

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2016
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NAME OF PROVIDER OR SUPPLIER THE CREST OF CLEMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 3/29/16 and 3/30/16.	D 000		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews and record review the facility failed to implement orders for blood pressure and heart rate checks three times weekly for 1 of 5 sampled residents (Resident #3).</p> <p>The findings are:</p> <p>Review of Resident #3's current FL2 dated 12/10/2015 revealed: -Diagnoses included hypertension, diabetes, mild retardation, asthma, dysphagia, dementia, transient ischemic attacks, pulmonary nodules and gastroesophageal reflux disease. -Orders for blood pressure twice daily. -Medication orders for metoprolol 25mg once daily (used to treat high blood pressure); hydralazine 50mg 1 tab three times daily (used to treat high blood pressure); and valsartan 160 mg twice daily (used to treat high blood pressure).</p>	D 276		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 276	<p>Continued From page 1</p> <p>Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 11/21/05.</p> <p>Review of Resident #3's record revealed: -A phsyician's order dated 01/21/16 to decrease metoprolol to 12.5mg daily, with orders to check the resident's blood pressure and heart rate three times weekly and if blood pressure was less than 90/60 or greater than 140/90 to notify the physician and if heart rate was less than 60 or greater than 100 to notify the physician.</p> <p>Review of Resident #3's January 21-January 31, 2016 Medication Administration Record (MAR) revealed: -There was no entry to check the resident's blood pressure and heart rate three times weekly and if blood pressure was less than 90/60 or greater than 140/90 to notify the physician and if heart rate was less than 60 or greater than 100 to notify the physician. -No heart rates were documented on the MAR. -Blood pressures were documented as taken everyday at 8:00 am and 8:00 pm. -Blood pressures exceeded 140/90 on 6 occasions and include: 1/21/16 at 8:00 am blood pressure was documented as 149/84, 1/23/16 at 8:00 am blood pressure was documented as 146/70 and at 8:00 pm 188/61, 1/28/16 at 8:00 am blood pressure was documented as 148/70, 1/25/16 at 8:00 pm blood pressure was documented as 144/78 and 1/28/16 at 8:00 am blood pressure was documented as 148/70.</p> <p>Review of Resident #3's February 2016 MAR revealed: --There was no entry to check the resident's blood pressure and heart rate three times weekly and if blood pressure was less than 90/60 or</p>	D 276		

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D 276	<p>Continued From page 2</p> <p>greater than 140/90 to notify the physician and if heart rate was less than 60 or greater than 100 to notify the physician.</p> <p>-No heart rates were documented on the MARs.</p> <p>-Blood pressures were documented as taken everyday at 8:00 am and 8:00 pm.</p> <p>-Blood pressures exceeded 140/90 on 20 occasions and examples include: 2/04/16 at 8:00 am blood pressure was documented as 150/81, 2/17/16 at 8:00 pm blood pressure was documented 168/57, 2/19/16 at 8:00 am blood pressure was documented as 150/78 and at 8:00 pm 160/72, 2/21/16 at 8:00 pm blood pressure was documented as 160/53, 2/23/16 at 8:00 pm blood pressure was documented as 158/62 and 2/27/16 at 8:00 pm blood pressure was documented as 160/54 .</p> <p>Review of Resident #3's March 1 - March 29, 2016 MAR revealed:</p> <p>-There was no entry to check the resident's blood pressure and heart rate three times weekly and if blood pressure was less than 90/60 or greater than 140/90 to notify the physician and if heart rate was less than 60 or greater than 100 to notify the physician.</p> <p>-No heart rates were documented on the MARs.</p> <p>-Blood pressures were documented as taken everyday at 8:00 am and 8:00 pm.</p> <p>-Blood pressures exceeded 140/90 on 18 occasions and examples include; 3/02/16 at 8:00 pm blood pressure was documented as 157/60, 3/07/16 at 8:00 pm blood pressure was documented as 154/75, 3/08/16 at 8:00 pm blood pressure was documented as 150/80, 3/09/16 at 8:00 pm blood pressure was documented as 156/76, 3/19/16 at 8:00 pm blood pressure was documented as 156/82 and 3/27/16 at 8:00 pm blood pressure was documented as 182/91.</p>	D 276		

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D 276	<p>Continued From page 3</p> <p>Review of Resident #3's record revealed: -No documented heart rates. -No documentation that the physician was notified when the blood pressure exceeded the ordered parameters.</p> <p>Interview on 3/30/16 at 11:52 am with the medical Nurse Practitioner (NP) revealed: -She was unaware that the order to obtain blood pressures and heart rate with parameters had not been initiated. -She expected that all of her orders be implemented the same day they were ordered. -She had not been notified that Resident #3's blood pressure had exceeded the parameters that she set. -She expected the staff notify her if the heart rate exceeded the parameters or if either the systolic or diastolic pressure exceeded the parameters.</p> <p>Interview on 03/30/16 at 12:11 pm with a pharmacy representative revealed: -They received an order on 1/21/06 to decrease the metoprolol to 12.5mg daily and the order was changed on Resident #3's eMARs. -They did not put the order to obtain the resident's blood pressures and heart rates with parameters three times weekly on the MARs because those orders were considered health care and the medical records department at the pharmacy entered those orders.</p> <p>Interview on 03/30/16 at 12:18 pm with a second pharmacy representative revealed: -The order entry department was to send the medical records department the blood pressure and heart rate orders to be entered on the MARs. -The order entry department never sent the blood pressure and heart rate orders over to their department and this was why it was not entered</p>	D 276		

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D 276	<p>Continued From page 4</p> <p>on to the February and March 2016 MARs.</p> <p>Interview on 03/29/16 at 2:45 pm with a Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -The supervisors and the Resident Care Coordinator (RCC) were the only members of the staff that were permitted to enter orders on the MARs. -The MA was not aware there was an order to obtain Resident #3's heart rate and report to the physician if the heart rate exceeded the set parameters. -The MA did obtain Resident #3's blood pressure in the morning, and had not reported to the NP because she did not know that there was an order in place that required her to do so. <p>Interview on 03/30/16 at 11:47 am with the RCC revealed:</p> <ul style="list-style-type: none"> -She or the supervisors were responsible for transcribing orders on to the MARs. -There was no process in place to check and ensure orders were transcribed onto the MARs correctly and completely. -She was the staff member that transcribed the metoprolol order to be decreased. -She did not know why she did not transcribe the blood pressure and heart rate order onto the January 2016 MAR and must have over looked the order. -The pharmacy should have put the blood pressure and heart rate order on Resident #3's February and March 2016 MARs. 	D 276		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the</p>	D 358		

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D 358	<p>Continued From page 5</p> <p>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> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 1 of 5 (#3) sampled residents regarding levothyroxine.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL2 dated 12/10/2015 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included hypertension, diabetes, mild retardation, asthma, dysphagia, dementia, transient ischemic attacks, pulmonary nodules and gastroesophageal reflux disease. -A physician's order for levothyroxine 75 mcg once daily (a medication used to treat hypothyroidism.) -An admission date of 11/21/05. <p>Review of Resident #3's record revealed:</p> <ul style="list-style-type: none"> -An physicians order dated 1/27/16 to increase the levothyroxine to 88 mcg daily. -A pharmacy recommendation dated 2/01/16 to increase the levothyroxine to 88 mcg with a physician response dated 2/04/16, "See new orders, Levothyroxine already increased to 88 mcg qd." -A telephone clarification order sheet dated 2/11/16, "Increase levothyroxine to 88 mcg tablet - take one daily on an empty stomach." 	D 358		

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D 358	<p>Continued From page 6</p> <p>Review of Resident #3's Medication Administration Records (MAR) for January 2016 revealed: -An entry for levothyroxine 75 mcg once daily at 6:00 am. -Documented as administered at 6:00 am from 1/01/16 to 1/31/16. -No entry for levothyroxine 88 mcg daily on the MAR.</p> <p>Review of Resident #3's MAR for February 2016 revealed: -An entry for levothyroxine 75 mcg once daily and documented as administered at 6:00 am from 2/01/16 to 2/10/16. -An entry for levothyroxine 88 mcg once daily and documented as administered at 6:00 am from 2/12/16 to 2/29/16.</p> <p>Interview on 03/29/16 at 2:45 pm with a Medication Aide (MA) revealed: -The supervisors and the Resident Care Coordinator (RCC) were the only members of the staff that were permitted to enter orders on the MARs. -The MA was not aware there was an order to change the levothyroxine from 75 mcg to 88 mcg. -She did not transcribe any orders and she did not administer 6:00 am medications.</p> <p>Interview with the prescribing Nurse Practitioner on 3/30/16 at 11:47 am revealed: -She expected that all of her orders be implemented the same day they were ordered. -She was not aware the levothyroxine order had not been administered until 2/12/16.</p> <p>Interview with the Resident Care Coordinator (RCC) on 3/29/16 at 3:24 pm revealed: -She and the supervisors were responsible for</p>	D 358		

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D 358	<p>Continued From page 7</p> <p>transcribing all orders.</p> <p>-She did not know about the first order dated 1/29/16 to increase the levothyroxine 88 mcg daily.</p> <p>-She did not know why it was not processed properly.</p> <p>Interview with the Administrator at 3/29/16 at 3:40 pm revealed:</p> <p>-She was not aware the order to increase the levothyroxine was not processed the first day it was ordered.</p> <p>-She expected the RCC to transcribe all medication changes or new orders into the MAR.</p> <p>Interview with the contracted pharmacy representative on 3/30/16 at 12:11 pm revealed the pharmacy only received one order to increase the levothyroxine to 88 mcg daily and this was the date the pharmacy sent the increased dose of levothyroxine to the facility.</p>	D 358		