

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2015
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NAME OF PROVIDER OR SUPPLIER ULTIMATE FCH 9	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 SANDERS DRIVE WILLOW SPRINGS, NC 27592
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C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on 09/15/15 - 09/16/15.	C 000		
C 105	<p>10A NCAC 13G .0317(d) Building Service Equipment</p> <p>10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C).</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure the hot water temperatures at 3 of 3 fixtures (sinks and tub/shower) used by residents were maintained at a minimum of 100 degrees Fahrenheit (F) and did not exceed 116 degrees F. The findings are:</p> <p>Observation of the kitchen sink on 09/15/15 at 9:04 a.m. revealed: - Hot water temperature at the sink was 118 degrees F. - No steam was observed.</p> <p>Observation of the residents' common bathroom on 09/15/15 at 9:31 a.m. revealed: - Hot water temperature in the bathtub/shower was 120 degrees F. - Hot water temperature at the sink was 118 degrees F. - No steam was observed.</p> <p>Interview with the medication aide on 09/15/15 at</p>	C 105		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 105	<p>Continued From page 1</p> <p>10:00 a.m. revealed:</p> <ul style="list-style-type: none"> - He did not know the required hot water temperature ranges. - He just started working at the facility about 3 weeks ago. - He did not know if the facility had a thermometer or water temperature log. - He would contact the Administrator about the hot water temperatures. - The residents have one common bathroom that they use. - The residents also have access to and use the kitchen sink. - No residents had complained about the water being too hot. <p>Interview with the medication aide on 09/15/15 at 10:58 a.m. revealed they just turned down the thermostat on the hot water heater.</p> <p>Recheck of hot water temperatures in the kitchen on 09/15/15 at 2:25 p.m. revealed:</p> <ul style="list-style-type: none"> - The hot water temperature at the sink was 120 degrees F. - Steam was observed. <p>Recheck of the hot water temperatures of the residents' common bathroom on 09/15/15 at 2:18 p.m.:</p> <ul style="list-style-type: none"> - Hot water temperature in the bathtub/shower was 120 degrees F. - Hot water temperature at the sink was 118 degrees F. - Steam was observed. <p>Interview with the Administrator on 09/15/15 at 2:28 p.m. revealed:</p> <ul style="list-style-type: none"> - She had not received any reports about the hot water temperatures being out of range until today. - The facility has a thermometer and staff on duty 	C 105		

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C 105	<p>Continued From page 2</p> <p>was supposed to check water temperatures monthly when they do the fire drill.</p> <ul style="list-style-type: none"> - She would look for the log and the thermometer. - They would turn down the thermostat on the hot water heater some more. <p>Recheck of hot water temperatures in the kitchen on 09/15/15 at 5:55 p.m. revealed:</p> <ul style="list-style-type: none"> - The hot water temperature at the sink was 116 degrees F. - No steam was observed. <p>Recheck of the hot water temperatures of the residents' common bathroom on 09/15/15 at 5:59 p.m.:</p> <ul style="list-style-type: none"> - Hot water temperature in the bathtub/shower was 116 degrees F. - Hot water temperature at the sink was 117 degrees F. - No steam was observed. <p>Interview with the Administrator on 09/16/15 at 10:02 a.m. revealed:</p> <ul style="list-style-type: none"> - They turned down the thermostat on the hot water heater again last night. - She found a log but there was only one documented temperature. - She found the thermometer in the staff room. <p>Recheck of hot water temperatures in the kitchen on 09/16/15 at 10:02 a.m. with surveyor and facility's thermometer revealed:</p> <ul style="list-style-type: none"> - The hot water temperature at the sink was 104 degrees F on both thermometers. - No steam was observed. <p>Recheck of the hot water temperatures of the residents' common bathroom on 09/16/15 at 10:04 a.m.:</p>	C 105		

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C 105	<p>Continued From page 3</p> <ul style="list-style-type: none"> - Hot water temperature in the bathtub/shower was 106 degrees F. - Hot water temperature at the sink was 104 degrees F. - No steam was observed. <p>Review of the hot water temperature log revealed one reading at the kitchen sink had been taken on 06/15/15 and was 114 degrees F.</p> <p>Confidential interviews with two residents revealed the water was not too hot and they could adjust it if needed.</p>	C 105		
C 140	<p>10A NCAC 13G .0405(a)(b) Test For Tuberculosis</p> <p>10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 3 staff (B, C) sampled were</p>	C 140		

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C 140	<p>Continued From page 4</p> <p>tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:</p> <p>1. Review of Staff B's personnel file revealed:</p> <ul style="list-style-type: none"> - There was no hire date listed. - There was a job application signed on 06/17/15. - There was one tuberculosis (TB) skin test placed on 05/05/15 and documented as negative on 05/07/15. - There was no documentation of any other TB skin test. <p>Interview with Staff B on 09/16/15 at 1:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He worked at a sister facility (group home) prior to working at this facility. - He first starting working at this facility on 08/28/15. - He had worked 24 hours a day, 7 days a week since he started on 08/28/15. - He had one TB skin test prior to hire. - He had not had another TB skin test. - The Supervisor-in-Charge had mentioned TB tests the other day but he had not scheduled an appointment to get it done. <p>Refer to interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m.</p> <p>2. Review of Staff C's personnel file revealed:</p> <ul style="list-style-type: none"> - There was no hire date listed. - There was a job application signed on 04/27/15. - There was one tuberculosis (TB) skin test placed on 04/27/15 and documented as negative on 04/29/15. - There was no documentation of any other TB 	C 140		

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C 140	<p>Continued From page 5</p> <p>skin test.</p> <p>Staff C was unavailable for interview during the survey on 09/15/15 - 09/16/15.</p> <p>Interview with the Administrator on 09/16/15 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff C worked at a sister facility (group home) prior to working at this facility. - Staff C was relief staff for this facility. - Staff C first starting working at this facility the first day she documented administering medications on the August 2015 MAR which was 08/11/15. <p>Refer to interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m.</p> <p>_____</p> <p>Interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> - She was responsible for assuring TB skin tests were completed upon hire to the facility. - The TB skin tests on file for Staff B and Staff C were done when they were hired at a sister mental health facility. - TB skin tests were not done for Staff B and Staff C when they started working at this facility. - She would make sure the TB skin tests get done. - She was working on putting a new system in place to track things. 	C 140		
C 145	<p>10A NCAC 13G .0406(a)(5) Other Staff Qualifications</p> <p>10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall:</p>	C 145		

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C 145	<p>Continued From page 6</p> <p>(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: Based on interview and review of personnel files, the facility failed to assure 2 of 3 staff (B, C) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry upon hire to the facility. The findings are:</p> <p>1. Review of Staff B's personnel file revealed:</p> <ul style="list-style-type: none"> - There was no hire date listed. - There was a job application signed on 06/17/15. <p>Interview with Staff B on 09/16/15 at 1:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He worked at a sister facility (group home) prior to working at this facility. - He first starting working at this facility on 08/28/15. - He had worked 24 hours a day, 7 days a week since he started on 08/28/15. - He did not know if a Health Care Personnel Registry (HCPR) check had been completed. <p>Review of Staff B's personnel file revealed:</p> <ul style="list-style-type: none"> - A Health Care Personnel Registry (HCPR) check was completed on 06/18/15 with no substantiated findings. - There was no HCPR check upon hire to this facility on 08/28/15. <p>Refer to interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m.</p> <p>2. Review of Staff C's personnel file revealed:</p> <ul style="list-style-type: none"> - There was no hire date listed. 	C 145		

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C 145	<p>Continued From page 7</p> <ul style="list-style-type: none"> - There was a job application signed on 04/27/15. <p>Staff C was unavailable for interview during the survey on 09/15/15 - 09/16/15.</p> <p>Interview with the Administrator on 09/16/15 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff C worked at a sister facility (group home) prior to working at this facility. - Staff C was relief staff for this facility. - Staff C first starting working at this facility the first day she documented administering medications on the August 2015 MAR which was 08/11/15. <p>Refer to interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m.</p> <hr/> <p>Interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> - She was responsible for assuring HCPR checks were completed upon hire to the facility. - The HCPR checks on file for Staff B and Staff C were done when they were hired at a sister mental health facility. - She did not do HCPR checks for Staff B and Staff C prior to them starting to work at this facility. 	C 145		
C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination</p> <p>(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted</p>	C 202		

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C 202	<p>Continued From page 8</p> <p>by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 3 residents (#1, #3) sampled were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 09/03/15 revealed a diagnoses of schizoaffective disorder and high functioning Asperger's.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 08/17/15.</p> <p>Review of Resident #1's record revealed:</p> <ul style="list-style-type: none"> - Documentation on the FL-2 dated 08/17/15 of one negative tuberculosis (TB) skin test from a hospital. - The date the TB skin test was placed and read was not documented. - No documentation of any other TB skin test. <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 11:25 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #1's insurance will only pay for a one step TB skin test. - Resident #1 has an appointment on 09/28/15 with his primary care provider. - She would check on the resident getting the TB skin test at that time and the facility would pay for it. 	C 202		

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C 202	<p>Continued From page 9</p> <p>2. Review of Resident #3's current FL-2 dated 08/10/15 revealed a diagnoses of schizoaffective disorder and mild intellectual disability.</p> <p>Review of Resident #3's record revealed no date of admission was documented.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 09/15/15 at 12:55 p.m. revealed Resident #3's date of admission was 08/11/15.</p> <p>Review of Resident #3's record revealed:</p> <ul style="list-style-type: none"> - One tuberculosis (TB) skin test was placed on 03/16/15 and read as negative on 03/19/15. - No documentation of any other TB skin test. <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 1:05 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #3 was admitted from a hospital on 08/11/15. - She thought the hospital had done a TB skin test before the resident was discharged to her facility on 08/11/15. - She did not notice that the documentation attached by the hospital was for a TB skin test done in March 2015. - She would get a second TB skin test done for Resident #3. 	C 202		
C 288	<p>10A NCAC 13G .0905(a) Activities Program</p> <p>10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.</p> <p>This Rule is not met as evidenced by:</p>	C 288		

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C 288	<p>Continued From page 10</p> <p>Based on observation, interview, and review of the facility's Activity Program calendar, the facility failed to develop a program of activities designed to promote the residents' active involvement. The findings are:</p> <p>Review of the Activity Program calendar posted in the dining room on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - The calendar was dated July 2015. - There was no calendar for September 2015. - Activities listed on the July 2015 calendar included: grocery shopping, library, memory game, news and views, bowling, blood work, Sunday school and church service, training, staff meeting, play basketball, fire drill and disaster drill, house meeting, and flea market. - Some activities were scheduled from 2 to 4 hours while others had a start time but no end time. - Some activities had no start or stop time. <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> - They watch movies sometimes at the facility. - The resident was not aware of any other activities being offered at the facility. - There was not a lot to do at the facility. - They sometimes go on outings. <p>Confidential interview with a second resident revealed:</p> <ul style="list-style-type: none"> - They go on outings on the van like to the flea market. - The only activity they have at the facility is watching television. <p>Confidential interview with a third resident revealed:</p> <ul style="list-style-type: none"> - They go on riding trips and go to the library sometimes. - When they are at the facility, they just watch 	C 288		

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C 288	<p>Continued From page 11</p> <p>television.</p> <p>Confidential interview with a fourth resident revealed the resident was bored and there was nothing to do at the facility.</p> <p>Interview with the medication aide on 09/15/15 at 5:10 p.m. revealed:</p> <ul style="list-style-type: none"> - They do not have a September 2015 activity calendar to his knowledge. - He just started working at the facility about 3 weeks ago on 08/28/15. - He had worked 24 hours a day 7 days a week since he started. - He was responsible for all duties during that time including medications, cooking, personal care, and activities. - They mostly go on walks or go on outings. - He recently took the residents to a cookout and to the park. - They mostly watch movies at the facility. - They do not have any activity supplies except he brought his own personal jigsaw puzzle to the facility. - He keeps it in the staff room - No residents had worked on the puzzle. - They do not have a basketball or basketball goal at the facility. - He had been talking with residents about what they want to do. - He wanted to get some board games and cards for the residents. <p>Interview with the Administrator on 09/15/15 at 5:17 p.m. revealed:</p> <ul style="list-style-type: none"> - She had made activities calendars and distributed to staff at all of her facilities. - There should be a September 2015 activity calendar in the facility. - She will sometimes list appointments, trainings, 	C 288		

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C 288	Continued From page 12 and meetings on the calendar as reminders to facility staff but they are not activities for the residents. - Staff on duty were responsible for posting the calendar and implementing the activities. Observation throughout the survey on 09/15/15 - 09/16/15 revealed: - No activities were observed to be done or offered in the facility. - The residents either stayed in their rooms, watched television, or went outside to smoke while at the facility.	C 288		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure clarification of medication orders for 2 of 3 residents (#1, #2)	C 315		

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NAME OF PROVIDER OR SUPPLIER ULTIMATE FCH 9	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 SANDERS DRIVE WILLOW SPRINGS, NC 27592
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C 315	<p>Continued From page 13</p> <p>sampled including medications for thyroid problems, psychosis, mood disorders, and anxiety. The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 09/03/15 revealed diagnoses included schizoaffective disorder and high functioning Asperger's.</p> <p>Review of Resident #1's Resident Register revealed he was admitted to the facility on 08/17/15.</p> <p>A. Review of Resident #1's current FL-2 dated 09/03/15 revealed an order for Synthroid 125mcg 1 tablet daily. (Synthroid is used to treat underactive thyroid disease.)</p> <p>Review of Resident #1's previous FL-2 dated 08/17/15 revealed an order for Synthroid 137mcg 1 tablet daily.</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - The August 2015 MAR was handwritten. - There was a handwritten entry for Synthroid 125mcg by mouth daily. - It appeared staff had written over 137mcg and changed it to 125mcg. - Synthroid 125mcg was scheduled and documented as administered from 08/17/15 - 08/31/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - There was a computer printed entry for Synthroid 137mcg 1 tablet daily. - Synthroid 137mcg was documented as administered at 8:00 a.m. from 09/01/15 - 09/15/15. 	C 315		

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C 315	<p>Continued From page 14</p> <p>Record review revealed no documentation the physician was contacted to clarify which strength of Synthroid the resident was supposed to be receiving.</p> <p>Review of active medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - One supply of Synthroid 137mcg tablets dispensed on 08/17/15. - Twenty-five of the 30 tablets dispensed remained on hand. <p>Review of pharmacy dispensing records from the primary pharmacy revealed one supply of Synthroid 137mcg tablets were dispensed in August 2015 and no Synthroid 125mcg tablets had been dispensed from 01/01/15 - 09/16/15.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 09/16/15 at 11:05 a.m. revealed:</p> <ul style="list-style-type: none"> - She usually copied medications orders from the MAR or previous FL-2 when she was filling out new FL-2 forms. - She did not fill out the FL-2 dated 09/03/15 for Resident #3. - Any signed FL-2s should be faxed to the pharmacy. - Resident #1's FL-2 dated 08/17/15 was from a hospital the resident came from upon admission to the facility. - Facility staff redone the FL-2 for a primary physician visit on 09/03/15. - She contacted the primary physician's office today, 09/16/15, and they told her the resident should be receiving Synthroid 125mcg according to their records. <p>Interview with the Administrator on 09/15/15 at 11:12 a.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware of the FL-2 dated 09/03/15. 	C 315		

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C 315	<p>Continued From page 15</p> <ul style="list-style-type: none"> - She went by the FL-2 they received upon admission on 08/17/15. - She did not realize the orders did not match. - She felt like staff copied the orders incorrectly on the FL-2 dated 09/03/15. - Resident #1 had medications with him when he was admitted but they did not document what was brought in upon admission. - She would contact the physician for clarification. <p>Interview with a pharmacist from the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The facility was supposed to fax any medication orders to the pharmacy. - They did not receive Resident #1's FL-2 dated 09/03/15. - They dispensed Synthroid 137mcg based on the order dated 08/17/15. <p>Review of a faxed forms from the primary physician's office on 09/16/15 revealed:</p> <ul style="list-style-type: none"> - The resident's TSH (thyroid stimulating hormone) level was 0.429 (reference range of 0.4500 - 4.500). [A low TSH level could be caused by receiving too much thyroid medication.] - A previous FL-2 dated 06/22/15 with order for Synthroid 125mcg once daily. <p>B. Review of Resident #1's current FL-2 dated 09/03/15 revealed an order for Risperdal 2mg every morning and 2mg at bedtime. (Risperdal is an antipsychotic.)</p> <p>Review of Resident #1's previous FL-2 dated 08/17/15 revealed an order for Risperdal 2mg every morning and 2mg at bedtime.</p> <p>Review of a prescription dated 08/17/15 revealed</p>	C 315		

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C 315	<p>Continued From page 16</p> <p>an order for Risperdal 4mg at bedtime.</p> <p>Review of Resident #1's record revealed no documentation to indicate the physician had been contacted for clarification.</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - The August 2015 MAR was handwritten. - There were a handwritten entries for Risperdal 2mg every morning and 4mg at bedtime. - Risperdal 2mg every morning and 4mg at bedtime were documented as administered from 08/17/15 - 08/31/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - There was a computer printed entry for Risperdal 2mg every morning and 4mg at bedtime. - Risperdal 2mg every morning and 4mg at bedtime were documented as administered from 09/01/15 - 09/15/15. <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - Risperdal 2mg tablets were dispensed on 08/17/15 with instructions to take 1 tablet in the morning. - Risperdal 4mg tablets were dispensed on 08/17/15 with instructions to take 1 tablet at bedtime. <p>Interview with a pharmacist from the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The facility was supposed to fax any medication orders to the pharmacy. - They did not receive Resident #1's FL-2 dated 09/03/15. - They dispensed Risperdal based on prescriptions dated 08/17/15. 	C 315		

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C 315	<p>Continued From page 17</p> <p>Interview with the Supervisor-in-Charge (SIC) on 09/16/15 at 11:05 a.m. revealed:</p> <ul style="list-style-type: none"> - Any signed FL-2s or other medication orders should be faxed to the pharmacy. - Resident #1's FL-2 dated 08/17/15 was from a hospital the resident came from upon admission to the facility. - Facility staff redid the FL-2 for a primary physician visit on 09/03/15. - She would contact the mental health provider for clarification because they usually order the psychiatric medications. <p>Interview with the Administrator on 09/15/15 at 11:12 a.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware of the FL-2 dated 09/03/15. - She went by the FL-2 they received upon admission on 08/17/15 from a hospital. - She did not realize the orders did not match. - She felt like staff copied the orders incorrectly on the FL-2 dated 09/03/15. - She did not know why staff filled out a another FL-2 form since the resident had one from the hospital upon admission. - Resident #1 had medications with him when he was admitted but they did not document what was brought in upon admission. - She would contact the physician for clarification. <p>Review of a clarification order dated 09/15/15 revealed the resident should receive Risperdal 4mg at bedtime.</p> <p>2. Review of Resident #2's current FL-2 dated 08/24/15 revealed diagnoses included paranoid schizophrenia, multiple rib fractures, right clavicular fracture, pleural effusion, anemia, dilated colon, macrocytosis, and smokes.</p>	C 315		

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C 315	<p>Continued From page 18</p> <p>Interview with the Administrator on 09/15/15 at 12:33 p.m. revealed Resident #2 was admitted to the facility from a hospital on 08/24/15.</p> <p>A. Review of the current FL-2 dated 08/24/15 and a prescription dated 08/24/15 revealed an order for Haldol 5mg by mouth daily. (Haldol is an antipsychotic.)</p> <p>Review of a prescription dated 09/02/15 revealed an order for Haldol 10mg take 1 and ½ tablets (15mg) once daily.</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - There was a handwritten entry for Haldol 5mg take 1 tablet in the morning. - Haldol was documented as administered as ordered at 8:00 a.m. from 08/26/15 - 08/31/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - There was a computer printed entry for Haldol 5mg 1 tablet every day at 8:00 a.m. and was documented as administered from 09/01/15 - 09/15/15. - There was a computer printed entry for Haldol 10mg take 1 and ½ tablets in the morning at 8:00 a.m. and was documented as administered from 09/01/15 - 09/15/15. <p>Review of Resident #2's record revealed no documentation the physician had been contacted to clarify the order for Haldol.</p> <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - A supply of Haldol 10mg tablets 1 and ½ daily in the morning. - No Haldol 5mg tablets were observed. 	C 315		

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C 315	<p>Continued From page 19</p> <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He forgot to mark off the Haldol 5mg tablets from the MARs. - He did not administer the Haldol but mistakenly documented he did on the MAR. - He had asked the pharmacy to send a new MAR because some of the orders were duplicates or old and it was confusing. <p>Interview with the Supervisor-in-Charge (SIC) on 09/16/15 at 11:05 a.m. revealed:</p> <ul style="list-style-type: none"> - Any signed FL-2s or other medication orders should be faxed to the pharmacy. - She would contact the mental health provider for clarification because they usually order the psychiatric medications. <p>Interview with a pharmacist at the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The most current order they had on file for Haldol was dated 08/24/15 for 5mg daily. - They had a previous order dated 07/29/15 for Haldol 10mg take 1 and ½ tablets daily. - They did not receive the order for Haldol 10mg dated 09/02/15. - They recently had a glitch in their computer system and some duplicate and previous medication orders were printed on the MARs. - Someone from the facility called and the pharmacy sent corrected MARs for September 2015 to the facility right after the first of the month. - The facility was supposed to fax any medication orders to the pharmacy and those orders are usually added to the MARs for the next month. <p>Interview with the Administrator on 09/16/15 at 3:40 p.m. revealed:</p>	C 315		

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C 315	<p>Continued From page 20</p> <ul style="list-style-type: none"> - She did not realize duplicate and old orders were printing on the MARs. - She was not aware of the pharmacy sending any corrected MARs. - They would contact the mental health provider to clarify the Haldol. <p>Telephone interview with a representative from the mental health provider's office on 09/16/15 at 12:15 p.m. revealed:</p> <ul style="list-style-type: none"> - The Nurse Practitioner was unavailable for interview. - Resident #2 was seen in their office this morning and they were working on some of his medication orders. - The facility staff was given some orders. <p>Interview with the medication aide on 09/16/15 at 2:30 p.m. revealed:</p> <ul style="list-style-type: none"> - He had given the new orders to the SIC on his way back to the facility so she could fax the orders to the pharmacy. - They do not have a fax machine at this facility. - The NP gave an order to discontinue Haldol 5mg once daily. - The resident was supposed to be taking Haldol 10mg 1 and ½ tablets daily. <p>Review of an order dated 09/16/15 revealed the NP wrote an order on 09/16/15 to discontinue Haldol 5mg once daily.</p> <p>B. Review of Resident #2's record revealed an order dated 09/02/15 for Trazodone 50mg at bedtime. (Trazodone is an antidepressant sometimes used to help with anxiety and insomnia.)</p> <p>Review of the September 2015 medication administration record (MAR) revealed:</p>	C 315		

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C 315	<p>Continued From page 21</p> <ul style="list-style-type: none"> - There was a computer printed entry for Trazodone 50mg take 1 tablet at bedtime. - Trazodone was scheduled to be administered at 8:00 p.m. - No Trazodone was documented as administered in September 2015. - No reasons for the omissions were documented. <p>Review of medications on hand on 09/15/15 revealed there was no Trazodone in Resident #2's medication storage bin.</p> <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #2 did not have any Trazodone on hand. - He has never administered the Trazodone because he thought the physician was going to stop it because the resident had been sleepy during the day. - He did not know if there was an order to discontinue the Trazodone. - He had not contacted the physician to clarify. <p>Interview with the Administrator on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - She thought they had an order to hold the Trazodone due to the resident being sleepy. - The pharmacy should have a copy of the order to discontinue the Trazodone. <p>Interview with a pharmacist at the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - They received the order for Trazodone on 09/02/15. - They did not dispense the medication because there was a handwritten note on the fax that said to hold all medications. - They did not receive an order to discontinue the 	C 315		

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C 315	<p>Continued From page 22</p> <p>Trazodone.</p> <p>Review of a fax sent by the pharmacy on 09/16/15 revealed:</p> <ul style="list-style-type: none"> - Copy of prescriptions dated 09/02/15 including the order for Trazodone. - Handwritten note "hold all" with no initials or signature. <p>Interview with the Administrator on 09/16/15 at 3:40 p.m. revealed:</p> <ul style="list-style-type: none"> - No one from the facility wrote to "hold all" on the fax with the orders for Resident #2. - She would contact the physician about the Trazodone. <p>Telephone interview with a representative from the mental health provider's office on 09/16/15 at 12:15 p.m. revealed:</p> <ul style="list-style-type: none"> - The Nurse Practitioner was unavailable for interview. - Resident #2 was seen in their office this morning and they were working on some of his medication orders. - The facility staff was given some orders. <p>Interview with the medication aide on 09/16/15 at 2:30 p.m. revealed:</p> <ul style="list-style-type: none"> - He had given the new orders to the SIC on his way back to the facility so she could fax the orders to the pharmacy. - They do not have a fax machine at this facility. - The NP gave an order today to discontinue Trazodone. <p>Review of an order dated 09/16/15 revealed the NP wrote an order on 09/16/15 to discontinue Trazodone.</p> <p>C. Review of Resident #2's current FL-2 dated</p>	C 315		

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C 315	<p>Continued From page 23</p> <p>08/24/15 revealed an order for Seroquel 800mg at bedtime. (Seroquel is an antipsychotic.)</p> <p>Review of Resident #2's record revealed an order dated 09/02/15 for Seroquel XR 400mg take 2 tablets at bedtime. (Seroquel XR is extended released form of Seroquel.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Seroquel XR 400mg take 2 tablets daily at 8:00 p.m. - Seroquel XR was documented as administered from 08/24/15 - 08/31/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Seroquel 400mg take 2 tablets at bedtime. - Seroquel was documented as administered at 8:00 p.m. from 09/01/15 - 09/14/15. <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - Seroquel 400mg tablets were dispensed on 08/24/15. - There was no Seroquel XR on hand. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He had not noticed the Seroquel on hand was not Seroquel XR. - He did not know why there was no Seroquel XR on hand. - He had asked the pharmacy to send a new MAR because some of the orders were duplicates or old and it was confusing. <p>Interview with a pharmacist at the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The resident's insurance would not pay for the 	C 315		

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C 315	<p>Continued From page 24</p> <p>Seroquel XR without prior authorization.</p> <ul style="list-style-type: none"> - The pharmacy sent prior authorization information to the physician's office but they had not heard back. - They recently had a glitch in their computer system and some duplicate and previous medication orders were printed on the MARs. - Someone from the facility called and the pharmacy sent corrected MARs for September 2015 to the facility right after the first of the month. - The order entry for Seroquel should be corrected on the next MAR in October 2015. <p>Interview with the Administrator on 09/16/15 at 3:40 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not realize duplicate and old orders were printing on the MARs. - She was not aware of the pharmacy sending any corrected MARs. - She was not aware the resident's insurance required prior authorization for the Seroquel XR. - She would contact the physician. <p>Telephone interview with a representative from the mental health provider's office on 09/16/15 at 12:15 p.m. revealed:</p> <ul style="list-style-type: none"> - The Nurse Practitioner was unavailable for interview. - Resident #2 was seen in their office this morning and they were working on some of his medication orders. - The facility staff was given some orders. <p>Review of orders received from the mental health provider office visit on 09/16/15 revealed no orders related to the resident's Seroquel.</p> <p>_____</p> <p>Review of the facility's plan of protection dated</p>	C 315		

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C 315	<p>Continued From page 25</p> <p>09/16/15 revealed:</p> <ul style="list-style-type: none"> - Administrator / Registered Nurse would immediately retrain staff on medication administration including current medication orders, FL-2 orders, medication administration records (MARs), and medications on hand. - Staff will be retrained to report any medication discrepancies to the Administrator. - Administrator conducted resident chart audits on 09/16/15. - Medication errors noted will be reported to the appropriate attending physician. - Facility will comply with physician's orders. - Supervisor-in-Charge (SIC) will conduct biweekly checks of the MARs, FL-2s, medication orders, and medications on hand. - SIC will contact pharmacy on monthly basis to reconcile any medication discrepancies based on monthly MAR reconciliation. - The Administrator will conduct bimonthly checks to ensure compliance. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.</p>	C 315		
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration</p> <p>(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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p>	C 330		

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C 330	<p>Continued From page 26</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered for 1 of 3 residents (#3) sampled including medications for psychosis, mood disorders, anxiety, insomnia, unwanted laughing and crying, thyroid problems, constipation, and dandruff. The findings are:</p> <p>Review of Resident #3's current FL-2 dated 08/10/15 revealed diagnoses included schizoaffective disorder and mild intellectual disability.</p> <p>A. Review of Resident #3's current FL-2 dated 08/10/15 and a prescription dated 08/25/15 revealed orders for Lithium 300mg twice daily. (Lithium is used to treat mood disorders.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - There was a handwritten entry for Lithium 300mg take 1 capsule every morning. - Lithium 300mg was documented as administered at 8:00 a.m. daily from 08/11/15 - 08/31/15. - There was a handwritten entry for Lithium 600mg take 1 capsule at bedtime. - Lithium 600mg was documented as administered at 8:00 p.m. from 08/11/15 - 08/25/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Lithium 300mg twice daily. - Lithium 300mg was documented as administered at 8:00 a.m. and 8:00 p.m. from 09/01/15 - 09/15/15. 	C 330		

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C 330	<p>Continued From page 27</p> <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - A card of Lithium 600mg capsules take 1 at bedtime with 16 of 60 capsules remaining stored in the actively used medication bin with a dispense date of 06/30/15. - One card of Lithium 300mg take 1 twice daily dispensed on 08/10/15 with all 60 capsules dispensed still remaining stored in the oversupply bin. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He had been administering Lithium from the card with 600mg capsules twice daily. - He had not noticed the Lithium in the card was 600mg instead of 300mg as ordered. - He did not realize there was a supply of Lithium 300mg capsules in the overstock storage container. - He had been working at the facility 24 hours a day and administering medications since 08/28/15. - He was the only one administering medications at the facility since he started on 08/28/15. <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #3 had some medications with him when he was admitted on 08/11/15. - They did not document any medications that were brought in upon admission. - She usually checked the MARs and medications on hand but she had not checked them for this facility yet. - The SIC came to the facility 2 weeks ago and she thought the SIC had checked the medications and MARs for accuracy. - Staff should read the MARs and medication 	C 330		

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C 330	<p>Continued From page 28</p> <p>labels to make sure the correct medication is being administered.</p> <ul style="list-style-type: none"> - Resident #3 will sometimes have attention seeking behaviors like having outbursts when he verbally gets loud or tries to hit himself. - This was not uncommon for Resident #3 and there had been no changes in his behavior. - She would notify the mental health provider about the medication error. <p>Observations of Resident #3 on 09/15/15 at 5:36 p.m. and 5:50 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident began talking and cursing loudly. - He indicated he was upset about his parents dying. - The medication aide attempted to talk to the resident to calm him down. - The resident swung his arm at the medication aide but did not hit him. - The medication aide talked with the resident. - The resident said his mother died when he was 17 years old and his dad died about a year ago. - The resident intentionally banged his forehead against the wall in the kitchen. - The medication aide intervened and redirected the resident from banging his head against the wall again. - The resident continued to curse and hit himself in the head with his open hand 3 times. - The resident hit himself with a closed fist on his right cheek. - The resident began to cry and say he wanted his daddy. - The resident was redirected by the medication aide and then the resident sat down in the living room. <p>Interviews with Resident #3 on 09/16/15 at 8:55 a.m. and 4:20 p.m. revealed:</p> <ul style="list-style-type: none"> - He was not sure what kind of medications he 	C 330		

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C 330	<p>Continued From page 29</p> <p>took.</p> <ul style="list-style-type: none"> - Staff keeps up with his medications and he takes what they give him. - His medication had made him a little sleepy and for the last few weeks. - He has been feeling tired for a while. - He was not aware of any other side effects from his medication. <p>Interview with the nurse at the mental health provider's office on 09/16/15 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The mental health physician was out of the office and unavailable for interview. - The resident's last Lithium level was within normal limits at 0.6 on 05/25/15. - The resident's Lithium dosage was changed during a recent hospitalization in 08/2015 when he was found to have thrombocytopenia (low level of platelets in the blood). - The Lithium dosage was decreased from 900mg a day to 600mg a day because of the thrombocytopenia. <p>Interview with the medical assistant at the primary care physician's office on 09/16/15 at 3:50 p.m. revealed:</p> <ul style="list-style-type: none"> - The mental health provider prescribes the resident's Lithium. - They last checked the resident's platelet count on 08/18/15 and it was low at 132 (normal range 150 - 400). <p>Review of a note from a hematology visit for Resident #3 on 09/01/15 revealed:</p> <ul style="list-style-type: none"> - The resident's complete blood count was "stable" (no specific lab values listed.) - They are to continue to monitor the resident's levels every 3 months. 	C 330		

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C 330	<p>Continued From page 30</p> <p>Attempt to contact Resident #3's hematologist on 09/16/15 was unsuccessful.</p> <p>B. Review of Resident #3's September 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Haldol 5mg twice daily at 8:00 a.m. and 8:00 p.m. (Haldol is an antipsychotic.) - Haldol 5mg was documented as administered twice daily from 09/01/15 - 09/15/15. <p>Review of Resident #3's record revealed a previous order dated 01/16/15 for Haldol 5mg twice daily.</p> <p>Review of Resident #3's current FL-2 dated 08/10/15 revealed no order for Haldol.</p> <p>Review of Resident #3's record revealed no other orders for Haldol.</p> <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - A supply of Haldol 5mg twice daily dispensed on 09/04/15. - There was 4 of 10 tablets remaining on hand. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He just started working at the facility on 08/28/15. - He administered the Haldol in September 2015 because it was listed on the MAR. - He had used some from a back-up supply he found and then the pharmacy sent the new supply from 09/04/15. - He did not know if there was a current order for Haldol. - He thought it was supposed to be given because it was listed on the MAR. 	C 330		

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C 330	<p>Continued From page 31</p> <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She thought the Haldol had been discontinued a while back. - She did not know why the Haldol was printed on the September 2015 MAR. - She would contact the physician about the Haldol. <p>Interview with the Supervisor-in-Charge (SIC) on 09/16/15 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #3 used a different mental health provider when he lived at a sister facility. - The order from January 2015 was from the previous mental health provider. - She did not administer medications at this facility but usually came for quality assurance to review records. - She came about 2 weeks ago but did not notice any issues with the medications. - They would contact the current mental health provider about the Haldol. <p>Interview with the pharmacist on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Someone called the pharmacy and requested the Haldol be refilled. - She did not know who called or which day they called. - They did not have an order to discontinue the Haldol so they dispensed 10 tablets so the resident would not be without the medication. - They contacted the physician's office when the 10 tablets were dispensed but had not heard back from them yet. - They did not have a new order for Haldol so she used the prescription from January 2015 since it had refills on it to dispense the 10 pills. - She had not heard anything else from the 	C 330		

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C 330	<p>Continued From page 32</p> <p>facility regarding the Haldol.</p> <p>Interviews with Resident #3 on 09/16/15 at 8:55 a.m. and 4:20 p.m. revealed:</p> <ul style="list-style-type: none"> - He was not sure what kind of medications he took. - Staff keeps up with his medications and he takes what they give him. - His medication had made him a little sleepy and for the last few weeks. - He has been feeling tired for a while. - He was not aware of any other side effects from his medication. <p>Interview with a medical assistant at the resident's current physician's office on 09/16/15 at 3:50 p.m. revealed:</p> <ul style="list-style-type: none"> - There was no documentation in their record of any orders for Haldol. - The resident was not supposed to be taking Haldol with his current regimen. <p>C. Review of Resident #3's current FL-2 dated 08/10/15 and a prescription dated 08/10/15 revealed orders for Levothyroxine 25mcg once daily. (Levothyroxine is used to treat underactive thyroid.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Levothyroxine was not included on the August 2015 MAR. - There was no documentation of any Levothyroxine being administered from admission on 08/11/15 - 08/31/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Levothyroxine 25mcg once daily at 8:00 a.m. - Levothyroxine 25mcg was documented as 	C 330		

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C 330	<p>Continued From page 33</p> <p>administered from 09/01/15 - 09/15/15.</p> <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - One supply of Levothyroxine 25mcg once daily dispensed on 08/10/15. - There was 15 of 30 tablets remaining. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He just started working at the facility on 08/28/15. - He had worked 24 hours a day since he started and was the only one that had administered medications since he started. - He did not know why Levothyroxine was not included on the August 2015 MAR. - He was not sure if Resident #3 had brought in a supply of Levothyroxine when he was admitted. - He would have documented on the MAR if he had administered the Levothyroxine in August 2015. <p>Review of pharmacy dispensing records from the primary pharmacy from 03/01/15 - 09/16/15 revealed the only supply of Levothyroxine dispensed to Resident #3 was the supply on hand dated 08/10/15 with 30 tablets.</p> <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not know why the Levothyroxine was not included on the August 2015 MAR. - Staff were supposed to fax FL-2s and orders to the pharmacy and then transcribe the orders on the MARs. - Resident #3 had some medications with him when he was admitted but they did not document any of the medications. - The resident was admitted from a hospital and 	C 330		

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C 330	<p>Continued From page 34</p> <p>that is where the FL-2 was completed.</p> <ul style="list-style-type: none"> - She would contact the physician about the error. <p>Interview with a medical assistant and the primary physician's office on 09/16/15 at 3:50 p.m. revealed:</p> <ul style="list-style-type: none"> - There was no documentation in their records that Resident #3 was supposed to get any thyroid medication. - Levothyroxine was not included in his list of medications. - She did not see where any thyroid labs had been drawn. - They were not aware the resident was receiving Levothyroxine but she would notify the primary physician. - The facility needs to set up an appointment for the resident to be seen so they could follow up on the resident's thyroid. <p>D. Review of Resident #3's record revealed an order dated 08/10/15 for Nuedexta 20/10mg once daily and an order dated 08/25/15 for Nuedexta 20/10mg once daily (stop twice daily). (Nuedexta is used to treat unwanted episodes of laughing or crying.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Nuedexta 20/10mg twice daily at 8:00 a.m. and 8:00 p.m. - Staff documented Nuedexta as administered twice daily from 08/11/15 - 08/25/15 at 8:00 a.m. when staff noted it was "d/c" (discontinued). - There was no entry for the order dated 08/25/15 for Nuedexta 20/10mg once daily. - No Nuedexta was documented as administered from 08/26/15 - 08/31/15. 	C 330		

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C 330	<p>Continued From page 35</p> <p>Review of the September 2015 MAR revealed Nuedexta was documented as administered once daily from 09/01/15 - 09/15/15.</p> <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - One supply of Nuedexta 20/10mg dispensed on 05/12/15 with 16 of 90 capsules remaining. - One supply of Nuedexta 20/10mg dispensed on 07/14/15 with 30 of 30 capsules remaining. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He had just started working at the facility on 08/28/15. - He gave medications that were listed on the MAR. - He did not know why the order dated 08/25/15 was not included on the MAR. - He thought Resident #3 had brought in medications from another facility when he was admitted. - Resident #3 would sometimes have outbursts of anger when he would get loud and sometimes the resident would cry. - Staff C was the medication aide who was working when he started on 08/28/15. <p>Staff C (medication aide) was not working and unavailable for interview during the survey on 09/15/15 - 09/16/15.</p> <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She was unaware the Nuedexta was not documented as administered at the end of August 2015. - Staff was supposed to fax orders to the pharmacy and then transcribe the order on the MAR. 	C 330		

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C 330	<p>Continued From page 36</p> <ul style="list-style-type: none"> - She had the facility's SIC come about 2 weeks ago to review records for accuracy. - She was not aware of any discrepancies found. - She usually checked the records also but had not done that yet for this facility. <p>E. Review of Resident #3's record revealed an order dated 08/18/15 for Selsun Blue shampoo with selenium sulfide, use 3 times a week for dandruff. (Selsun Blue is a medication shampoo used to treat flaking, scaling, and itching of the scalp.)</p> <p>Review of the August 2015 and September 2015 medication administration records (MARs) revealed:</p> <ul style="list-style-type: none"> - No entries for Selsun Blue on either MAR. - There was no documentation of the use of any Selsun Blue. <p>Review of medications on hand on 09/15/15 revealed there was no Selsun Blue shampoo at the facility.</p> <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He just started working at the facility on 08/28/15. - He was not aware of an order for Selsun Blue shampoo. - He had not seen any Selsun Blue shampoo. - The resident had not complained about dandruff to him. - Staff C was the medication aide who was working when he started on 08/28/15. <p>Staff C (medication aide) was not working and unavailable for interview during the survey on 09/15/15 - 09/16/15.</p>	C 330		

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C 330	<p>Continued From page 37</p> <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She was unaware of the order for Selsun Blue shampoo. - Staff are supposed to fax orders to the pharmacy and then transcribe the order on the MAR. - She was unable to locate any Selsun Blue shampoo for the resident. <p>Review of pharmacy dispensing records from the primary pharmacy from 03/01/15 - 09/16/15 revealed no Selsun Blue shampoo had been dispensed to Resident #3.</p> <p>Interview with the pharmacist at the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - They never received an order for Selsun Blue shampoo. - They had not dispensed any but it could be bought over-the-counter without a prescription. <p>Observation of Resident #3 on 09/16/15 at 4:20 p.m. revealed:</p> <ul style="list-style-type: none"> - The resident had white flakes scattered throughout his hair. - The flakes were larger in the hair on the sides of his head above his ears. <p>Interview with Resident #3 on 09/16/15 at 4:20 p.m. revealed:</p> <ul style="list-style-type: none"> - He has a problem with dandruff. - He does not have or use any medicated shampoo. - His scalp itches. <p>F. Review of Resident #3's current FL-2 dated 08/10/15 and prescriptions dated 08/10/15 and 08/25/15 revealed orders for Trazodone 100mg at bedtime. (Trazodone is an antidepressant)</p>	C 330		

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C 330	<p>Continued From page 38</p> <p>sometimes used to help with anxiety and insomnia.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Handwritten entry for Trazodone 100mg at bedtime at 8:00 p.m. - Staff documented the administration of Trazodone at bedtime starting on 08/26/15 - 08/31/15. - There was no Trazodone documented as administered from admission on 08/11/15 - 08/25/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Trazodone 100mg at bedtime. - Trazodone was documented as administered as ordered from 09/01/15 - 09/14/15. <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - One supply of Trazodone 100mg at bedtime dispensed on 08/10/15. - There was 8 of 30 tablets remaining. - There were 22 tablets (22 day supply) used for a 35 day time period from admission on 08/11/15 - 09/15/15. <p>Review of pharmacy dispensing records from the primary pharmacy from 03/01/15 - 09/16/15 revealed the only supply of Trazodone dispensed to Resident #3 was the supply on hand dated 08/10/15.</p> <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He just started working at the facility on 08/28/15. - He did not know if the resident received any 	C 330		

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C 330	<p>Continued From page 39</p> <p>Trazodone prior to that or if the resident had a supply of Trazodone when admitted.</p> <ul style="list-style-type: none"> - Staff C was the medication aide who was working when he started on 08/28/15. <p>Staff C (medication aide) was not working and unavailable for interview during the survey on 09/15/15 - 09/16/15.</p> <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not know why the administration of Trazodone was not documented until 08/26/15. - Resident #3 had some medications with him when he was admitted but they did not document any of the medications. - The resident was admitted from a hospital and that is where the FL-2 was completed. - She had the SIC check the MARs for accuracy about 2 weeks ago but the Administrator had not check them herself yet. <p>G. Review of Resident #3's current FL-2 dated 08/10/15 and prescriptions dated 08/10/15 and 08/25/15 revealed orders for Vistaril 25mg 3 times daily. (Vistaril may be used to treat anxiety and tension.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Handwritten entry for Vistaril 25mg 3 times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. - Staff documented the administration of Vistaril 3 times daily starting at 8:00 a.m. on 08/26/15 - 08/31/15. - There was no Vistaril documented as administered from admission on 08/11/15 - 08/25/15. <p>Review of the September 2015 MAR revealed:</p>	C 330		

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C 330	<p>Continued From page 40</p> <ul style="list-style-type: none"> - Computer printed entry for Vistaril 25mg 3 times a day. - Vistaril was documented as administered as ordered from 09/01/15 - 09/15/15. <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - One supply of Vistaril 25mg 3 times daily dispensed on 08/10/15. - There was 48 of 90 capsules remaining. - There were 42 capsules (14 day supply) used for a 35 day time period from admission on 08/11/15 - 09/15/15. <p>Review of pharmacy dispensing records from the primary pharmacy from 03/01/15 - 09/16/15 revealed the only supply of Vistaril dispensed to Resident #3 was the supply on hand dated 08/10/15.</p> <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He just started working at the facility on 08/28/15. - He did not know if the resident received any Vistaril prior to that or if the resident had a supply of Vistaril when admitted. - Staff C was the medication aide who was working when he started on 08/28/15. <p>Staff C (medication aide) was not working and unavailable for interview during the survey on 09/15/15 - 09/16/15.</p> <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not know why the administration of Vistaril was not documented until 08/26/15. - Resident #3 had some medications with him when he was admitted but they did not document 	C 330		

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C 330	<p>Continued From page 41</p> <p>any of the medications.</p> <ul style="list-style-type: none"> - The resident was admitted from a hospital and that is where the FL-2 was completed. - She had the SIC check the MARs for accuracy about 2 weeks ago but the Administrator had not check them herself yet. <p>H. Review of Resident #3's current FL-2 dated 08/10/15 and a prescription dated 08/10/15 revealed orders for Colace 100mg twice daily. (Colace is a stool softener.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Handwritten entry for Colace 100mg twice daily at 8:00 a.m. and 8:00 p.m. - Staff documented the administration of Colace twice daily starting at 8:00 p.m. on 08/19/15 - 08/31/15. - There was no Colace documented as administered from admission on 08/11/15 - 08/18/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Colace 100mg twice daily. - Colace was documented as administered as ordered from 09/01/15 - 09/15/15. <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - One supply of Colace 100mg twice daily dispensed on 08/10/15. - There was 5 of 60 capsules remaining. - There were 55 capsules (27.5 day supply) used for a 35 day time period from admission on 08/11/15 - 09/15/15. <p>Review of pharmacy dispensing records from the primary pharmacy from 03/01/15 - 09/16/15</p>	C 330		

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C 330	<p>Continued From page 42</p> <p>revealed the only supply of Colace dispensed to Resident #3 was the supply on hand dated 08/10/15.</p> <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He just started working at the facility on 08/28/15. - He did not know if the resident received any Colace prior to that or if the resident had a supply of Colace when admitted. - Staff C was the medication aide who was working when he started on 08/28/15. - The resident had no complained of constipation to his knowledge. <p>Staff C (medication aide) was not working and unavailable for interview during the survey on 09/15/15 - 09/16/15.</p> <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not know why the administration of Colace was not documented until 08/19/15. - Resident #3 had some medications with him when he was admitted but they did not document any of the medications. - The resident was admitted from a hospital and that is where the FL-2 was completed. - She had the SIC check the MARs for accuracy about 2 weeks ago but the Administrator had not check them herself yet. <hr/> <p>Review of the facility's plan of protection dated 09/16/15 revealed:</p> <ul style="list-style-type: none"> - Administrator / Registered Nurse would immediately retrain staff on medication administration including current medication orders, FL-2 orders, medication administration 	C 330		

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C 330	<p>Continued From page 43</p> <p>records (MARs), and medications on hand.</p> <ul style="list-style-type: none"> - Staff will be retrained to report any medication discrepancies to the Administrator. - Administrator conducted resident chart audits on 09/16/15. - Medication errors noted will be reported to the appropriate attending physician. - Facility will comply with physician's orders. - Supervisor-in-Charge (SIC) will conduct biweekly checks of the MARs, FL-2s, medication orders, and medications on hand. - SIC will contact pharmacy on monthly basis to reconcile any medication discrepancies based on monthly MAR reconciliation. - The Administrator will conduct bimonthly checks to ensure compliance. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.</p>	C 330		
C 342	<p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ol style="list-style-type: none"> (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 	C 342		

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C 342	<p>Continued From page 44</p> <p>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 interview and record review, the facility failed to assure medication administration records were accurate and complete for 2 of 3 residents (#1, #2) sampled including medications used for psychosis, mood disorders and anxiety. The findings are:</p> <p>1. Review of Resident #3's current FL-2 dated 08/10/15 revealed diagnoses included schizoaffective disorder and mild intellectual disability.</p> <p>Review of the August 2015 medication administration record (MAR) revealed: - Computer printed entry for Haldol 5mg twice daily at 8:00 a.m. and 8:00 p.m. (Haldol is an antipsychotic.) - There was a handwritten note of "d/c" beside the entry for Haldol and none was documented as administered.</p> <p>Review of the September 2015 MAR revealed: - Computer printed entry for Haldol 5mg twice daily at 8:00 a.m. and 8:00 p.m. (Haldol is an antipsychotic.) - Haldol 5mg was documented as administered twice daily from 09/01/15 - 09/15/15.</p> <p>Review of Resident #3's record revealed a previous order dated 01/16/15 for Haldol 5mg twice daily.</p>	C 342		

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C 342	<p>Continued From page 45</p> <p>Review of Resident #3's current FL-2 dated 08/10/15 revealed no order for Haldol.</p> <p>Review of Resident #3's record revealed no other orders for Haldol.</p> <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - A supply of Haldol 5mg twice daily dispensed on 09/04/15. - There was 4 of 10 tablets remaining on hand. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He just started working at the facility on 08/28/15. - He administered the Haldol in September 2015 because it was listed on the MAR. - He had used some from a overstock supply he found and then the pharmacy sent the new supply from 09/04/15. - He did not know if there was a current order for Haldol. - He thought it was supposed to be given because it was listed on the MAR. - He had not noticed the entry for Haldol was marked as discontinued on the August 2015 MAR. <p>Interview with the Administrator / Registered Nurse on 09/15/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She thought the Haldol had been discontinued a while back when the resident resided at a sister facility. - She did not know why the Haldol was printed on the August and September 2015 MARs. - She would contact the physician and pharmacy about the Haldol. - The Supervisor-in-Charge (SIC) came to the 	C 342		

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C 342	<p>Continued From page 46</p> <p>facility about 2 weeks ago to check the records including orders and MARs and medications.</p> <ul style="list-style-type: none"> - No discrepancies were reported to the Administrator. - She usually checked the MARs herself but had not done that yet at this facility. <p>Interview with the SIC on 09/16/15 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #3 used a different mental health provider when he lived at a sister facility. - The order from January 2015 was from the previous mental health provider. - She did not administer medications at this facility but usually came for quality assurance to review records, including MARs. - She came about 2 weeks ago but did not notice any issues with the medications or MARs. <p>Interview with the pharmacist on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Someone called the pharmacy and requested the Haldol be refilled. - She did not know who called or which day they called. - They did not have an order to discontinue the Haldol so they dispensed a 10 tablets so the resident would not be without the medication. - Haldol was printed on the August and September 2015 MARs because they had not received an order to discontinue it. <p>Interview with a medical assistant at the resident's current provider on 09/16/15 at 3:50 p.m. revealed:</p> <ul style="list-style-type: none"> - There was no documentation in their record of any orders for Haldol. - The resident was not supposed to be taking Haldol with his current regimen. 	C 342		

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C 342	<p>Continued From page 47</p> <p>2. Review of Resident #2's current FL-2 dated 08/24/15 revealed diagnoses included paranoid schizophrenia, multiple rib fractures, right clavicular fracture, pleural effusion, anemia, dilated colon, macrocytosis, and smokes.</p> <p>Interview with the Administrator on 09/15/15 at 12:33 p.m. revealed Resident #2 was admitted to the facility from a hospital on 08/24/15.</p> <p>A. Review of the current FL-2 dated 08/24/15 and a prescription dated 08/24/15 revealed an order for Haldol 5mg by mouth daily. (Haldol is an antipsychotic.)</p> <p>Review of a prescription dated 09/02/15 revealed an order for Haldol 10mg take 1 and ½ tablets (15mg) once daily.</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - There was a computer printed entry for Haldol 10mg 1 and ½ tablets daily in the morning at 8:00 a.m. - There was a handwritten note with the word "rewritten" beside the entry for Haldol 10mg. - There was a handwritten entry for Haldol 5mg take 1 tablet in the morning. - Haldol was documented as administered as ordered at 8:00 a.m. from 08/26/15 - 08/31/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - There was 3 entries for Haldol on the MAR. - There was a computer printed entry for Haldol 5mg 1 tablet every day at 8:00 a.m. and it was documented as administered from 09/01/15 - 09/15/15. - There was a computer printed entry for Haldol 10mg take 1 and ½ tablets in the morning at 8:00 a.m. and it was documented as administered 	C 342		

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C 342	<p>Continued From page 48</p> <p>from 09/01/15 - 09/15/15.</p> <ul style="list-style-type: none"> - There was a computer printed entry for Haldol 10mg take 1 and ½ tablets in the morning at 8:00 a.m. and it was crossed out and marked as "duplicate". <p>Review of medications on hand on 09/15/15 revealed:</p> <ul style="list-style-type: none"> - A supply of Haldol 10mg tablets 1 and ½ daily in the morning. - No Haldol 5mg tablets were observed. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He forgot to mark off the Haldol 5mg tablets from the MARs. - He did not administer the Haldol but mistakenly documented he did on the MAR. - He had asked the pharmacy to send a new MAR because some of the orders were either duplicates or old orders and it was confusing. - He did not receive a new corrected MAR to his knowledge. <p>Interview with a pharmacist at the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The most current order they had on file for Haldol was dated 08/24/15 for 5mg daily. - They had a previous order dated 07/29/15 for Haldol 10mg take 1 and ½ tablets daily. - They did not receive the order for Haldol 10mg dated 09/02/15. - They recently had a glitch in their computer system and some duplicate and previous medication orders were printed on the MARs. - Someone from the facility called and the pharmacy sent corrected MARs for September 2015 to the facility right after the first of the month. - The facility was supposed to fax any medication 	C 342		

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C 342	<p>Continued From page 49</p> <p>orders to the pharmacy and those orders are usually added to the MARs for the next month.</p> <p>Interview with the Administrator on 09/16/15 at 3:40 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not realize duplicate and old orders were printing on the MARs. - She was not aware of the pharmacy sending any corrected MARs. - The Supervisor-in-Charge checked the records and MARs about 2 weeks ago but reported no discrepancies. <p>B. Review of Resident #2's current FL-2 dated 08/24/15 revealed an order for Seroquel 800mg at bedtime. (Seroquel is an antipsychotic.)</p> <p>Review of Resident #2's record revealed an order dated 09/02/15 for Seroquel XR 400mg take 2 tablets at bedtime. (Seroquel XR is extended released form of Seroquel.)</p> <p>Review of the August 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Seroquel XR 400mg take 2 tablets daily at 8:00 p.m. - Seroquel XR was documented as administered from 08/24/15 - 08/31/15. <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Computer printed entry for Seroquel 400mg take 2 tablets at bedtime. - Seroquel was documented as administered at 8:00 p.m. from 09/01/15 - 09/14/15. - Computer printed entry for Seroquel XR 400mg take 2 tablets at bedtime. - The entry for Seroquel XR had been crossed out and none documented as administered. <p>Review of medications on hand on 09/15/15</p>	C 342		

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C 342	<p>Continued From page 50</p> <p>revealed:</p> <ul style="list-style-type: none"> - Seroquel 400mg tablets were dispensed on 08/24/15. - There was no Seroquel XR on hand. <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He had not noticed the Seroquel on hand was not Seroquel XR. - He did not know why there was no Seroquel XR on hand. - There was duplicate orders on the MAR and it made it confusing for him. <p>Interview with a pharmacist at the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The resident's insurance will not pay for the Seroquel XR without prior authorization. - The pharmacy sent prior authorization information to the physician's office but they had not heard back. - They recently had a glitch in their computer system and some duplicate and previous medication orders were printed on the MARs. - Someone from the facility called and the pharmacy sent corrected MARs for September 2015 to the facility right after the first of the month. - The order entry for Seroquel should be corrected on the next MAR in October 2015. <p>Interview with the Administrator on 09/16/15 at 3:40 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not realize duplicate and old orders were printing on the MARs. - She was not aware of the pharmacy sending any corrected MARs. - She was not aware the resident's insurance required prior authorization for the Seroquel XR. 	C 342		

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C 342	<p>Continued From page 51</p> <p>C. Review of Resident #2's record revealed an order dated 09/02/15 for Trazodone 50mg at bedtime. (Trazodone is an antidepressant sometimes used to help with anxiety and insomnia.)</p> <p>Review of the September 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - There was a computer printed entry for Trazodone 50mg take 1 tablet at bedtime. - Trazodone was scheduled to be administered at 8:00 p.m. - No Trazodone was documented as administered in September 2015. - No reasons for the omissions were documented. <p>Review of medications on hand on 09/15/15 revealed there was no Trazodone in Resident #2's medication storage bin.</p> <p>Interview with the medication aide on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #2 did not have any Trazodone on hand. - He has never administered the Trazodone because he thought the physician was going to stop it because the resident had been sleepy during the day. - He did not know if there was an order to discontinue the Trazodone. - He did not document the reason for the omissions on the MAR. <p>Interview with the Administrator on 09/15/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - She thought they had an order to hold the Trazodone due to the resident being sleepy. - The pharmacy should have a copy of the order to discontinue the Trazodone. 	C 342		

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C 342	<p>Continued From page 52</p> <p>Interview with a pharmacist at the primary pharmacy on 09/16/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - They received the order for Trazodone on 09/02/15. - They did not dispense the medication because there was a handwritten note on the fax that said to hold all medications. - They did not receive an order to discontinue the Trazodone. <p>Review of a fax sent by the pharmacy on 09/16/15 revealed:</p> <ul style="list-style-type: none"> - Copy of prescriptions dated 09/02/15 including the order for Trazodone. - Handwritten note "hold all" with no initials or signature. <p>Interview with the Administrator on 09/16/15 at 3:40 p.m. revealed:</p> <ul style="list-style-type: none"> - No one from the facility wrote to "hold all" on the fax with the orders for Resident #2. - She would contact the physician about the Trazodone. - Staff should documented the reason for omissions on the MAR. <p>Telephone interview with a representative from the mental health provider's office on 09/16/15 at 12:15 p.m. revealed:</p> <ul style="list-style-type: none"> - The Nurse Practitioner was unavailable for interview. - Resident #2 was seen in their office this morning and they were working on some of his medication orders. - The facility staff was given some orders. <p>Interview with the medication aide on 09/16/15 at 2:30 p.m. revealed:</p> <ul style="list-style-type: none"> - He had given the new orders to the SIC on his 	C 342		

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C 342	Continued From page 53 way back to the facility she could fax the orders to the pharmacy. - They do not have a fax machine at this facility. - The NP gave an order today to discontinue Trazodone. Review of an order dated 09/16/15 revealed the NP wrote an order on 09/16/15 to discontinue Trazodone.	C 342		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication orders and medication aides training and competency evaluation requirements. The findings are: 1. Based on observation, interview, and record review, the facility failed to assure clarification of medication orders for 2 of 3 residents (#1, #2) sampled including medications for thyroid problems, psychosis, mood disorders, and anxiety. [Refer to Tag C315 10A NCAC 13G .1002(a) Medication Orders (Type B Violation).] 2. Based on interviews and record reviews, the	C 912		

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C 912	Continued From page 54 facility failed to assure 2 of 2 medication aides (Staff B, C) sampled who administered medications had a clinical skills evaluation checklist completed prior to administering medications to the residents. [Refer to Tag C935 G.S. 131D-4.5B(b) Adult Care Home Medication Aides Training and Competency Evaluation Requirements (Type B Violation).]	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure residents were free of neglect as related to medication administration. The findings are: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered for 1 of 3 residents (#3) sampled including medications for psychosis, mood disorders, anxiety, insomnia, unwanted laughing and crying, thyroid problems, constipation, and dandruff. [Refer to Tag C330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation).]	C 914		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care	C935		

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C935	<p>Continued From page 55</p> <p>home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ul style="list-style-type: none"> a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ul style="list-style-type: none"> a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ul style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. <p>This Rule is not met as evidenced by:</p>	C935		

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C935	<p>Continued From page 56</p> <p>TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to assure 2 of 2 medication aides (Staff B, C) sampled who administered medications had a clinical skills evaluation checklist completed prior to administering medications to the residents. The findings are:</p> <ol style="list-style-type: none"> Review of Staff B's personnel file revealed: <ul style="list-style-type: none"> - There was no hire date listed. - There was a job application signed on 06/17/15. - There was a certificate for 5 hour and 10 hour medication aide training but it was not the certificate for the state approved training. - Staff B passed the medication aide written exam on 07/17/15. - There was no medication administration clinical skill evaluation checklist. <p>Review of the 08/2015 and 09/2015 medication administration records (MARs) revealed Staff B documented the administration of medications from 08/28/15 - 09/16/15.</p> <p>Interview with Staff B on 09/16/15 at 1:35 p.m. revealed:</p> <ul style="list-style-type: none"> - He worked at a sister facility (group home) prior to working at this facility. - He first starting working at this facility on 08/28/15. - He had worked 24 hours a day, 7 days a week since he started on 08/28/15. - He had administered medications to the residents since he started working at the facility on 08/28/15. - He had not been competency validated and did not have medication clinical skills checklist. - He recalled doing medication training but he 	C935		

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C935	<p>Continued From page 57</p> <p>was unsure if it was the state approved courses.</p> <p>Refer to interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m.</p> <p>2. Review of Staff C's personnel file revealed:</p> <ul style="list-style-type: none"> - There was no hire date listed. - There was a job application signed on 04/27/15. - There was a certificate for 5 hour and 10 hour medication aide training but it was not the certificate for the state approved training. - There was no medication administration clinical skill evaluation checklist. <p>Review of the 08/2015 and 09/2015 medication administration records (MARs) revealed Staff C documented the administration of medications from 08/11/15 - 08/14/15 and 08/22/15 - 08/28/15.</p> <p>Staff C was unavailable for interview during the survey on 09/15/15 - 09/16/15.</p> <p>Interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff C worked at a sister facility (group home) prior to working at this facility. - Staff C was relief staff for this facility and was responsible for administering medications when she worked at the facility. - Staff C first starting working at this facility the first day she documented administering medications on the August 2015 MAR which was 08/11/15. - Staff C had not been competency validated and did not have medication clinical skills checklist. <p>Refer to interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m.</p>	C935		

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C935	<p>Continued From page 58</p> <p>Interview with the Administrator / Registered Nurse on 09/16/15 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> - She was aware a medication clinical skills validation checklist should be completed prior to staff administering medications. - She had done some checklists for Staff B and Staff C at the group home prior to them working at this facility. - The checklist she did at the group home was not the medication administration clinical skills checklist. - She was responsible for assuring the medication clinical skills validation checklists were completed. - This was a new facility and she had not had time to complete the medication clinical skills validation checklists for Staff B and Staff C yet. - She used the on-line state approved 5 hour and 10 hour training courses but used her own certificates. - She would print and complete the on-line certificates for Staff B and Staff C and attach it to the certificates she made independently so it would be clear that she used the approved training courses. <hr/> <p>Review of the facility's plan of protection dated 09/16/15 revealed:</p> <ul style="list-style-type: none"> - Registered Nurse would immediately complete the medication administration clinical skills validation checklist for current staff. - Administrator will assure staff are registered for the written exam and pass the exam within 60 days of hire. - Supervisor-in-Charge will ensure that medication clinical skills checklists and requirements are met prior to staff assuming duties of administering medications. 	C935		

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C935	<p>Continued From page 59</p> <ul style="list-style-type: none"> - Administrator will assure any new staff will have the required training prior to administering medications. - Administrator will conduct monthly checks on staff training to ensure compliance. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.</p>	C935		