

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL078101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2015
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NAME OF PROVIDER OR SUPPLIER PARKTON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1165 WEST PARKTON TOBEMORY RD PARKTON, NC 28371
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D 000	Initial Comments	D 000		
D 317	<p>10A NCAC 13F .0905 (d) Activities Program</p> <p>10A NCAC 13F .0905 Activities Program</p> <p>(d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure there were a minimum of 14 hours of planned group activity per week including activities that promote socialization, physical interaction, creative expression, and increased knowledge and learning of new things.</p> <p>The findings are:</p> <p>Observation of the posted activity calendar for the week of 12/6/15 - 12/11/15 revealed:</p>	D 317		

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

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D 317	<p>Continued From page 1</p> <ul style="list-style-type: none"> - Sunday - Church 10-11 - Monday - Store 9-10, Coffee 10-11, Workout 11-12, Bingo 1-2 - Tuesday - GB (bible study group) 10-11, Spirit Power and Praise 7-8 - Wednesday - Store 9-10, Coffee 10-11, SB (shuffle board) 11-12, Fancy Nails 1-2 - Thursday - Lunch with Holy Sisters 12-1 - Friday - Store 9-10, Coffee 10-11, Workout 11-12, Shopping 1-4 <p>Observation on Thursday 12/10/15 from 12:00pm - 1:00pm revealed lunch was brought in by a church group, no activity was involved.</p> <p>Observation on Friday 12/11/15 from 8:45am - 5pm revealed:</p> <ul style="list-style-type: none"> - Activity Director was not at the facility. - Activity room was locked all day. - No activities were completed. <p>10 resident interviews on 12/9/15 at 11:10am revealed:</p> <ul style="list-style-type: none"> - There were no activities offered at the facility recently (last 3-4 months). - The residents were not interested in the activities that were done. - The only outing was occasional shopping and the residents did not have money for shopping. - Most residents like to play bingo, but it had not been offered in a long time (several months). - A resident had asked the facility's activity director (4 months ago) to provide a ping pong table or a pool table for residents' activities but was told they would think about it. - There was nothing to do but go outside and smoke and the residents were tired of just being here and doing nothing. - The residents were playing bingo at one time, but have not played in several months. 	D 317		

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D 317	<p>Continued From page 2</p> <ul style="list-style-type: none"> - Resident would like to have more activities. <p>Telephone interview on 12/10/15 at 12:05pm with the Activity Director revealed:</p> <ul style="list-style-type: none"> - Activity Director works three days per week - Monday, Wednesday and Friday. - 'Fancy nails' activity was held on 12/9/15 and 2 or 3 residents participated, while a few residents colored. - 'Coffee' activity is held every Monday, Wednesday and Friday, during this time residents come into activity room have coffee and have discussions. - 'Store' on the calendar is the store that is run out of the activity room and it is open on Monday, Wednesday and Friday from 9am - 10am, during this time residents can make purchases from the store. - The store was operated by one of the residents, so it is an independent activity for her. - Activities were offered, but activity director can not make residents participate. - Bingo is an activity, but right now there were no prizes, so residents do not want to play. - Activity director stated 'SB' on the calendar was shuffle board and 'GB' was a bible study group that comes in. - There are no funds for parties or games like 'deal or no deal' that residents may enjoy and the DVD player used for watching movies is broken. - Shopping day is scheduled twice a month and is listed on activity calendar. - Only three residents can be transported at the time, so several trips are made, no sign up list is posted for shopping days. <p>Interview on 12/10/15 at 2:50pm with the Administrator revealed:</p> <ul style="list-style-type: none"> - Administrator was not aware of the DVD player being broken, and was not aware that no prizes 	D 317		

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D 317	Continued From page 3 were available for activities. - Funds were available and supplies would have been purchased for activity program. - Activity director should have sign-up sheet on her door for shopping days so residents could sign up for time and day. Interview on 12/11/15 at 3:00pm with a Medication Aide (MA) revealed: - MA has observed some residents having their nails done or playing checkers. - MA has observed residents going shopping occasionally when they ask. - MA is not aware of their being a sign up sheet for shopping days and is not aware of any other activities.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure medications were administered as ordered for 3 of 5 sampled residents (Resident # 3 Vitamin D; Resident #1 Lantus insulin; and Resident #2 Coumadin. The findings are: 1. Review of Resident #3's current FL-2 dated 9/22/15 revealed:	D 358		

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D 358	<p>Continued From page 4</p> <ul style="list-style-type: none"> - Diagnoses which included dementia, congestive heart failure, vitamin D deficiency and chronic kidney disease. - The resident was admitted to the facility on 7/01/15. <p>Review of a pharmacy "Note to Attending Physician/Prescriber" dated 8/8/15 revealed:</p> <ul style="list-style-type: none"> - Resident #3's Vitamin D was [discontinued] on 7/6/15, but the [medication] was reordered by mistake on the 8/3/15 physician's order sheet. Please verify Vitamin D was [discontinued] as follows: Plan: [discontinue vitamin D]. - Physician/Prescriber response was "agree" (signed on 8/17/15 by prescriber). <p>Review of Resident #3's MARS for August 2015, September 2015 and October 2015 revealed Vitamin D 2000 softgel, 1 capsule by mouth was documented as administered 2 times a day at 8:00am and 8:00pm.</p> <p>Review of a pharmacy "Note to Attending Physician/Prescriber" dated 10/29/15 revealed:</p> <ul style="list-style-type: none"> - Resident #3's Vitamin D was [discontinued] on 8/17/15, but the [medication] was reordered by mistake on the 10/13/15 physician's order sheet. Please verify Vitamin D was [discontinued] as follows: Plan: [discontinue vitamin D]. - Physician/Prescriber response was "agree" (signed on 11/26/15 by prescriber). <p>Review of Resident #3's MARS for November 2015, and December 1st through December 10th, 2015 revealed Vitamin D 2000 softgel, 1 capsule by mouth was documented as administered 2 times a day at 8:00am and 8:00pm.</p> <p>Interview with facility pharmacist on 12/11/15 at 10:10am revealed:</p>	D 358		

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D 358	<p>Continued From page 5</p> <ul style="list-style-type: none"> - Resident #3's Vitamin D 2000 softgel order was originally filled from FL-2 dated 7/01/15 and was scheduled for monthly refills. - Vitamin D 2000 softgel, 60 to 62 capsules were dispensed each month from July to December 2015. - The physician order sheets automatically print with monthly MARS. If the pharmacy did not receive order to change or discontinue a medication, the medication was dispensed on monthly refills. - The facility faxed a discontinue order for Vitamin D 2000 softgels on 12/10/15. The discontinue order was signed by the physician on 11/26/15. <p>Observation of Resident #3's medications on hand at the facility on 12/11/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - (2) pre-packaged bubble packs of Vitamin D 2000 softgel with 11 capsules in 1st pack (20 tablets were removed) and 31 tablets in 2nd pack. - Instructions on both packs were "Vitamin D 2000 softgels, take 1 capsule by mouth twice a day", 62 capsules [dispensed on] 12/01/15". <p>Interview with the 1st shift MA on 12/11/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - Resident #3 was administered Vitamin D 2000 softgel, 1 capsule, this morning at the 8:00am medication pass. - The order for Vitamin D had not been discontinued and was on current MAR. - The resident was administered Vitamin D capsule 2 times a day at 8:00am and 8:00pm since admission (July, 2015). <p>Review of Resident #3's December 2015 on 12/11/15 at 11:05am revealed Vitamin D 2000</p>	D 358		
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D 358	<p>Continued From page 6</p> <p>softgel was documented as administered at 8:00am.</p> <p>Interview with the facility's RCC on 12/11/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - When the Vitamin D was discontinued on 8/17/15, the medication order should have been discontinued on the current MAR and the medication removed from the medication by the RCC or the medication aide (MA). The order should have been faxed to the facility's pharmacy. - The Vitamin D 2000 softgels was discontinued again by the physician on 12/10/15 and the order was faxed to the pharmacy. - The medication should not be in the medication cart today, should have been removed from the cart on 12/10/15 by the MA. - The Vitamin D capsules will be removed from the medication cart immediately. <p>Refer to interview with the facility's RCC on 12/11/15 at 3:45pm.</p> <p>2. Review of Resident #1's FL-2 dated 9/22/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses which included Diabetes, contracture of hands, hypertension, and history of cerebral vascular accident. - An order for Lantus, inject 25 units at bedtime. <p>Review of a physician's order dated 8/25/15 revealed:</p> <ul style="list-style-type: none"> - An order to decrease Lantus to 25 units at bedtime. - Handwritten below the order was "faxed to [facility's pharmacy] on 8/25/15". <p>Review of Resident #1's Medication</p>	D 358		

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D 358	<p>Continued From page 7</p> <p>Administration Record (MAR) for August 2015 revealed:</p> <ul style="list-style-type: none"> - Preprinted administration instructions for Lantus insulin, inject 30 units under skin (subcutaneous) at bedtime which was discontinued (handwritten) on 8/25/15. - Lantus insulin, 30 units, was documented as administered from 8/01/15 to 8/25/15 at 8:00pm. - Handwritten on the MAR was "8/25/15, Lantus injection 100/ml, inject 25 units under the skin at bedtime at 8:00pm". - Lantus insulin 25 units was documented as administered from 8/26/15 to 8/31/15. <p>Review of Resident #1's September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Preprinted administration instructions for Lantus 30 units, under the skin [subcutaneous] at bedtime. "Order change 8/27/15" was handwritten in the documentation area. - Handwritten on the MAR was "8/27/15, inject 30 units [subcutaneous] at bedtime". Lantus insulin 30 units was documented as administered from 9/01/15 to 9/30/15. <p>Review of the facility's "Consultant Pharmacist's Medication Regimen Review" (dated 10/29/15) for recommendations for Resident #1 revealed:</p> <ul style="list-style-type: none"> - Please note Lantus was decreased from 30 units at HS [bedtime] to 25 units at HS on 8/27/15. - Staff [discontinued] the 30 units order on September MAR but rewrote order with exact same instructions for 30 units instead of 25 units, so September MAR looks like 30 units continued to be given through the end of the month. (October MAR is correct). <p>Review of the resident's September 2015 blood sugars (ordered 4 times aday before meals and</p>	D 358		

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D 358	<p>Continued From page 8</p> <p>at bedtime) revealed ranges from 71 to 231. The resident had 3 BS readings which was documented as 75 (on 9/7/15), 71 (on 9/12/15) and 73 (on 9/13/15) at 6:00am.</p> <p>Interview with 1st shift medication aide (MA) on 12/11/15 at 11:15am revealed:</p> <ul style="list-style-type: none"> - Resident #1 was administered 30 units of Lantus insulin from 09/01/15 through 09/30/15. - The order for Lantus insulin was handwritten on the September 2015 MAR by facility staff because the order was recieved at the end of August (8/27/15), which was too late for the pharmacy to preprint new order on MAR. - Did not know why Lantus 30 units at bedtime was handwritten on the September MAR instead of Lantus 25 units at bedtime. - The facility's RCC checked the new preprinted MAR's for accuracy when received from the facility's pharmacy and made corrections if needed. <p>Interview with the facility's Administrator on 12/11/15 at 3:15pm revealed:</p> <ul style="list-style-type: none"> - She was not aware the facility's pharmacy consultant provided a "Medication Regimen Review" sheet with the recommendations for the facility follow-up. - She was not aware Resident #1's order for Lantus 25 units at bedtime had been transcribed incorrectly on the September 2015 MAR. - The facility's Resident Care Coordinator (RCC) was responsible for assuring all orders are correct. - The Administrator will immediately begin to check the recommendations after all quarterly pharmacy reviews to prevent medication errors. <p>Interview with the facility's RCC on 12/11/15 at</p>	D 358		

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D 358	<p>Continued From page 9</p> <p>3:40pm revealed:</p> <ul style="list-style-type: none"> - She was not aware Resident #1's order for Lantus 25 units at bedtime had been transcribed incorrectly on the September 2015 MAR (30 units instead of 25 units at bedtime). - The staff documented on September MAR, the resident's Lantus, 30 units, was administered each day at bedtime. <p>Review of Resident #1's 2015 MARs for the months of October, November and December revealed Lantus was preprinted on each MAR (Lantus injection, 25 units, under the skin at bedtime).</p> <p>Refer to interview with the facility's RCC on 12/11/15 at 3:45pm.</p> <p>3. Review of Resident #2's current FL2 dated 9/22/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included dementia, acute congestive heart failure, history of cerebral vascular accident, high blood pressure, atrial fib, and bipolar disorder. - An order for Warfarin 5mg daily. - An order for Warfarin 2.5mg on Tuesday and Thursday. <p>Review of INR lab report dated 9/25/15 revealed:</p> <ul style="list-style-type: none"> - INR - 1.3 - Therapeutic range INR 2.0 - 3.0 - Written order (no date) to discontinue the current Coumadin dose and start Coumadin 6mg on Tuesday, Thursday and Sunday. Coumadin 5mg all other days. - Repeat PT/INR on Thursday 10/8/15. <p>Review of INR lab report dated 10/9/15 revealed:</p> <ul style="list-style-type: none"> - INR - 1.4 	D 358		

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D 358	<p>Continued From page 10</p> <p>Review of Resident #2's October 2015 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> - An order was handwritten on the MAR effective 10/1/15 as "Coumadin 5mg take one by mouth on Tuesday, Thursday, Sunday" and "Coumadin 6mg take one by mouth on Monday, Wednesday, Friday, Saturday". - The numbers (5 and 6) in the handwritten order appear to have been written over and changed, the '6' was changed to '5' and the '5' was changed to '6'. - Coumadin 5mg was documented as administered every Tuesday, Thursday and Sunday from 10/1/15 - 10/31/15. - Coumadin 6mg was documented as administered every Monday, Wednesday, Friday and Saturday from 10/1/15 - 10/31/15. <p>Review of Resident #2's pharmacy review completed on 10/29/15 by pharmacy provider revealed:</p> <ul style="list-style-type: none"> - Coumadin 6mg ordered on Tuesday, Thursday and Sunday with 5mg other days of the week (on 10/1/15). Staff A wrote the order correctly on October MAR, but another staff wrote over the 5mg and 6mg and switched them so that 5mg is given on Tuesday, Thursday, and Sunday and 6mg other days. This is incorrect, told RCC to make facility physician aware of how the medication was given so physician can make appropriate adjustment at next INR. <p>Interview on 12/10/15 at 11:50am with Resident #2 revealed:</p> <ul style="list-style-type: none"> - Resident does not know the names of his medication, he takes what he is given. - Resident is not aware of any problems or errors with his medication. 	D 358		

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D 358	<p>Continued From page 11</p> <ul style="list-style-type: none"> - Resident #2 is aware he is on a blood thinner and he has regular labs completed. <p>Refer to interview with the facility's RCC on 12/11/15 at 3:45pm.</p> <hr/> <p>Interview on 12/11/15 at 3:50pm with Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> - RCC is working as a temporary Resident Care Coordinator, previous RCC left around the end of October and RCC took over these duties. - RCC was previously a Medication Aide until taking over duties of RCC. - RCC transcribed the 10/1/15 Coumadin order for Resident #2 correctly, but previous RCC changed the 6mg to 5mg and changed the 5mg to 6mg when she reviewed the order. <p>Interview on 12/11/15 at 3:10pm with the Administrator revealed:</p> <ul style="list-style-type: none"> - Resident medication administration records (MAR's) are reviewed at the beginning of each month by quality improvement staff and the med aide. - The RCC is responsible for reviewing all orders that have been transcribed to the MAR. - Administrator recently learned of previous RCC changing the handwritten order for Resident #2 and that is one of the reasons previous RCC is no longer employed. 	D 358		
D 406	<p>10A NCAC 13F .1009(b) Pharmaceutical Care</p> <p>10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or</p>	D 406		

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D 406	<p>Continued From page 12</p> <p>appropriate health professional has been informed of the findings when necessary.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interview and record review, the facility failed to assure action was taken to recommendations from the pharmacy medication review for 4 of 5 sampled residents (Resident #1 Lantus insulin; Resident # 3 Vitamin D; Resident #2 Coumadin and Resident #4 Zyprexa). The findings are:</p> <p>1. Review of Resident #3's current FL-2 dated 9/22/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses which included dementia, congestive heart failure, vitamin D deficiency and chronic kidney disease. - The resident was admitted to the facility on 7/01/15. <p>Review of a pharmacy "Note to Attending Physician/Prescriber" dated 8/8/15 revealed:</p> <ul style="list-style-type: none"> - Resident #3's Vitamin D was [discontinued] on 7/6/15, but the [medication] was reordered by mistake on the 8/3/15 physician's order sheet. Please verify Vitamin D was [discontinued] as follows: Plan: [discontinue vitamin D]. - Physician/Prescriber response was "agree" (signed on 8/17/15 by prescriber). <p>Review of Resident #3's MARS for August 2015, September 2015 and October 2015 revealed Vitamin D 2000 softgel, 1 capsule by mouth was documented as administered 2 times a day at 8:00am and 8:00pm.</p> <p>Review of a pharmacy "Note to Attending</p>	D 406		

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D 406	<p>Continued From page 13</p> <p>Physician/Prescriber" dated 10/29/15 revealed:</p> <ul style="list-style-type: none"> - Resident #3's Vitamin D was [discontinued] on 8/17/15, but the [medication] was reordered by mistake on the 10/13/15 physician's order sheet. Please verify Vitamin D was [discontinued] as follows: Plan: [discontinue vitamin D]. - Physician/Prescriber response was "agree" (signed on 11/26/15 by prescriber). <p>Review of Resident #3's MARS for November 2015, and December 1st through December 10th, 2015 revealed Vitamin D 2000 softgel, 1 capsule by mouth was documented as administered 2 times a day at 8:00am and 8:00pm.</p> <p>Interview with facility pharmacist on 12/11/15 at 10:10am revealed:</p> <ul style="list-style-type: none"> - Resident #3's Vitamin D 2000 softgel order was originally filled from FL-2 dated 7/01/15 and was scheduled for monthly refills. - Vitamin D 2000 softgel, 60 to 62 capsules were dispensed each month from July to December 2015. - The physician order sheets automatically print with monthly MARS. If the pharmacy did not receive order to change or discontinue a medication, the medication was dispensed on monthly refills. - The facility faxed a discontinue order for Vitamin D 2000 softgels on 12/10/15. The discontinue order was signed by the physician on 11/26/15. <p>Observation of Resident #3's medications on hand at the facility on 12/11/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - (2) pre-packaged bubble packs of Vitamin D 2000 softgel with 11 capsules in 1st pack (20 tablets were removed) and 31 tablets in 2nd pack. 	D 406		

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D 406	<p>Continued From page 14</p> <ul style="list-style-type: none"> - Instructions on both packs were "Vitamin D 2000 softgels, take 1 capsule by mouth twice a day", 62 capsules [dispensed on] 12/01/15". <p>Interview with the 1st shift MA on 12/11/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - Resident #3 was administered Vitamin D 2000 softgel, 1 capsule, this morning at the 8:00am medication pass. - The order for Vitamin D had not been discontinued and was on current MAR. - The resident was administered Vitamin D capsule 2 times a day at 8:00am and 8:00pm since admission (July, 2015). <p>Review of Resident #3's December 2015 on 12/11/15 at 11:05am revealed Vitamin D 2000 softgel was documented as administered at 8:00am.</p> <p>Interview with the facility's RCC on 12/11/15 at 11:00am revealed:</p> <p>Refer to Interview with the facility's Administrator on 12/11/15 at 3:15PM.</p> <p>Refer to interview with the facility's RCC on 12/11/15 at 3:45pm.</p> <ul style="list-style-type: none"> - When the Vitamin D was discontinued on 8/17/15, the medication order should have been discontinued on the current MAR and the medication removed from the medication by the RCC or the medication aide (MA). The order should have been faxed to the facility's pharmacy. - The Vitamin D 2000 softgels was discontinued again by the physician on 12/10/15 and the order was faxed to the pharmacy. - The medication should not be in the medication cart today, should have been removed from the cart on 12/10/15 by the MA. 	D 406		

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D 406	<p>Continued From page 15</p> <ul style="list-style-type: none"> - The Vitamin D capsules will be removed from the medication cart immediately. <p>2. Review of Resident #1's FL-2 dated 9/22/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses which included Diabetes, contracture of hands, hypertension, and history of cerebral vascular accident. - An order for Lantus, inject 25 units at bedtime. <p>Review of a physician's order dated 8/25/15 revealed:</p> <ul style="list-style-type: none"> - An order to decrease Lantus to 25 units at bedtime. - Handwritten below the order was "faxed to [facility's pharmacy] on 8/25/15". <p>Review of Resident #1's Medication Administration Record (MAR) for August 2015 revealed:</p> <ul style="list-style-type: none"> - Preprinted administration instructions for Lantus insulin, inject 30 units under skin (subcutaneous) at bedtime which was discontinued (handwritten) on 8/25/15. - Lantus insulin, 30 units, was documented as administered from 8/01/15 to 8/25/15 at 8:00pm. - Handwritten on the MAR was "8/25/15, Lantus injection 100/ml, inject 25 units under the skin at bedtime at 8:00pm". - Lantus insulin 25 units was documented as administered from 8/26/15 to 8/31/15. <p>Review of Resident #1's September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - Preprinted administration instructions for Lantus 30 units, under the skin [subcutaneous] at bedtime. "Order change 8/27/15" was handwritten in the documentation area. 	D 406		

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D 406	<p>Continued From page 16</p> <ul style="list-style-type: none"> - Handwritten on the MAR was "8/27/15, inject 30 units [subcutaneous] at bedtime". Lantus insulin 30 units was documented as administered from 9/01/15 to 9/30/15. <p>Review of the facility's "Consultant Pharmacist's Medication Regimen Review" (dated 10/29/15) for recommendations for Resident #1 revealed:</p> <ul style="list-style-type: none"> - Please note Lantus was decreased from 30 units at HS [bedtime] to 25 units at HS on 8/27/15. - Staff [discontinued] the 30 units order on September MAR but rewrote order with exact same instructions for 30 units instead of 25 units, so September MAR looks like 30 units continued to be given through the end of the month. (October MAR is correct). <p>Review of the resident's September 2015 blood sugars (ordered 4 times aday before meals and at bedtime) revealed ranges from 71 to 231. The resident had 3 BS readings which was documented as 75 (on 9/7/15), 71 (on 9/12/15) and 73 (on 9/13/15) at 6:00am.</p> <p>Interview with the facility's Administrator on 12/11/15 at 3:15pm revealed:</p> <ul style="list-style-type: none"> - She was not aware Resident #1's order for Lantus 25 units at bedtime had been transcribed incorrectly on the September 2015 MAR. - The facility's Resident Care Coordinator (RCC) was responsible for assuring all orders are correct. <p>Interview with 1st shift medication aide (MA) on 12/11/15 at 11:15am revealed:</p> <ul style="list-style-type: none"> - Resident #1 was administered 30 units of Lantus insulin from 09/01/15 through 09/30/15. - The order for Lantus insulin was handwritten on the September 2015 MAR by facility staff 	D 406		

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D 406	<p>Continued From page 17</p> <p>because the order was recieved at the end of August (8/27/15), which was too late for the pharmacy to preprint new order on MAR.</p> <ul style="list-style-type: none"> - Did not know why Lantus 30 units at bedtime was handwritten on the September MAR instead of Lantus 25 units at bedtime. - The facility's RCC checked the new preprinted MAR's for accuracy when received from the facility's pharmacy and made corrections if needed. <p>Interview with the facility's RCC on 12/11/15 at 3:40pm revealed:</p> <ul style="list-style-type: none"> - She was not aware Resident #1's order for Lantus 25 units at bedtime had been transcribed incorrectly on the September 2015 MAR (30 units instead of 25 units at bedtime). - The staff documented on September MAR, the resident's Lantus, 30 units, was administered each day at bedtime. <p>Review of Resident #1's 2015 MARs for the months of October, November and December revealed Lantus was preprinted on each MAR (Lantus injection, 25 units, under the skin at bedtime).</p> <p>Refer to interview with the facility's Administrator on 12/11/15 at 3:15PM.</p> <p>Refer to interview with the facility's RCC on 12/11/15 at 3:45pm</p>	D 406		

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D 406	<p>Continued From page 18</p> <p>3. Review of Resident #2's current FL2 dated 9/22/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included dementia, acute congestive heart failure, history of cerebral vascular accident, high blood pressure, atrial fib, and bipolar disorder. - An order for Warfarin 5mg daily. - An order for Warfarin 2.5mg on Tuesday and Thursday. <p>Review of INR lab report dated 9/25/15 revealed:</p> <ul style="list-style-type: none"> - INR - 1.3 (Therapeutic range INR 2.0 - 3.0) - Written order (no date) to discontinue the current Coumadin dose and start Coumadin 6mg on Tuesday, Thursday and Sunday. Coumadin 5mg all other days. - Repeat PT/INR on Thursday 10/8/15. <p>Review of INR lab report dated 10/9/15 revealed INR - 1.4.</p> <p>Review of Resident #2's October 2015 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> - An order was handwritten to the MAR effective 10/1/15 as "Coumadin 5mg take one by mouth on Tuesday, Thursday, Sunday" and "Coumadin 6mg take one by mouth on Monday, Wednesday, Friday, Saturday". - The numbers (5 and 6) in the handwritten order appear to have been written over and changed, the '6' was changed to '5' and the '5' was changed to '6'. - Coumadin 5mg was documented as administered every Tuesday, Thursday and Sunday from 10/1/15 - 10/31/15. - Coumadin 6mg was documented as 	D 406		

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D 406	<p>Continued From page 19</p> <p>administered every Monday, Wednesday, Friday and Saturday from 10/1/15 - 10/31/15.</p> <p>Review of Resident #2's pharmacy review completed on 10/29/15 by pharmacy provider revealed:</p> <ul style="list-style-type: none"> - Coumadin 6mg ordered on Tuesday, Thursday and Sunday with 5mg other days of the week (on 10/1/15). Staff A wrote the order correctly on October MAR, but another staff wrote over the 5mg and 6mg and switched them so that 5mg is given on Tuesday, Thursday, and Sunday and 6mg other days. - This is incorrect, told RCC to make facility physician aware of how the medication was given so physician can make appropriate adjustment at next INR. <p>Record review for Resident #2 revealed no documentation that facility physician was contacted regarding Coumadin error.</p> <p>Interview on 12/10/15 at 11:50am with Resident #2 revealed:</p> <ul style="list-style-type: none"> - Resident does not know the names of his medication, he takes what he is given. - Resident is not aware of any problems or errors with his medication. - Resident #2 is aware he is on a blood thinner and he has regular labs completed. <p>Interview on 12/11/15 at 3:50pm with Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> - RCC is working as a temporary Resident Care Coordinator, previous RCC left around the end of October and RCC took over these duties. 	D 406		

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D 406	<p>Continued From page 20</p> <ul style="list-style-type: none"> - RCC was previously a medication aide until taking over duties of RCC. - RCC transcribed the 10/1/15 Coumadin order for Resident #2 correctly, but previous RCC changed the 6mg to 5mg and changed the 5mg to 6mg when she reviewed the order. - RCC did not contact facility physician to report the Coumadin error. <p>Interview on 12/11/15 at 3:30pm with the facility physician revealed:</p> <ul style="list-style-type: none"> - Physician was not aware of the Coumadin error in transcribing the 10/1/15 order. - When lab was repeated Resident #2's INR was stable, there was no negative outcome to resident. <p>Refer to interview with the facility's Administrator on 12/11/15 at 3:15PM.</p> <p>Refer to interview with the facility's RCC on 12/11/15 at 3:45pm</p> <p>4. Review of Resident # 4's current FL-2 dated 9/22/15 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included schizoaffective disorder, personality disorder, mental retardation, intellectually challenged, hypertension, chronic obstructive pulmonary disease (COPD), anemia, thrombocytopenia [sic], gastritis, gastroesophageal reflux disease (GERD), and tobacco abuse. <p>An order for Zyprexa, 20mg tablet by mouth at hour of sleep, take 1 and ½ tablets to equal 30 mg was listed on the FL-2 dated 9/22/15. (Zyprexa, also known as Olanzapine, is used to</p>	D 406		

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D 406	<p>Continued From page 21</p> <p>treat schizophrenia and manic episodes in bipolar disorder.)</p> <p>Review of a physician note dated 8/20/15 revealed a Family Nurse Practitioner from a local hospital's behavioral health clinic wrote a prescription for Zyprexa 30 mg tablets, take 1 tablet by mouth at hour of sleep.</p> <p>Review of the August 2015 Medication Administration Record (MAR) for Resident #4 showed the following documentation: -A handwritten entry for Zyprexa 30 mg by mouth at bedtime was dated 8/26/15. -The 30 mg Zyprexa was documented as administered to Resident #4 from 8/26/15 through 8/31/15.</p> <p>Review of a physician note dated 9/6/16 revealed a hospitalist wrote a prescription for 20 mg Zyprexa by mouth at hour of sleep.</p> <p>Review of the September 2015 MAR for Resident #4 showed the following documentation: -Zyprexa 30 mg tablet by mouth at bedtime (8PM) was typed by the pharmacy on the September 2015 MAR with an order date of 8/24/15. -Zyprexa was offered for administration to Resident #4 at 8:00PM. -The initials of the Medication Aide (MA) administering the Zyprexa appear to have been circled 21 times, documenting Resident #4 refused the medication.</p> <p>There was no documentation in Resident #4's Resident Record that the facility had notified the hospitalist of Resident #4's medication refusals.</p> <p>Telephone calls to the hospitalist were not returned by the close of the survey.</p>	D 406		

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D 406	<p>Continued From page 22</p> <p>Interview with the first shift MA on 12/11/15 at 10:15AM revealed: -She thought the Resident Care Coordinator (RCC) contacted one of Resident #4's health care providers. -She did not notify any prescribing practitioners of medication refusals. -She documented resident medication refusals on the MAR by circling her initials on the date listed for the medication when a resident refused the medication.</p> <p>Interview with the RCC at 3:00PM on 12/11/15 revealed: -Resident #4 had a history of medication refusals, and his primary health care providers and behavioral clinic counselors were aware of this by reviewing his resident record and talking to her, the facility staff, and the resident during their appointments with Resident #4. -She contacted Resident #4's neurologist, primary care physician and nurse practitioners and social worker of the behavioral health clinic by telephone and fax to inform them of the resident's medication refusals. -The neurologist, social worker, facility physician, and nurse practitioners were aware of Resident #4's ongoing medication refusals.</p> <p>Review of the October 2015 MAR for Resident #4 showed the following documentation: -Zyprexa 20 mg tablet by mouth at bedtime (8PM) was typed by the pharmacy on the October MAR with an order date of 9/8/15. -Zyprexa 20 mg was offered to Resident #4 from 10/1/15 to 10/11/15. -The initials of the Medication Aide (MA) administering the Zyprexa appear to have been circled 11 times, indicating Resident #4 refused</p>	D 406		

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D 406	<p>Continued From page 23</p> <p>the medication from 10/1/15 through 10/11/15. -A handwritten note documented the medication was discontinued on 10/12/15.</p> <p>Review of a physician note dated 10/12/15 revealed Resident #4's neurologist wrote orders to increase dose of Zyprexa to 30 mg (six 5 mg tablets) daily at bedtime.</p> <p>Continued review of the October 2015 MAR for Resident #4 showed the following documentation: -The October 2015 MAR had a handwritten entry for Zyprexa 5 mg tablet, take 1 tablet by mouth at bedtime (8PM). -The Zyprexa 5 mg dose was documented as administered to Resident #4 by the MAs from 10/13/15 through 10/31/15.</p> <p>Telephone call to the nurse manager at Resident #4's neurologist's office at 2:45PM on 12/11/15 revealed: -Resident #4 had a history of medication refusals. -They were aware of the changes made in dosages of Resident #4's Zyprexa medication.</p> <p>Review of the November 2015 MAR for Resident #4 showed the following documentation: -Zyprexa 5 mg tablet, take one tablet by mouth at bedtime (8PM) was typed by the pharmacy on the MAR with an order date of 10/12/15. -The MAs documented refusal of the medication on 11/1/15, and initialed administration of the 5mg tablet from 11/2/15 through 11/5/15. -The typed order and the initials of the MAs for 11/1/15 through 11/5/15 had a line through them, with a handwritten note "order written wrong". -The November 2015 for Resident #4 had a handwritten entry for Zyprexa 15 mg, take 2 tablets by mouth at bedtime (8PM). -The initials of the MAs documented</p>	D 406		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL078101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2015
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NAME OF PROVIDER OR SUPPLIER PARKTON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1165 WEST PARKTON TOBEMORY RD PARKTON, NC 28371
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 406	<p>Continued From page 24</p> <p>administration of 30 mg Zyprexa on 11/3/15 and 11/5/15 through 11/11/15.</p> <p>-There was a handwritten note that the order was discontinued.</p> <p>-The November 2015 MAR for Resident #4 had a handwritten entry for Zyprexa 20 mg, take 1 tablet by mouth at bedtime, with an order date of 11/11/15.</p> <p>-The MAs had documented that the 20 mg dose of this medication was administered to Resident #4 from 11/6/15 through 11/14/15, 11/16/15 through 11/23/15, and 11/25/15 through 11/30/15.</p> <p>-Refusals to take the Zyprexa were documented on 11/15/15 and 11/24/15.</p> <p>Interview with the RCC at 3:00PM in 12/11/15 revealed she had informed the behavioral health clinic social worker and the nurse practitioner of Resident #4's medication refusals.</p> <p>Review of documentation dated 11/16/15 by a nurse practitioner revealed:</p> <p>-Resident #4 occasionally refused medications.</p> <p>-Resident #4's chief complaints included low motivation, boredom, intellectual disabilities, learning difficulties, inattention, verbal aggression.</p> <p>Review of documentation dated 11/19/15 by the behavioral health clinic social worker revealed:</p> <p>-Resident stated he had impairment of function.</p> <p>-Social worker documented several factors in impairment of function, including not taking medications as prescribed.</p> <p>Resident #4 was not interviewable due to diagnoses including schizoaffective disorder, personality disorder, mental retardation, and intellectually challenged.</p> <p>Review of the facility's "Consultant Pharmacist's</p>	D 406		

Division of Health Service Regulation

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D 406	<p>Continued From page 25</p> <p>Medication Regimen Review" dated 10/29/15 revealed: -"Please note the [prescription] dated 9/6/15 has the Zyprexa dose decreased to 20mg, but then increased to 30mg on 9/22/15 FL-2. The [September 2015] MAR shows the dose decrease to 20mg was never started and 30mg was documented the entire month."</p> <p>Interview with the facility's RCC on 12/11/15 at 11:30AM revealed: -She was aware Resident #4's order for Zyprexa had been changed frequently by multiple caregivers. -She stated there was only one correct medication order for Resident #4's Zyprexa since mid-October. She stated the neurologist was the authority she contacted about Resident #4's behavioral medications. -She reviewed Resident #4's resident record, pulled out the order written by Resident #4's neurologist on 10/12/15, and pointed to his typed note to increase Resident #4's dose of Zyprexa to 30 mg (six 5 mg tablets) daily at bedtime.</p> <p>Interview with the first shift MA on 12/11/15 at 12:30pm revealed: -She referred to the MAR to tell her what medications the residents should receive and when she should administer them. -The RCC checked the medication orders for accuracy. -If the RCC is not working in the facility when a new order comes in, the MA on duty would transcribe the new order onto the MAR.</p> <p>_____</p> <p>Refer to interview with the facility's Administrator</p>	D 406		

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D 406	<p>Continued From page 26 on 12/11/15 at 3:15PM.</p> <p>Refer to interview with the facility's RCC on 12/11/15 at 3:45pm</p> <hr/> <p>Interview with the facility's Administrator on 12/11/15 at 3:15pm revealed:</p> <ul style="list-style-type: none"> - She was not aware the facility's pharmacy consultant provided a "Medication Regimen Review" sheet with the recommendations for the facility follow-up. - The facility's Resident Care Coordinator (RCC) was responsible for assuring all orders are correct. - The Administrator will immediately begin to check the recommendations after all quarterly pharmacy reviews to prevent medication errors. <p>Interview with the facility's RCC on 12/11/15 at 3:45pm revealed:</p> <ul style="list-style-type: none"> -When a new order was received, the RCC was responsible for transcribing the new order on the resident's current MAR. If the RCC was not available, the medication aide (MA) was responsible for transcribing the order on the MAR and faxing order to the pharmacy. -If a new medication order was received near the end of the month and not preprinted on the next month's MAR, the RCC updated the MAR with the correct order when reviewing the new MARs. <hr/> <p>According to the facility's Plan of Protection dated 12/11/15, the Administrator will review the quarterly pharmacy reviews/recommendation within 24 hours after the onsite pharmacy review and will make sure any identified issues are</p>	D 406		

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D 406	Continued From page 27 addressed as recommended. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 25, 2016	D 406		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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 residents received adequate and appropriate care and services in compliance with relevant federal and state laws and rules and regulations related to pharmaceutical recommendations. The findings are: Based on interview and record review, the facility failed to assure action was taken to recommendations from the pharmacy medication review for 4 of 5 sampled residents (Resident #1 Lantus insulin; Resident # 3 Vitamin D; Resident #2 Coumadin and Resident #4 Zyprexa). [Refer to tag 0406, 10A NCAC 13F .1009(b) Parmaceutical Care (Type B Violation)].	D912		