily scheduled for administration at 9:00am and 6:00pm.
-There was documentation carvedilol 12.5mg was administered twice daily from 03/01/21 through 03/31/21.
-There was no entry on the MAR for carvedilol 25mg twice daily.

Review of Resident #2's April 2021 MAR revealed:
-There was an entry for carvedilol 12.5mg twice daily scheduled for administration at 9:00am and 6:00pm.
-There was documentation carvedilol 12.5mg was administered twice daily from 04/01/21 through 04/30/21.
-There was no entry on the MAR for carvedilol 25mg twice daily.

Review of Resident #2's May 2021 MAR revealed:
-There was an entry for carvedilol 12.5mg twice daily scheduled for administration at 9:00am and 6:00pm.

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-There was documentation carvedilol 12.5mg was administered twice daily from 05/01/21 through 05/13/21.
-There was no entry on the MAR for carvedilol 25mg twice daily.

Observation of Resident #2's medications on hand at the on 05/12/21 at 3:15pm revealed:
-Carvedilol 12.5mg was available for administration.
-Carvedilol 25mg was not available for administration.

Interview the medication aide (MA) on 05/12/21 at 3:12pm revealed:
-Resident #2's Primary Care Provider (PCP) did not visit the facility.
-Resident #2 went out to the PCP office and usually returned with paperwork which included a list of the resident's current medications.
-The MA on duty should take Resident #2's paperwork and review the medication list for new or changed orders.
-The PCP usually electronically sent orders to the pharmacy.
-The MA was responsible for checking the list so she knew about the medication changes and/or new orders.

Telephone interview with Resident #2's PCP on 04/13/21 at 9:20am revealed:
-Resident #2 was last seen by the PCP on 05/11/21.
-When the resident was in the office, they gave her a list of her current medications to take back to the facility; so, the facility knew the resident's current medications.
-Resident #2's current medication regimen included carvedilol 25mg twice daily.
-The carvedilol order was changed in June 2020

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from 12.5mg to 25mg.
-Carvedilol was ordered to decrease the resident's blood pressure.
-When the medication list was given to the resident, the PCP expected Resident #2's medications to be administered as ordered.
-On 05/11/21 Resident #2's blood pressure was 134/70.

Interview with the Administrator on 05/13/21 at 4:50pm revealed:
-She was not aware Resident #2's order for carvedilol was for 25mg twice daily.
-When orders were received at the facility the care manager was responsible for checking the orders.
-If there was a problem or discrepancy, the care manager should contact the PCP.
-The previous care manager should have checked Resident #2's medication list that was sent by the PCP to identify new or changed medication orders.
-She recently noticed there were medication orders not on the MARs.
-Two weeks ago, she started auditing records at the facility.

Telephone interview with the facility's contracted pharmacy on 04/13/21 at 10:14am revealed:
-The pharmacy started contracted services for the facility on 02/08/21.
-The facility provided the pharmacy with orders for Resident #2's medications.
-The pharmacy had physicians order dated 12/31/20 for carvedilol 12.5mg.
-The pharmacy did not have an order for carvedilol 25mg.
-If the resident was ordered carvedilol 25mg the pharmacy never received the order.

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Based on observation, record review and interview, it was determined that Resident #2 was not interviewable.

b. Review of Resident #2's current FL2 dated 05/11/21 21 revealed an order for levothyroxine 137mcg (used to treat low thyroid hormone) once daily.

Review of Resident #2's previous FL2 dated 09/09/21 revealed an order for levothyroxine 125mcg (used to treat low thyroid hormone) once daily.

Review of Resident #2's physician's order dated 12/31/21 revealed an order for levothyroxine 125mcg

Review of Resident #2's physician's office medication list revealed:
-On 03/02/21 Resident #2's current medications included levothyroxine 137mcg once daily.
-On 03/12/21 Resident #2's current medications included levothyroxine 137mcg once daily.
-On 05/11/21 Resident #2's current medications included levothyroxine 137mcg once daily.

Review of Resident #2's March 2021 MAR revealed:
-There was an entry for levothyroxine 125mcg once daily scheduled for administration at 6:00am.
-There was document levothyroxine 125mcg was administered from 03/01/21 through 03/31/21.
-There was no entry for levothyroxine 137mcg.

Review of Resident #2's April 2021 MAR revealed:
-There was an entry for levothyroxine 125mcg once daily scheduled for administration at

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D 358	Continued From page 5 6:00am. -There was document levothyroxine 125mcg was administered from 04/01/21 through 04/30/21. -There was no entry for levothyroxine 137mcg. Review of Resident #2's May 2021 MAR revealed: -There was an entry for levothyroxine 125mcg once daily scheduled for administration at 6:00am. -There was document levothyroxine 125mcg was administered from 05/01/21 through 05/13/21. -There was no entry for levothyroxine 137mcg. Observation of Resident #2's medication on hand at the facility on 05/12/21 at 3:15pm revealed: -Levothyroxine 125mcg was available for administration. -Levothyroxine 137mcg was not available for administration. Review Resident #2's laboratory results for TSH (thyroid stimulating hormone) dated 05/11/21 revealed a TSH level of 0.045 (normal reference range is 0.450 to 4.500). Review of Resident #2's laboratory results for Free T4 (evaluate thyroid function) dated 05/11/21 revealed a Free T4 result of 1.86 (normal reference range is 0.82 to 1.77). Interview the medication aide (MA) on 05/12/21 at 3:12pm revealed: -She was not aware Resident #2's levothyroxine was the wrong dose. -When Resident #2 returned with orders the MA should make a note and check to make sure the correct order was on the MAR. Telephone interview with Resident #2's Primary	D 358		

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Care Provider (PCP) on 04/13/21 at 9:20am revealed:
-Resident #2 was last seen by the PCP on 05/11/21.
-Resident #2's levothyroxine was changed from 125mcg to 137mcg in back in May 2020.
-On 05/11/21 Resident #2's TSH and T4 levels were tested and returned abnormal.
-The low numbers could possibly be a result of not getting the correct dose of the levothyroxine.
-The PCP expected Resident #2's medications to be administered as ordered.

Interview with the Administrator on 05/13/21 at 4:50pm revealed:
-She was not aware Resident #2's order for levothyroxine was being administered incorrectly.
-She thought maybe the MA did not consider the medication list as medication orders because the medication list was not signed by the PCP.
-If the MA was not sure about the medications listed on the medication list sent by the PCP office, then the MA should have contacted the PCP.

Telephone interview with the facility's contracted pharmacy on 04/13/21 at 10:14am revealed:
-The pharmacy had physicians order dated 12/31/20 for levothyroxine 125mg once daily.
-The pharmacy did not have an order for levothyroxine 137mcg.

Based on observation, record review and interview. it was determined that Resident #2 was not interviewable.

c. Review of Resident #2's current FL2 dated 05/11/21 revealed an order for furosemide 20mg once daily (used to treat reduce blood pressure/edema).

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Review of Resident #2's physician's office medication list revealed:
-On 03/02/21 Resident #2's current medications included furosemide 20mg once daily.
-On 03/12/21 Resident #2's current medications included furosemide 20mg once daily.
-On 05/11/21 Resident #2's current medications included furosemide 20mg once daily.

Review of Resident #2's March, April, and May 2021 medication administration records (MARs) revealed there was no entry for furosemide 20mg once daily on the MARs.

Observation of Resident #2's medication on hand at the facility on 05/12/21 at 3:15pm revealed furosemide 20mg was not available for administration.

Interview the medication aide (MA) on 05/12/21 at 3:12pm revealed:
-She did not know Resident #2 had an order for furosemide 20mg once daily.
-She could not recall if she had ever administered Resident #2 furosemide.
-She received Resident #2's dated 05/11/21 and she faxed it to the pharmacy.
-She had seen the medication list sent from Resident #2's Primary Care Provider (PCP) but did not consider them orders.
-She did not the check the medication list that was sent back to the facility with Resident #2 to see if medication orders had changed.

Telephone interview with Resident #2's PCP on 04/13/21 at 9:20am revealed:
-Resident #2 was ordered furosemide 20 once daily due to hypertension, edema and chronic kidney disease.

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-The furosemide 20mg was ordered in March 2021.
-The PCP expected Resident #2's medications to be administered as ordered.

Interview with the Administrator on 05/13/21 at 4:50pm revealed:
-She did not know Resident #2 had an order for furosemide 20mg once daily and the medication was not being administered.
-She expected the care managers to review all paperwork received the PCP's office.
-If there was confusion with the orders then the care manager should contact the PCP.
-The care manager no long worked at the facility and she was unable to explain why the medication list in Resident #2's record was not clarified with the PCP.

Telephone interview with the facility's contracted pharmacy on 04/13/21 at 10:14am revealed they never received an order for furosemide 20mg once daily.

Based on observation, record review and interview, it was determined that Resident #2 was not interviewable.