Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	HAL011130		02/12/2015

NAME OF PROVIDER OR SUPPLIER
RICHARD A WOOD, JR ASSISTED LIVING CEN

STREET ADDRESS, CITY, STATE, ZIP CODE
100 WESLEY DRIVE
ASHEVILLE, NC 28803

(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 Buncombe County Department of Social Services conducted a biennial survey on February 11, 2015 and February 12, 2105.	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, record review and interview, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 (Resident #3) sampled residents. (Ibuprofen and Carafate.) The findings are: Review of Resident #3's current FL2 dated 2/26/14 revealed: - Diagnoses of arthritis-multiple joints, chronic back pain, and gastroesophageal reflux disease (GERD). - An admission date of 2/24/14. 1. Continued review of Resident #3's record revealed: - A telephoned medication order for Ibuprofen 200mg, 2 tablets once a day with food dated 11/21/14. (Ibuprofen is nonsteroidal	D 358		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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D 358	Continued From page 1 anti-inflammatory drug (NSAID) used to treat pain and inflammation). - The telephone order above was countersigned by the prescribing physician on 12/12/14 with prn (as needed) added to the end of order by the physician. - A clarification telephone order dated 11/24/14 and countersigned by the prescribing physician on 12/12/14, "OK to given 2 tablets Ibuprofen 200mg daily with food, MD aware of allergies." (Resident #3 had noted medication allergies to NSAIDs in her record). Review of a signed physician order sheet (POS) dated 1/9/15 revealed: - A typewritten order for Ibuprofen 200mg, 2 tablets by mouth every day with food with a scheduled time of administration of 9:00am. - A handwritten entry by the physician beside the Ibuprofen order, "change to prn, pls" (please.) - A separate typewritten order for Ibuprofen 200mg, 2 tablets up to twice daily if pain persists/chest pain. Review of a signed POS dated 2/5/15 revealed: - A typewritten order for Ibuprofen 200mg, 2 tablets by mouth every day with food with a scheduled time of administration of 9:00am. - A handwritten entry by the physician beside the Ibuprofen order, "clarification (second request) this prn please." Review of Resident #3's Medication Administration Records (MARs) for December 2014, and January and February 2015 revealed: - The am Ibuprofen 200mg, 2 tablets had been initialed as administered every day at 9:00am from 12/1/14 through 2/12/15. - One dose of the prn Ibuprofen 200mg, 2 tablets up to twice daily as needed for chest pain, was	D 358		

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D 358	Continued From page 2 administered on 12/5/14. Resident #3 received an additional medication order dated 1/28/15 for Diclofenac 75mg, 1 tablet twice daily for one month. (Diclofenac 75mg is an NSAID used to treat pain and inflammation, and should not be administered with other NSAIDS such as Ibuprofen). Review of Resident #3's Medication Administration Records (MARs) for January and February 2015 revealed Diclofenac 75mg had been administered twice daily at 8:00am and 8:00pm from 1/29/15 through 2/12/15. Interview with dispensing Pharmacist on 2/12/15 at 1:00pm revealed: - The most recent orders the pharmacy had on file for Ibuprofen for Resident #3 were for a routine morning dose with food, and a prn dose up to twice daily, dated 11/24/14. - The most recent refills for Ibuprofen 200mg (2 tablets) was on 1/12/15 for 60 tablets, and 2/4/15 for 30 tablets. (The refills had both prn and routine labels on the package of tablets.) Interview with Resident #3's Physician on 2/12/15 at 1:30pm revealed: - She was not aware the resident had an order for Diclofenac. (Per review, the Diclofenac was from a Nurse Practitioner in the same practice.) - Resident #3 should not have been taking routine NSAIDs. - She wrote prescription orders for Resident #3 on the triplicate medication order forms from the facility, but orders were frequently not implemented. - When the medication orders weren't implemented, the Physician would write clarifications on the POS sheets.	D 358		

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D 358	Continued From page 3 Review of Resident #3's medications on hand on the morning of 2/12/15 revealed: - A bubble pack of Ibuprofen 200mg tablets, with a dispense date of 1/12/15 for 60 tablets with 4 tablets remaining. - A bubble pack of Ibuprofen 200mg tablets, with a dispense date of 2/4/15 for 30 tablets with no tablets used. - Both bubble packs contained both prescription labels, Ibuprofen 200mg, 2 tablets daily with food, and 2 tablets up to twice daily if pain persists. Refer to interview with the facility Director of Nursing (DON) on 2/12/15 at 9:10am. Refer to interview with the Resident #3 on 2/12/15 at 9:15am. 2. Review of Resident #3's record revealed: - A physician's order dated 11/3/14 for Carafate, 10ml at bedtime with a stop date of 12/1/14. (Carafate is a medication used to treat gastric and esophageal ulcers, and GERD.) - Signed POSs dated 12/2/14, 1/9/15, and 2/5/15 with medication orders for Carafate 1gm/10ml up to three times a day as needed for abdominal pain. - A signed POS dated 1/9/15 for Carafate 1gm/10ml, take 10ml at bedtime, with a scheduled administration time of 9:00pm, and a handwritten physician's note beside the order, "change to prn stomach pain." - A signed POS dated 2/5/15 for Carafate 1gm/10ml, take 10ml at bedtime, with a scheduled administration time of 9:00pm, and a handwritten physician's note beside the order, "clarification: prn please." Review of Resident #3's Medication	D 358		

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D 358	Continued From page 4 Administration Records (MARs) for December 2014, and January and February 2015 revealed: - An entry for Carafate 1gm/10ml, 10ml by mouth at bedtime, with a scheduled administration time of 9am, and initialed as administered daily. - No doses of prn Carafate initialed as administered. Interview with the Pharmacist at the dispensing pharmacy on 2/12/15 at 1:00pm revealed: - The original orders for Carafate, both routine at bedtime and 3 times a day prn were written on 11/3/14. - The last time the Carafate was dispensed was on 1/18/15 for 473ml, and the bottle had both the routine and prn labels on the bottle. - There was a stop date on the routine dose of Carafate of 12/1/14, and that order should have been discontinued. Review of Resident #3's medications on hand on the morning of 2/12/15 revealed: - A 473ml bottle of Carafate liquid, 1gm/10ml, with a dispense date of 1/18/15. - Half of the bottle of Carafate had been administered to Resident #3. - Both the prn and routine dose labels for Carafate were on the bottle dispensed on 1/18/15. Interview with Resident #3's Physician on 2/12/15 at 1:30pm revealed: - She wrote prescription orders for Resident #3 on the triplicate medication order forms from the facility, but orders were frequently not implemented. - When the medication orders weren't implemented, the Physician would write clarifications on the POS sheets.	D 358		

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D 358	Continued From page 5 Interview with the Medication Aide on 2/12/15 at 9:40am revealed Resident #3 doesn't ask for prn doses of Carafate. Refer to interview with the facility Director of Nursing (DON) on 2/12/15 at 9:10am. Refer to interview the Resident #3 on 2/12/15 at 9:15am. _____ Interview with the facility Director of Nursing (DON) on 2/12/15 at 9:10am revealed: - Only original scripts and telephone orders written on triplicate order sheets are considered medication orders. - Medication changes written on the signed physician orders sheets (POS) are not faxed to the the pharmacy. - The signed POSs go to the ward clerk to file in the resident's record. - Resident #3's physician will not complete the triplicate order sheets for medication order changes per facility policy. Interview the Resident #3 on 2/12/15 at 9:15am revealed: - She believed she received her medications as ordered by her physician. - She received her prn medications when she requested them. - She has not had any increased stomach upset or reflux over the past two weeks, i.e. the time period she was taking the Ibuprofen and Diclofenac together routinely.	D 358		

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D 400	Continued From page 6	D 400		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care	D 400		
	10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide adequate pharmaceutical care in identifying medication			

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D 400	Continued From page 7 related problems for 1 of 5 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 2/26/14 revealed: - Diagnoses of arthritis-multiple joints, chronic back pain, and gastroesophageal reflux disease (GERD). - An admission date of 2/24/14. 1. Continued review of Resident #3's record revealed: - A telephoned medication order for Ibuprofen 200mg, 2 tablets once a day with food dated 11/21/14. (Ibuprofen is nonsteroidal anti-inflammatory drug (NSAID) used to treat pain and inflammation). - The telephone order above was countersigned by the prescribing physician on 12/12/14 with prn (as needed) added to the order. - A clarification telephone order dated 11/24/14 and countersigned by the prescribing physician on 12/12/14, "OK to given 2 tablets Ibuprofen 200mg daily with food, MD aware of allergies." (Resident #3 had noted medication allergies to NSAID in her record). Review of a signed Physician's order sheet (POS) dated 1/9/15 revealed: - A typewritten order for Ibuprofen 200mg, 2 tablets by mouth every day with food with a scheduled time of administration of 9:00am. - A handwritten entry by the Physician beside the Ibuprofen order, "change to prn, pls" (please.) - A separate typewritten order for Ibuprofen 200mg, 2 tablets up to twice daily if pain persists/chest pain.	D 400		

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D 400	Continued From page 8 Review of a signed POS dated 2/5/15 revealed: - A typewritten order for Ibuprofen 200mg, 2 tablets by mouth every day with food with a scheduled time of administration of 9:00am. - A handwritten entry by the physician beside the Ibuprofen order, "clarification (second request) this prn please." Review of Resident #3's Medication Administration Records (MARs) for December 2014, and January and February 2015 revealed: - The am Ibuprofen 200mg, 2 tablets had been initialed as administered every day at 9:00am from 12/1/14 through 2/12/15. - One dose of the prn Ibuprofen 200mg, 2 tablets up to twice daily as needed for chest pain, was administered on 12/5/14. Interview with Resident #3's Physician on 2/12/15 at 1:30pm revealed: - Resident #3 should not have been taking routine NSAIDs. - She wrote prescription orders for Resident #3 on the triplicate medication order forms from the facility, but orders were frequently not implemented. - When the medication orders weren't implemented, the Physician would write clarifications on the POS sheets. Review of Resident #3's drug regimen review on 1/28/15 revealed: - No recommendations. - No mention of Resident #3 receiving routine Ibuprofen after it was changed to prn. Review of Resident #3's medications on hand on the morning of 2/12/15 revealed: - A bubble pack of Ibuprofen 200mg tablets, with a dispense date of 1/12/15 for 60 tablets with 4	D 400		

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D 400	Continued From page 9 tablets remaining. - A bubble pack of Ibuprofen 200mg tablets, with a dispense date of 2/4/15 for 30 tablets with no tablets used. - Both bubble packs contained both prescription labels, Ibuprofen 200mg, 2 tablets daily with food, and 2 tablets up to twice daily if pain persists. Refer to interview with the facility Director of Nursing (DON) on 2/12/15 at 9:10am. Refer to the interview with the Consultant Pharmacist on 2/12/15 at 1:50pm. 2. Review of Resident #3's record revealed: - A physician's order dated 11/3/14 for Carafate, 10ml at bedtime with a stop date of 12/1/14. (Carafate is a medication used to treat gastric and esophageal ulcers, and GERD.) - Signed POSs dated 12/2/14, 1/9/15, and 2/5/15 with medication orders for Carafate 1gm/10ml up to three times a day as needed for abdominal pain. - A signed POS dated 1/9/15 for Carafate 1gm/10ml, take 10ml at bedtime, with a scheduled administration time of 9:00pm, and a handwritten physician's note beside the order, "change to prn stomach pain." - A signed POS dated 2/5/15 for Carafate 1gm/10ml, take 10ml at bedtime, with a scheduled administration time of 9:00pm, and a handwritten physician's note beside the order, "clarification: prn please." Review of Resident #3's Medication Administration Records (MARs) for December 2014, and January and February 2015 revealed: - An entry for Carafate 1gm/10ml, 10ml by mouth at bedtime, with a scheduled administration time of 9:00am, and initialed as administered daily.	D 400		

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D 400	Continued From page 10 - No doses of prn Carafate initialed as administered. Interview with the Pharmacist at the dispensing pharmacy on 2/12/15 at 1:00pm revealed there was a stop date on the routine dose of Carafate of 12/1/14, and that order should have been discontinued. Review of Resident #3's medications on hand on the morning of 2/12/15 revealed: - A 473ml bottle of Carafate liquid, 1gm/10ml, with a dispense date of 1/18/15. - Half of the bottle of Carafate had been administered to Resident #3. - Both the prn and routine dose labels for Carafate were on the bottle dispensed on 1/18/15. Interview with Resident #3's Physician on 2/12/15 at 1:30pm revealed: - She wrote prescription orders for Resident #3 on the triplicate medication order forms from the facility, but orders were frequently not implemented. - When the medication orders weren't implemented, the Physician would write clarifications on the POS sheets. Review of Resident #3's drug regimen review on 1/28/15 revealed: - No recommendations. - No mention of Resident #3 receiving routine Carafate at bedtime after it was changed to prn. Refer to interview with the facility Director of Nursing (DON) on 2/12/15 at 9:10am. Refer to interview with the Consultant Pharmacist on 2/12/15 on 1:50pm.	D 400		

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D 400	Continued From page 11 Interview with the facility Director of Nursing (DON) on 2/12/15 at 9:10am revealed: - Only original scripts and telephone orders written on triplicate order sheets are considered medication orders. - Medication changes written on the signed physician orders sheets (POS) are not faxed to the the pharmacy. - The signed POSs go the the ward clerk to file in the resident's record. - Resident #3's physician will not complete the triplicate order sheets for medication orders per facility policy. Interview with the Consultant Pharmacist on 2/12/15 at 1:50pm revealed: - He had completed a drug regimen review for Resident #3 on 1/28/15. - He routinely checks the MARs but does not look at any medication order changes written on the signed POS. - He was not used to seeing medication changes on the POS. - Medication changes are usually written on the triplicate telephone order forms. - "I guess I missed it," i.e. the medication order changes for Resident #3.	D 400		