

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/14/2016
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NAME OF PROVIDER OR SUPPLIER LEAKSVILLE REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 915 IRVING AVENUE EDEN, NC 27288
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 01/14/15.	C 000		
C 315	<p>10A NCAC 13G .1002(a) Medication Orders</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure clarification of medication orders for 1 of 3 sampled residents (#1) with a physician's order for Chantix.</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL-2 dated 03/07/15 revealed diagnoses included chronic obstructive pulmonary disease, hypertension, diabetes, hypothyroidism, left heart catheterization and history of substance abuse.</p> <p>Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/07/15.</p>	C 315		

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

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C 315	<p>Continued From page 1</p> <p>Review of Resident #1's physician orders dated 10/05/15 revealed an order for Chantix "Starting Month Box 0.5mg (11) - 1mg (42) Take as directed." (used for smoking cessation).</p> <p>Observation of medication on hand revealed the Chantix was sent back and not present in Resident #1's medication bin.</p> <p>Review of the October 2015 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Chantix Starting Month Box with instructions to "Take as directed on pack." -The medication started 10/06/15 and documented as administered daily from 10/06/15 through 10/31/15 8:00 am.</p> <p>Review of the November 2015 MAR revealed: -There was an entry for Chantix Starting Month Box with instructions to take as directed on pack and was documented as administered at 8:00 am on 11/01/15 and 11/02/15. -There was an entry for Chantix Continuing Month Pack with instructions to take as directed on pack and was documented as administered daily at 8:00 am on 11/03/15 through 11/12/15, and documented as refused daily from 01/13/15 through 11/30/15. -There was no documentation that explained why Resident #1 refused the Chantix.</p> <p>Review of the December 2015 MAR revealed: -There was an entry for Chantix Starting Month Box with instructions to take as directed on pack and was documented as administered at 8:00 am on 12/01/15 through 12/04/15 and documented as refused daily from 12/05/15 through 12/21/15. -There was an entry for Chantix Continuing</p>	C 315		

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C 315	<p>Continued From page 2</p> <p>Month Pack with instructions to take as directed on pack and was documented as administered daily at 8:00 am on 12/01/15 through 12/04/15 and documented as refused daily from 12/05/15 through 12/21/15.</p> <p>-There was no documentation that explained why Resident #1 refused the Chantix.</p> <p>Record review revealed no documentation the physician was contacted to clarify how Chantix was to be administered.</p> <p>Interview with a representative of the contracting pharmacy on 01/14/16 at 3:04 pm revealed:</p> <ul style="list-style-type: none"> -The facility was sent a Chantix started pack 10/05/15 which contains 11, 0.5mg tablets and 28, 1mg tablets. -The Chantix, per the instructions, was to be administered 0.5 mg daily for three days and then 0.5 mg twice daily for four more days, then the dosing was increased to 1 mg twice daily. -The starter pack was to last three weeks. -One continuing pack was dispensed 11/04/15. -The continuing packs included 4 cards with each card containing 14, 1mg tablets to be administered twice daily. -The continuing packs were to last one month. -When they received an order for "Take as directed" the program automatically set the time for administration for 8:00 am even if the medication was to be administered more than once daily. -The pharmacy staff expected the staff at the facility to either call for additional entries to be manually entered or for the facility staff to write the order out on a separate, hand written MAR. -The representative did not know if this was communicated to the facility. <p>Interview with the Administrator on 01/14/16 at</p>	C 315		

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C 315	<p>Continued From page 3</p> <p>2:26 pm revealed:</p> <ul style="list-style-type: none"> -She knew that "Take as directed" was not a complete order. -She did not call Resident #1's physician's office to obtain clarification of the Chantix order to "Take as directed" . -She did not know how Chantix was initially administered, but did know that it increased to twice a day. -She knew Resident #1 had received the medication in the morning and the evening. -She knew Resident #1 started to refuse the morning dose because the medication made her nauseous. -She thought there was an entry for Chantix to be given in the morning and the evening on the eMAR. -She did not know why there was not an evening entry for Chantix. -She knew it was given in the evening because she had administered it in the evening and that was how the Chantix dosing pack instructed to administer the medication. -She knew to document refusals on the eMAR and had not done so. <p>Interview with the Supervisor-in-Charge on 01/14/15 at 3:09 pm revealed:</p> <ul style="list-style-type: none"> -She knew that "take as directed" was not a complete order, but did not seek clarification with the physician's office. -She knew Chantix was to be given twice daily and had administered it twice daily. -She did not know why the evening dose was not on the MAR. -She gave the medication in the evening because that is what the directions indicated. -She administered the Chantix as directed on the pack and was not aware she was not signing the evening dose out. 	C 315		

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C 315	<p>Continued From page 4</p> <p>Interview with Resident #1 on 01/14/16 at 5:15 p.m. revealed: -She did take the Chantix and eventually started to refuse the morning dose because it would make her nauseous. -She knew she was given Chantix at night and did not mind taking it at night because she could sleep through the side effects. -She quit smoking the week she started Chantix and it had been very effective. -She had no desire to smoke and no longer had cravings.</p> <p>Interview with a Nurse at Resident #1's primary care physician's office on 1/14/16 at 3:50 pm revealed: -Facility staff never called to clarify the Chantix orders. -The office never received notification that Resident #1 was refusing the morning dose of Chantix. -Resident #1 had quit smoking and this was the intended effect of the medication regardless of refusals or error in administration.</p>	C 315		
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: (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;</p>	C 342		

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C 342	<p>Continued From page 5</p> <p>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;</p> <p>(6) date and time of administration;</p> <p>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and</p> <p>(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 sampled residents (#1, #2) with physician's orders for medications used for smoking cessation, constipation, allergies and post-surgical eye drops.</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL-2 dated 03/07/15 revealed diagnoses included chronic obstructive pulmonary disease, hypertension, diabetes, hypothyroidism, left heart catheterization and history of substance abuse.</p> <p>Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/07/15.</p> <p>1. Review of Resident #1's physician orders dated 10/05/15 revealed an order for "Chanitx Starting Month Box 0.5mg (11) - 1mg (42) Take as directed."</p> <p>Observation of medication on hand revealed the</p>	C 342		

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C 342	<p>Continued From page 6</p> <p>Chantix was sent back and not present in Resident #1's medication bin.</p> <p>Review of the October 2015 Medication Administration Record (MAR) revealed: -There was an entry for Chantix Starting Month Box with instructions to "Take as directed on pack." -The medication started 10/06/15 and documented as administered daily from 10/06/15 through 10/31/15 8:00 am.</p> <p>Review of the November 2015 MAR revealed: -There was an entry for Chantix Starting Month Box with instructions to take as directed on pack and was documented as administered at 8:00 am on 11/01/15 and 11/02/15. -There was an entry for Chantix Continuing Month Pack with instructions to take as directed on pack and was documented as administered daily at 8:00 am on 11/03/15 through 11/12/15 and documented as refused daily from 01/13/15 through 11/30/15. -There was no documentation that explained why Resident #1 refused the Chantix.</p> <p>Review of the December 2015 MAR revealed: -There was an entry for Chantix Starting Month Box with instructions to take as directed on pack and was documented as administered at 8:00 am on 12/01/15 through 12/04/15 and documented as refused daily from 12/05/15 through 12/21/15. -There was an entry for Chantix Continuing Month Pack with instructions to take as directed on pack and was documented as administered daily at 8:00 am on 12/01/15 through 12/04/15 and documented as refused daily from 12/05/15 through 12/21/15. -There was no documentation that explained why Resident #1 refused the Chantix.</p>	C 342		

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C 342	<p>Continued From page 7</p> <p>-There was a hand written discontinue on the Chantix Continuing pack entry dated 12/16/15.</p> <p>Record review revealed no documentation the physician was contacted to clarify how Chantix was to be administered.</p> <p>Review of physican orders for Resident #1 dated 12/16/15 revealed the Chantix was discontinued on 12/16/15.</p> <p>Interview with the Administrator on 01/14/16 at 2:26 pm revealed:</p> <p>-She knew that "Take as directed" was not a complete order.</p> <p>-She did not call Resident #1's physician's office to obtain clarification of the Chantix order to "Take as directed".</p> <p>-She did not know how Chantix was initially administered, but did know that it increased to twice a day.</p> <p>-She knew Resident #1 had received the medication in the morning and the evening.</p> <p>-She knew Resident #1 started to refuse the morning dose because the medication made her nauseous.</p> <p>-She thought there was an entry for Chantix to be given in the morning and the evening on the eMAR.</p> <p>-She did not know why there was not an evening entry for Chantix.</p> <p>-She knew that it was given in the evening because she had administered it in the evening and that was how the Chantix dosing pack instructed to administer the medication.</p> <p>-She knew to document refusals on the MAR and had not done so.</p> <p>-She did not know why the Chantix was documented as refused from 12/16/15 through 12/21/15 because it was discontinued on</p>	C 342		

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C 342	<p>Continued From page 8</p> <p>12/16/15.</p> <p>Interview with the Supervisor-in-Charge on 01/14/15 at 3:09 p.m. revealed:</p> <ul style="list-style-type: none"> -She knew that "take as directed" was not a complete order, but did not seek clarification with the physician's office. -She knew that Chantix was to be given twice daily and had administered it twice daily. -She did not know why the evening dose was not on the MAR. -She administered the Chantix as directed on the pack and was aware she was not signing the evening dose out. -She knew to document refusals on the MAR and had not done so. -She did not know what the Chantix was documented as refused from 12/16/15 through 12/21/15 because it was discontinued on 12/16/15. <p>Interview with Resident #1 on 01/14/16 at 5:15 p.m. revealed:</p> <ul style="list-style-type: none"> -She did take the Chantix and eventually started to refuse the morning dose because it would make her nauseous. -She knew she was given Chantix at night and did not mind taking it at night because she could sleep through the side effects. -She quit smoking the week she started Chantix and it had been very effective. -She had no desire to smoke and no longer had cravings. <p>Interview with Resident #1's Physician's nurse on 1/14/16 at 3:50 pm revealed:</p> <ul style="list-style-type: none"> -Facility staff never called to clarify the Chantix orders. -The office never received notification that Resident #1 was refusing the morning dose of 	C 342		

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C 342	<p>Continued From page 9</p> <p>Chantix. -Resident #1 had quit smoking and this was the intended effect of the medication regardless of refusals or error in administration.</p> <p>Refer to interview with the Administrator on 01/14/16 at 4:02 p.m.</p> <p>2. Review of Resident #1's Physician orders dated 10/15/15 revealed an order for Senna-S two tablets at bedtime.</p> <p>Review of the October 2015 Medication Administration Record (MAR) revealed the Senna-S was administered as ordered from 10/16/15 through 10/31/15.</p> <p>Review of the November 2015 MAR revealed the Senna-S was documented as administered as ordered from 11/01/15 through 11/25/15.</p> <p>Review of the December 2015 MAR revealed the Senna-S was documented as administered on 12/01/15 through 12/13/15.</p> <p>Review of physican orders dated 11/25/15 revealed the Senna-S was discontinued.</p> <p>Interview with a representative from the contracting pharmacy on 01/14/15 at 4:55 pm revealed: -They received an order to discontinue the Senna-S from the facility on 11/25/15. -The pharmacy dispensed 30 doses of the Senna-S was on 10/15/15. -The pharmacy dispensed 15 more doses of the Senna-S on 11/13/15 and this was to last until their next cycle fill on 11/28/15. -The pharmacy did not have a record of how many doses were returned to the pharmacy from</p>	C 342		

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C 342	<p>Continued From page 10</p> <p>the facility because it was over the counter and was destroyed as there were only 3 doses that remained.</p> <p>-They did not know why the Senna-S entry was not removed from the December MAR but it should have been removed.</p> <p>-The pharmacy was responsible for removing the entry from the MAR.</p> <p>Interview with the Adminstrator on 01/14/16 at 4:00 pm revealed:</p> <p>-When she received an order to discontinue a medication she would immediately remove the medication from the medication bin and place it in the tote to be returned to the pharmacy.</p> <p>-They did not have or use medication disposition forms.</p> <p>Refer to interview with the Adminstrator on 01/14/16 at 4:02 pm</p> <p>3. Review of Resident #1's Physician orders dated 11/12/15 revealed an order for azelastine 137 mcg nasal spray, two sprays in each nostril twice daily.</p> <p>Review of the November 2015 Medication Administration Record (MAR) revealed the azelastine 137 mcg nasal spray was documented as administered as ordered from 11/01/15 through 11/30/15 at 8:00 am and 8:00 pm.</p> <p>Review of the December 2015 MAR revealed the azelastine 137 mcg nasal spray was documented as administered as ordered on 12/01/15 through 12/13/15 at 8:00 am and 8:00 pm.</p> <p>Review of physican orders dated 12/08/15 revealed the azelastine 137 mcg nasal spray was discontinued.</p>	C 342		

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C 342	<p>Continued From page 11</p> <p>Refer to interview with the Administrator on 01/14/16 at 4:02 p.m.</p> <p>B. Review of Resident #2's current FL2 dated 07/17/15 revealed diagnoses included hypertension, osteoporosis, memory loss, anxiety, and depression.</p> <p>Review of Resident #2's record revealed: -A physician's order dated 08/04/15 for Prednisolone Acetate 1% ophthalmic solution use one drop in four times a day. Begin 3 hours post operatively to the operated eye until the bottle is empty.</p> <p>Review of Resident #2's November 2015 Medication Administration Record (eMAR) revealed: -A computer generated entry for Prednisolone Acetate 1% ophthalmic solution use one drop in four times a day. Begin 3 hours post operatively to the operated eye until the bottle is empty. -The start date for the Prednisolone Acetate drops was 08/10/2015. -Documented initials on 11/01/15, 11/02/15, 11/03/15, and 11/04/15 that the Prednisolone Acetate drops were administered at 8:00 am.</p> <p>Review of medications on the medication cart for Resident #2 revealed Prednisolone Acetate drops were filled on 11/05/15 and were available for administration.</p> <p>Interview with a Medication Aide (MA) on 01/14/16 at 3:30 pm revealed: -She was responsible for medication administration and documenting on the MAR. -Resident #2 had cataract surgery in August 2015</p>	C 342		

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C 342	<p>Continued From page 12</p> <p>and again in November 2015.</p> <ul style="list-style-type: none"> -The Resident required several types of eye drops following the surgery. -She gave the Prednisolone Acetate drops following the surgery in August 2015, but the resident was not receiving the eye drops on 11/01/15, 11/02/15, 11/03/15, and 11/04/15. -She was not sure why she documented on 11/01/15, 11/02/15, 11/03/15, and 11/04/15 that the Prednisolone Acetate drops were administered at 8:00 am. -The resident was out of the drops by that time, so she would not have had any to administer. -The facility was responsible for notifying the pharmacy when a medication had been discontinued. <p>Interview with the Pharmacist at the contract pharmacy on 01/14/16 at 5:00 pm revealed:</p> <ul style="list-style-type: none"> -The pharmacy was responsible for removing discontinued medications from the MARs after they were no longer ordered. -There was a new physician's order dated 11/03/15 for Prednisolone Acetate 1% ophthalmic solution use one drop in four times a day. Begin 3 hours post operatively to the operated eye until the bottle is empty. -The new order was because Resident #2 had been scheduled for a second eye surgery in November. -He filled and delivered to the facility, the Prednisolone Acetate eye drops on 11/05/15. <p>Interview with the Administrator on 01/14/16 at 4:45 pm revealed:</p> <ul style="list-style-type: none"> -She did not know why the pharmacy did not remove the order for the Prednisolone Acetate eye drops that were originally ordered on 08/04/15. -Resident #2 had completed the first eye drops 	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/14/2016
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NAME OF PROVIDER OR SUPPLIER LEAKSVILLE REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 915 IRVING AVENUE EDEN, NC 27288
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C 342	<p>Continued From page 13</p> <p>ordered on 08/04/05.</p> <p>-Resident #2 was now receiving the Prednisolone Acetate eye drops twice a day as the physician wrote an order on 11/30/15 to change the frequency from four times a day to twice a day.</p> <p>Refer to interview with the Adminstrator on 01/14/16 at 4:02 p.m.</p> <hr/> <p>Interview with the Adminstrator on 01/14/16 at 4:02 p.m. revealed:</p> <p>-When she received an order to discontinue a medication she wrote discontinue on the medication entry on the MAR by hand writing "discontinued"or "D/C" and the date.</p> <p>-She faxed the pharmacy the order and they were to remove the entry from the MAR.</p> <p>-She was responsible for checking the MARs at the end of every month to ensure the next months MARs were accurate.</p> <p>-She had checked the MARs at the end of every month.</p> <p>-She did not know why some medication stayed on the eMAR.</p> <p>-She did not know why she did not observe the entries that should have been discontinued from the previous month.</p> <p>-She nor the MA noticed they had been signing out the medications despite they had been discontinued and the medication was not in the facility.</p>	C 342		