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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL029001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ <i>es</i>	(X3) DATE SURVEY COMPLETED  02/05/2015
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NAME OF PROVIDER OR SUPPLIER  WESTANNA FAMILY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 716 WEST 5TH STREET LEXINGTON, NC 27292  <i>County: Davidson</i>
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(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
C 000	Initial Comments  An annual survey was conducted by staff with the Adult Care Licensure Section on 02/04-05/2015.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care  10A NCAC 13G .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 observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health care needs for 2 of 3 sampled residents (Residents #1 and #3) regarding ordered laboratory tests and physician response to pharmacy recommendations.  The findings are:  A. Review of Resident #3's current FL-2 dated 10/27/14 revealed diagnoses included schizoaffective disorder bipolar type, anemia, vitamin D deficiency, and hypertension.  Review of Resident #3's record revealed: -A physician's order dated 01/29/15 for a BMP (basic metabolic profile) and a CBC (complete blood count). -No documentation the BMP or CBC was completed or scheduled for completion.  Interview on 02/04/15 at 9:15 am with the Supervisor-in-Charge (SIC) revealed: -She did not schedule the laboratory tests ordered on 01/29/15. -She thought it was the Nurse Practitioner's (NP's) responsibility to schedule ordered	C 246	<i>The Administrator shall ensure referral + follow up related to health care are met to ensure routine + acute health care need of each resident. The Administrator will monitor this rule area using a healthcare followup form to ensure compliance. Monitoring shall be done weekly X3, Biweekly X3, Monthly X3, + Quarterly thereafter. Monitoring reports shall be available at the facility for review</i>	<i>3/9/15</i>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>C. Ullip M. Culshaw</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/14/2015</i>
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POC Approved  
per B. Moore / *es*  
03-24-2014

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C 246	<p>Continued From page 1</p> <p>laboratory tests "because she's the one who wrote the order".</p> <ul style="list-style-type: none"> <li>-An employee from a sister facility routinely transported all residents to any scheduled appointments, so if the NP did not schedule an appointment, she would assume the transportation employee would do it.</li> <li>-The SIC did not call the sister facility to inform them of the order for laboratory tests.</li> <li>-The SIC confirmed she was not sure what her responsibility was when the physician wrote orders for laboratory tests.</li> </ul> <p>Interview on 02/04/15 at 9:30 am with the SIC of the sister facility revealed:</p> <ul style="list-style-type: none"> <li>-There was an employee whose primary responsibility was to transport residents from all their managed facilities to scheduled appointments.</li> <li>-It was the responsibility of the SIC at each individual facility to call and schedule appointments with the transportation employee.</li> </ul> <p>Interview on 02/04/15 at 10:00 am with Resident #3 revealed she was unaware the physician had ordered laboratory testing or that the tests had not been scheduled.</p> <p>B. Review of Resident #1's current FL-2 dated 09/11/14 revealed diagnoses included osteopenia and osteoarthritis.</p> <p>Review of Resident #1's record revealed:</p> <ul style="list-style-type: none"> <li>-A pharmacy recommendation dated 09/30/14 asking the physician to consider adding a calcium and vitamin D supplement to decrease the risk of fracture due to the resident's long term use of a medication which can increase fracture risk.</li> <li>-The pharmacy recommendation was signed by the physician but did not include a response to</li> </ul>	C 246		

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C 246	<p>Continued From page 2</p> <p>the recommendation.</p> <p>-There were two "Faxed" stamps on the recommendation indicating it was faxed from the physician's office to the facility on 10/01/14 and 10/02/14.</p> <p>-No documentation the facility followed up with the physician to request a response to the recommendation.</p> <p>Interview on 02/04/15 at 10:20 am with the Supervisor-in-Charge (SIC) revealed:</p> <p>-She faxed the pharmacy recommendation to the physician's office.</p> <p>-She did not know why she did not follow up with the physician when the recommendation was returned without a response.</p> <p>Telephone interview on 02/04/15 at 10:45 am with a representative from the physician's office revealed:</p> <p>-The pharmacy recommendation was signed by the Physician's Assistant (PA) and returned to the facility via fax on 10/01/14 and again on 10/02/14.</p> <p>-She did not know if the PA's failure to respond to the recommendation meant she did not want to start the medication, or if the PA's signature indicated she agreed with the recommendation and wanted the medication started.</p> <p>-She did not know why the facility did not follow up with the office for clarification.</p> <p>Review of documentation received via fax on 02/04/15 after follow up by facility staff revealed the physician wrote an order for Caltrate D twice daily. (Caltrate D is a calcium/vitamin D supplement.)</p> <p>Based on record review and interviews with staff, it was determined Resident #1 was not interviewable.</p>	C 246		

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C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family 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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications (probiotics) were administered as ordered for 1 of 3 sampled residents (Resident #2).</p> <p>The findings are:</p> <p>1. Review of Resident #2's current FL-2 dated 05/20/14 revealed diagnoses included type II diabetes, dysphagia, hypertension, gastroesophageal reflux disease, and hypothyroidism.</p> <p>Review of Resident #2's record revealed a physician order dated 08/04/14 for an antibiotic (Levaquin), a urinary anti-infective (Cystex) and for probiotics 1 tablet by mouth daily with instructions to "stay on (probiotics) continuously. (Probiotics are microorganisms used to replenish "good bacteria".)</p> <p>Review of the August 2014 Medication Administration Record (MAR) revealed the probiotics order was not transcribed to the MAR for administration to the resident.</p>	C 330	<p>The Administrator shall ensure that the preparation and Administration of medications, prescription and non-prescription and treatments by staff are in accordance with MD orders which are maintained in the Residents record and Medication Administration follow facility policies + procedures.</p> <p>The Administrator will monitor this rule area using a monitoring form. Monitoring shall be done weekly X3, Biweekly X3, Monthly X3 + Quarterly thereafter. Reports will be available for review.</p>	3/1/15

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C 330	<p>Continued From page 4</p> <p>Review of the September 2014 MAR through February 2015 MAR revealed there was no probiotics scheduled for administration.</p> <p>Review of Resident #2's medications on hand revealed there was no probiotics available for administration to the resident.</p> <p>Interview on 02/04/15 at 2:50 pm with a representative from the facility's contracted pharmacy revealed: -The 08/04/14 orders were not faxed to the pharmacy. -It was the facility's responsibility to fax all medication orders, even if being filled by someone else, so the medications could be entered into the system and appear on the MAR for administration.</p> <p>Interview on 02/04/15 at 3:20 pm with a representative from the local pharmacy revealed they filled the antibiotic order but did not dispense the other medication because it was available over-the-counter.</p> <p>Telephone interview on 02/04/15 at 3:30 pm with Resident #2's family member revealed: -She purchased a bottle of over-the-counter probiotics in August 2014. -She did not know how many tablets were in the bottle or when the supply was depleted. -She had not purchased additional probiotics because the facility purchased refills through the contracted pharmacy. -She was confident the facility administered medications as ordered by the physician.</p> <p>Interview on 02/05/15 at 8:40 am with the Supervisor-in-Charge (SIC) revealed: -She did not remember giving the probiotics but</p>	C 330		

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C 330	<p>Continued From page 5</p> <p>since it was several months ago, she might have given it and not remember.</p> <ul style="list-style-type: none"> <li>-She was not aware the probiotics were ordered to be administered on a continual basis.</li> <li>-She did not know why the probiotics order was not transcribed to the MAR for administration.</li> <li>-She thought she did not need to fax medication orders to the pharmacy if the medication was being provided by a family member.</li> </ul> <p>Interview on 02/05/15 at 8:45 am with Resident #2 revealed:</p> <ul style="list-style-type: none"> <li>-She relied on the facility staff to administer her medications as ordered by the physician.</li> <li>-She thought the facility administered her medications as ordered by the physician and had no complaints regarding her medications.</li> <li>-She "got several things" in August 2014 but was not sure whether or not she received the probiotics.</li> <li>-She was not sure whether or not she was taking the probiotics currently.</li> </ul> <p>2. Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> <li>-A physician's order dated 11/11/14 for Nizoral cream twice daily under breasts with instructions to keep at bedside. (Nizoral is an antifungal cream.)</li> <li>-The order did not include a stop date.</li> </ul> <p>Review of the November 2014 Medication Administration Record (MAR) revealed the Nizoral cream was not transcribed to the MAR for administration to the resident.</p> <p>Review of the December 2014 through February 2015 MARs revealed the Nizoral cream was not listed for administration to the resident.</p> <p>Interview on 02/04/15 at 1:10 pm with Resident</p>	C.330		

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C 330	<p>Continued From page 6</p> <p>#2 revealed: -She finished the "breast cream" but still had some in case she needed some more. -The resident located a tube of ketoconazole (generic for Nizoral) in her dresser drawer. -The ketoconazole had a local pharmacy label indicating it was dispensed on 11/11/14.</p> <p>Interviews on 02/04/15 at 12:45 pm and 02/05/15 at 8:40 am with the Supervisor-in-Charge (SIC) revealed: -The Nizoral was filled at the local pharmacy by the resident's family member. -The resident's family member said the medication could be kept at the bedside, so the SIC thought it did not need to be transcribed to the MAR. -She did not monitor the resident's use of the Nizoral; therefore, she did not know the resident was not applying it twice daily as ordered.</p> <p>3. Review of Resident #2's record revealed a physician's order dated 01/20/15 for Polysporin twice daily to right cheek surgery as needed for 7 days. (Polysporin is an antibiotic ointment.)</p> <p>Review of the January 2015 Medication Administration Record (MAR) revealed the Polysporin was not transcribed to the MAR for administration to the resident.</p> <p>Interview on 02/04/15 at 1:10 pm with Resident #2 revealed: -She located a tube of Polysporin in her dresser drawer. -She used the ointment twice a day on her cheek. -The Polysporin had a local pharmacy label indicating it was dispensed on 01/20/15.</p> <p>Interviews on 02/04/15 at 12:45 pm and 02/05/15</p>	C 330		

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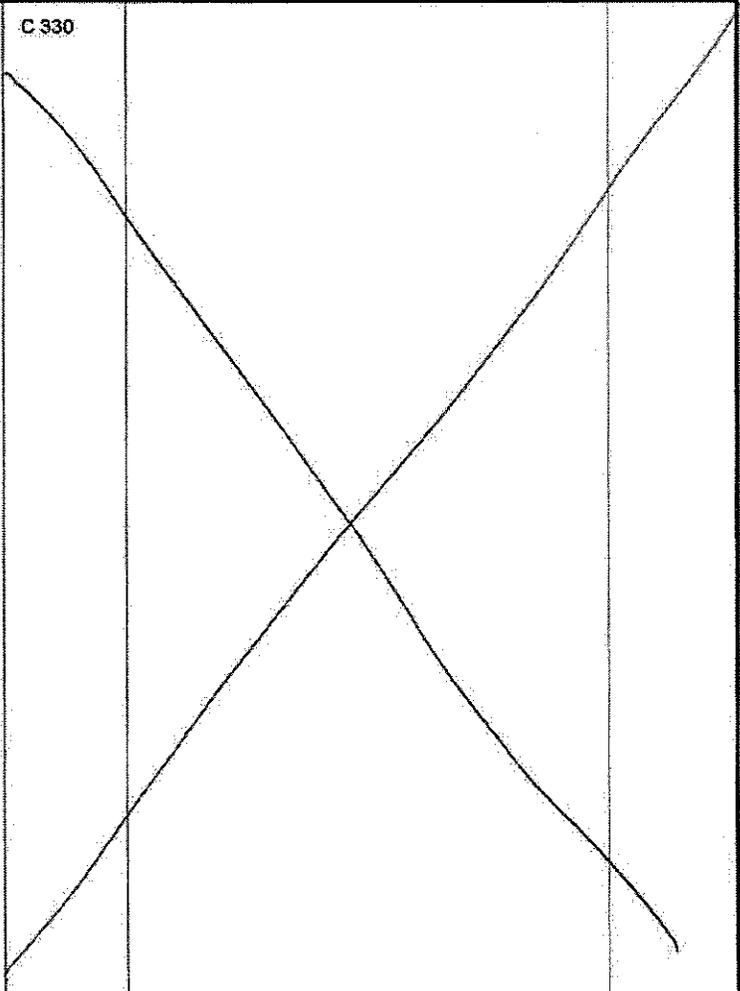
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C 330	<p>Continued From page 7</p> <p>at 8:40 am with the Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> <li>-The Polysporin was filled at the local pharmacy by the resident's family member.</li> <li>-The resident's family member said the medication could be kept at the bedside, so the SIC thought it did not need to be transcribed to the MAR.</li> <li>-She did not monitor the resident's use of the Polysporin; therefore, she did not know the resident continued to use the ointment after the time frame ordered by the physician.</li> </ul> <p>4. Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> <li>-A physician's order for triamcinolone twice daily to back. (Triamcinolone is a topical corticosteroid.)</li> <li>-The order did not include a stop date.</li> </ul> <p>Review of the January 2015 Medication Administration Record (MAR) revealed the triamcinolone was transcribed to the MAR and documented as administered twice daily from 01/20/15 through 01/31/15.</p> <p>Review of the February 2015 MAR revealed the triamcinolone was listed on the MAR for administration to the resident.</p> <p>Observation on 02/04/15 at 1:00 pm of Resident #2's medications on hand revealed:</p> <ul style="list-style-type: none"> <li>-There was a tube of triamcinolone ointment stored with the resident's medications.</li> <li>-The triamcinolone had a local pharmacy label indicating it was dispensed on 01/20/15.</li> <li>-The pharmacy label was from a local pharmacy and not from the facility's contracted pharmacy.</li> </ul> <p>Interview on 02/04/15 at 2:50 pm with a representative from the facility's contracted</p>	C 330		

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C 330	<p>Continued From page 8</p> <p>pharmacy revealed: -The 01/20/15 order was not faxed to the pharmacy. -It was the facility's responsibility to fax all medication orders, even if being filled by someone else, so the medications could be entered into the system and the MARs printed accurately.</p> <p>Interviews on 02/04/15 at 12:45 pm and 02/05/15 at 8:40 am with the Supervisor-in-Charge (SIC) revealed: -The triamcinolone was filled at the local pharmacy by the resident's family member. -She did not know why the triamcinolone was not listed on the February MAR for administration to the resident. -She thought she did not need to fax medication orders to the pharmacy if the medication was being provided by a family member. -The triamcinolone was no longer being administered to the resident. -The SIC did not realize the triamcinolone order was written as a continuous order without a stop date.</p> <p>Interview on 02/04/15 at 1:10 pm with Resident #2 revealed: -She used the ointment for "back itch" but was finished with it. -The staff had more of the triamcinolone in case she needed it again.</p>	C 330		
C 342	<p>10ANCAC 13G .1004(j) Medication Administration</p> <p>10ANCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the</p>	C 342	<p>see next page</p>	

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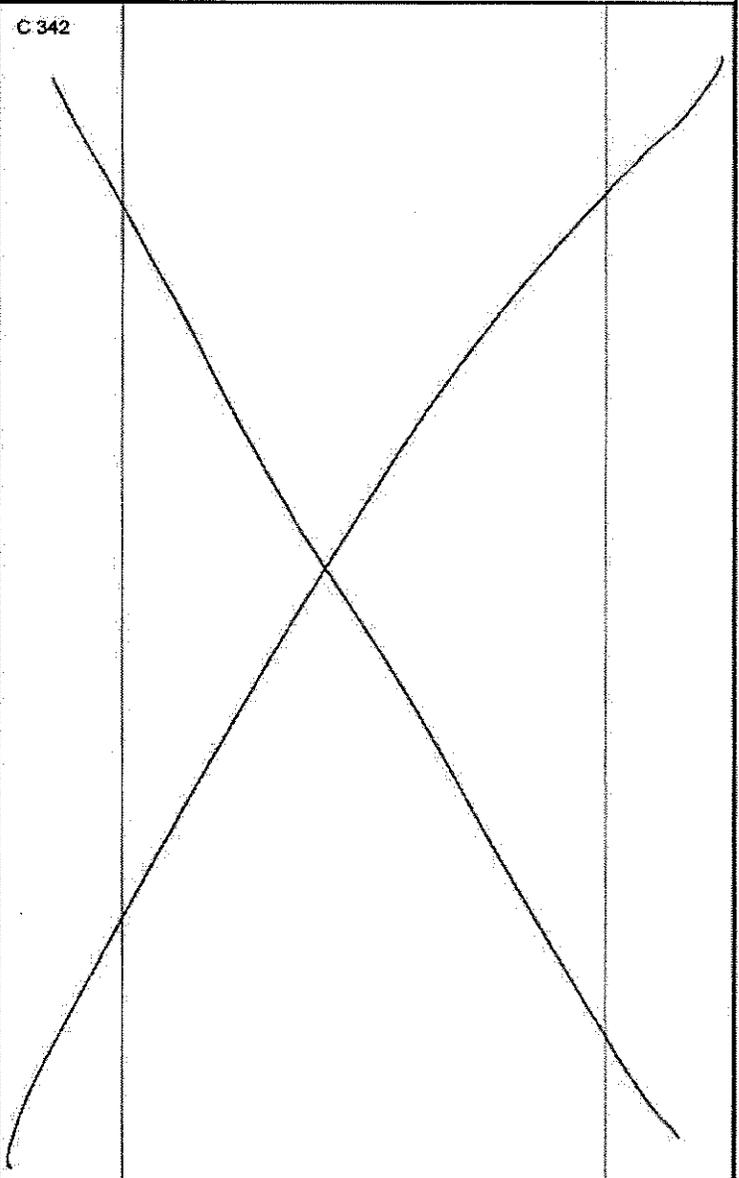
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C 342	<p>Continued From page 9</p> <p>following:                      (1) resident's name;                      (2) name of the medication or treatment order;                      (3) strength and dosage or quantity of medication administered;                      (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).</p> <p>This Rule is not met as evidenced by:                      Based on observations, interviews, and record reviews, the facility failed to ensure the Medication Administration Records (MARs) for 2 of 3 sampled residents (Residents #1 and #2) were accurate and included the name and dosage of the medication and instructions for administration.</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL-2 dated 05/20/14 revealed diagnoses included type II diabetes, dysphagia, hypertension, gastroesophageal reflux disease, and hypothyroidism.</p> <p>1. Review of Resident #2's record revealed a physician's order dated 08/04/14 for Levaquin 500 mg daily for 7 days, Cystex 30 cc daily for 7</p>	C 342	<p>The Administrator shall ensure the residents medication Administration record shall be accurate + include items 1 thru 8 as listed in Rule 10A NCAC 136 .1004(j). The Administrator will monitor the Medication Admin Records for accuracy. Monitoring will be done by the Admin. using a Monitoring form. Monitoring will be done Weekly x 3, Biweekly x 3, Monthly x 3, then quarterly thereafter. Monitoring will be available at the facility for review.</p>	3-1-15

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C 342	<p>Continued From page 10</p> <p>days, and probiotics 1 tablet daily with instructions to stay on the probiotics continuously. (Levaquin is an antibiotic; Cystex is a urinary antinfective; and probiotics are microorganisms used to replenish "good bacteria".)</p> <p>Review of the August 2014 Medication Administration Record (MAR) revealed: -The Levaquin was transcribed and documented as administered daily from 08/04/14 through 08/10/14. -Neither the probiotics nor the Cystex was transcribed to the MAR for administration to the resident.</p> <p>Review of the September 2014 MAR through February 2015 MAR revealed there was no probiotics listed on the MAR for administration.</p> <p>Interview on 02/04/15 at 2:50 pm with a representative from the facility's contracted pharmacy revealed: -The 08/04/14 orders were not faxed to the pharmacy. -It was the facility's responsibility to fax all medication orders, even if being filled by someone else, so the medications could be entered into the system and the MARs printed accurately.</p> <p>Telephone interview on 02/04/15 at 3:30 pm with Resident #2's family member revealed: -She purchased over-the-counter probiotics and Cystex in August 2014. -She did not know how many doses were in either bottle or when the supply was depleted. -She had not purchased additional probiotics because the facility purchased refills through the contracted pharmacy. -She was confident the facility administered</p>	C 342		

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(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
C 342	<p>Continued From page 11</p> <p>medications as ordered by the physician.</p> <p>Interview on 02/05/15 at 8:40 am with the Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> <li>-She did not remember giving the Cystex or probiotics but since it was several months ago, she might have given them and not remember.</li> <li>-She was not aware the probiotics were ordered to be administered on a continual basis.</li> <li>-She did not know why the 08/04/14 order for probiotics and Cystex was not transcribed to the MAR for administration.</li> <li>-She thought she did not need to fax medication orders to the pharmacy if the medication was being provided by a family member.</li> </ul> <p>Interview on 02/05/15 at 8:45 am with Resident #2 revealed:</p> <ul style="list-style-type: none"> <li>-She relied on the facility staff to administer her medications as ordered by the physician.</li> <li>-She "got several things" in August 2014 but was not sure the names of the medications.</li> <li>-She had no complaints regarding her medications.</li> </ul> <p>2. Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> <li>-A physician's order dated 11/11/14 for Nizoral cream twice daily under breasts with instructions to keep at bedside. (Nizoral is an antifungal cream.)</li> <li>-The order did not include a stop date.</li> </ul> <p>Review of the November 2014 Medication Administration Record (MAR) revealed the Nizoral cream was not transcribed to the MAR for administration to the resident.</p> <p>Review of the December 2014 through February 2015 MARs revealed the Nizoral cream was not listed for administration to the resident.</p>	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL029001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WESTANNA FAMILY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>716 WEST 5TH STREET LEXINGTON, NC 27292</b>
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C 342	<p>Continued From page 12</p> <p>Interview on 02/04/15 at 1:10 pm with Resident #2 revealed:</p> <ul style="list-style-type: none"> <li>-She finished the "breast cream" but still had some in case she needed some more.</li> <li>-The resident located a tube of ketoconazole (generic for Nizoral) in her dresser drawer.</li> <li>-The ketoconazole had a pharmacy label indicating it was dispensed on 11/11/14.</li> <li>-The pharmacy label was from a local pharmacy and not from the facility's contracted pharmacy.</li> </ul> <p>Interview on 02/04/15 at 2:50 pm with a representative from the facility's contracted pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-The 11/11/14 order was not faxed to the pharmacy.</li> <li>-It was the facility's responsibility to fax all medication orders, even if being filled by someone else, so the medications could be entered into the system and the MARs printed accurately.</li> </ul> <p>Interviews on 02/04/15 at 12:45 pm and 02/05/15 at 8:40 am with the Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> <li>-The Nizoral was filled at the local pharmacy by the resident's family member.</li> <li>-The resident's family member said the medication could be kept at the bedside, so the SIC thought it did not need to be transcribed to the MAR.</li> <li>-She thought she did not need to fax medication orders to the pharmacy if the medication was being provided by a family member.</li> <li>-She did not monitor or document the resident's use of the Nizoral.</li> </ul> <p>3. Review of Resident #2's record revealed a physician's order dated 01/20/15 for Polysporin</p>	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL029801</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
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C 342	<p>Continued From page 13</p> <p>twice daily to right cheek surgery as needed for 7 days. (Polysporin is an antibiotic ointment.)</p> <p>Review of the January 2015 Medication Administration Record (MAR) revealed the Polysporin was not transcribed to the MAR for administration to the resident.</p> <p>Interview on 02/04/15 at 1:10 pm with Resident #2 revealed: -She located a tube of Polysporin in her dresser drawer. -She uses the ointment twice a day on her cheek. -The Polysporin had a pharmacy label indicating it was dispensed on 01/20/15. -The pharmacy label was from a local pharmacy and not from the facility's contracted pharmacy.</p> <p>Interview on 02/04/15 at 2:50 pm with a representative from the facility's contracted pharmacy revealed: -The 01/20/15 order was not faxed to the pharmacy. -It was the facility's responsibility to fax all medication orders, even if being filled by someone else, so the medications could be entered into the system and the MARs printed accurately.</p> <p>Interviews on 02/04/15 at 12:45 pm and 02/05/15 at 8:40 am with the Supervisor-in-Charge (SIC) revealed: -The Polysporin was filled at the local pharmacy by the resident's family member. -The resident's family member said the medication could be kept at the bedside, so the SIC thought it did not need to be transcribed to the MAR. -She thought she did not need to fax medication orders to the pharmacy if the medication was</p>	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL029001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
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C 342	<p>Continued From page 14</p> <p>being provided by a family member. -She did not monitor or document the resident's use of the Polysporin.</p> <p>4. Review of Resident #2's record revealed: -A physician's order for triamcinolone twice daily to back. (Triamcinolone is a topical corticosteroid.) -The order did not include a stop date.</p> <p>Review of the January 2015 Medication Administration Record (MAR) revealed the triamcinolone was transcribed to the MAR and documented as administered twice daily from 01/20/15 through 01/31/15.</p> <p>Review of the February 2015 MAR revealed the triamcinolone was listed on the MAR for administration to the resident.</p> <p>Observation on 02/04/15 at 1:00 pm of Resident #2's medications on hand revealed: -There was a tube of triamcinolone ointment stored with the resident's medications. -The triamcinolone had a pharmacy label indicating it was dispensed on 01/20/15. -The pharmacy label was from a local pharmacy and not from the facility's contracted pharmacy.</p> <p>Interview on 02/04/15 at 2:50 pm with a representative from the facility's contracted pharmacy revealed: -The 01/20/15 order was not faxed to the pharmacy. -It was the facility's responsibility to fax all medication orders, even if being filled by someone else, so the medications could be entered into the system and the MARs printed accurately.</p>	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL029001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
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C 342	<p>Continued From page 15</p> <p>Interviews on 02/04/15 at 12:45 pm and 02/05/15 at 8:40 am with the Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> <li>-The triamcinolone was filled at the local pharmacy by the resident's family member.</li> <li>-She did not know why the triamcinolone was not listed on the February MAR for administration to the resident.</li> <li>-She thought she did not need to fax medication orders to the pharmacy if the medication was being provided by a family member.</li> <li>-The triamcinolone was no longer being administered to the resident.</li> <li>-The SIC did not realize the triamcinolone order was written as a continuous order without a stop date.</li> </ul> <p>Interview on 02/04/15 at 1:10 pm with Resident #2 revealed:</p> <ul style="list-style-type: none"> <li>-She used the ointment for "back itch" but was finished with it.</li> <li>-The staff had more of the triamcinolone in case she needed it again.</li> </ul> <p>B. Review of Resident #1's current FL-2 revealed diagnoses included Alzheimer's dementia, hypertension, chronic obstructive pulmonary disease, and angina.</p> <p>1. Review of Resident #1's record revealed:</p> <ul style="list-style-type: none"> <li>-A physician's order dated 12/22/14 for Trazodone 50 mg as needed every night at bedtime. (Trazodone is an antidepressant often used for sleep.)</li> <li>-A subsequent physician's order dated 01/05/15 to decrease the Trazodone to 25 mg nightly.</li> <li>-A subsequent physician's order dated 01/19/15 to discontinue the Trazodone.</li> </ul> <p>Review of the December 2014 Medication</p>	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL029001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
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C 342	<p>Continued From page 16</p> <p>Administration Record (MAR) revealed Trazodone 50 mg was documented as administered nightly from 12/26/14 through 12/31/14.</p> <p>Review of the January 2015 MAR revealed: -The Trazodone 50 mg entry was not discontinued on 01/05/15 as ordered by the physician. -The 01/05/15 order for Trazodone 25 mg nightly was not transcribed to the MAR. -Trazodone 50 mg was documented as administered nightly from 01/01/15 through 01/18/15.</p> <p>Review of the February 2015 MAR revealed: -Trazodone 25 mg was scheduled for administration nightly at 8:00 pm. -Trazodone 25 mg was documented as administered nightly from 02/01/15 through 02/04/15.</p> <p>Interview on 02/04/15 at 11:05 am with the Supervisor-in-Charge (SIC) revealed: -When she received the 01/05/15 order to decrease the Trazodone, she was instructed by the pharmacist to cut the 50 mg tablets in half and give a half tablet. -She only gave a half tablet of Trazodone 50 mg from 01/05/15 through 01/18/15. -She knew she was supposed to change the entry on the January MAR to the new dosage and instructions, but she did not know why she did not change it. -She discontinued the Trazodone as ordered on 01/19/15, but inadvertently signed the February MAR as having administered the medication. -She did not administer any Trazodone to Resident #2 in February.</p>	Q 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL029001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
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C 342	<p>Continued From page 17</p> <p>Interview on 2/04/15 at 11:17 am with a representative from the facility's contracted pharmacy revealed the 01/19/15 order to discontinue the Trazodone was not faxed to the pharmacy; therefore, it was not discontinued in the computer system and continued to appear on the MARs for administration.</p> <p>Observation on Resident #1's medications on hand revealed: -A bubble pack of Trazodone 50 mg whole tablets with a dispense date of 01/02/15. -There were 22 of the 30 dispensed tablets remaining in the pack. -A second bubble pack of Trazodone 50 mg half tablets with a dispense date of 01/26/15. -There were 30 of the 30 dispensed half tablets remaining in the pack.</p> <p>Based on record review and interviews with staff, it was determined Resident #1 was not interviewable.</p> <p>2. Review of Resident #1's record revealed a physician's order dated 01/05/15 for Naprosyn 500 mg twice daily for 7 days. (Naprosyn is a nonsteroidal anti-inflammatory drug.)</p> <p>Review of the January 2015 Medication Administration Record (MAR) revealed the Naprosyn was not transcribed to the MAR for administration to the resident.</p> <p>Interview on 02/04/15 at 11:05 am with the Supervisor-In-Charge (SIC) revealed: -She knew she administered the Naprosyn as ordered by the physician. -She did not know why she did not transcribe the order to the MAR or document the administration of the medication.</p>	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL029001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
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C 342	<p>Continued From page 18</p> <p>Interview on 02/04/15 at 11:17 am with a representative from the facility's contracted pharmacy revealed 14 tablets of Naprosyn 500 mg were dispensed on 01/05/15.</p> <p>Based on record review and interviews with staff, it was determined Resident #1 was not interviewable.</p>	C 342		

## Shook, Linda

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**From:** Moore, Bonnie  
**Sent:** Tuesday, March 24, 2015 8:12 AM  
**To:** stout, nina  
**Cc:** Shook, Linda  
**Subject:** Plan of Correction for Westanna Family Care  
**Attachments:** Westanna Family Care 2015-02-05 POC SFMR11.pdf

Please find attached to this email the approved Plan of Correction for Westanna Family Care, FCL-029-001 Davidson County.

Thank you,

Bonnie Moore, RN  
N.C. Department of Health and Human Services  
Facility Survey Consultant - Division of Health Service Regulation  
Adult Care Licensure Section  
12 Barbetta Drive  
Asheville, NC 28806  
Phone: 336-341-8130  
Fax: 828-260-5040  
[Bonnie.moore@dhhs.nc.gov](mailto:Bonnie.moore@dhhs.nc.gov)  
[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr)

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