

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2016
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NAME OF PROVIDER OR SUPPLIER SPRING ARBOR OF RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 NEW HOPE ROAD RALEIGH, NC 27604
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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on 04/06/16, 04/07/16, and 04/08/16.	D 000		
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 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: TYPE B VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 7 residents (#6, #7, #8) observed during the medication passes, including errors with an anticonvulsant (#6), medications for nebulizer treatments, a cough syrup, and a skin care ointment (#7), and a supplement (#8) and 3 of 5 residents (#1, #4, #5) sampled for record review including errors with an anticonvulsant used for nerve pain (#1), errors with medications for constipation and iron deficiency anemia (#5), and errors with an antibiotic and a diuretic (#4). The findings are:</p> <p>1. The medication error rate was 19% as evidenced by the observation of 5 errors out of 26</p>	D 358		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 358	<p>Continued From page 1</p> <p>opportunities during the 2:00 p.m./3:00 p.m. and 5:00 p.m. medication passes on 04/06/16 and the 8:00 a.m./9:00 a.m. medication pass on 04/07/16.</p> <p>A. Review of Resident #6's current FL-2 dated 08/27/15 revealed diagnoses included frontal temporal lobe dementia, diabetes type 2, urinary incontinence, and dysphagia.</p> <p>Review of a physician's order dated 02/22/16 revealed an order for Depakote 250mg, take 1 three times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Depakote is an anticonvulsant used to treat seizures and bipolar disorder.)</p> <p>Review of the April 2016 medication administration record (MAR) revealed Depakote was scheduled to be administered 3 times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m.</p> <p>Observation during the 2:00 p.m. medication pass on 04/06/16 revealed:</p> <ul style="list-style-type: none"> - The medication aide (MA) crushed the Depakote tablet and mixed it with yogurt in a soufflé cup. - The resident was walking around in her room when the MA administered the crushed medication with yogurt. - The resident swallowed the yogurt without difficulty. <p>Observation of the medication label for the Depakote on 04/06/16 at 2:10 p.m. revealed a yellow sticker that read, "Do not crush; take whole."</p> <p>Interview with the MA on 04/06/16 at 2:55 p.m. revealed:</p> <ul style="list-style-type: none"> - The medication label did not say the Depakote could not be crushed. 	D 358		

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D 358	<p>Continued From page 2</p> <ul style="list-style-type: none"> - The MAR did not say not to crush the Depakote and there was no reminder that popped up prior to giving it. - The MA did recall that there were capsules that could be untwisted and opened. - Some of the packs come from the pharmacy with a "don't crush" label on them. - The Depakote had to be crushed for Resident #6 or the resident would not take the medication. - Some residents would try to spit the pills out. - The MA had not contacted the physician to get the medication changed. - The MA had not noticed the label on Resident #6's Depakote that read not to crush. - The MA did not know if there was a list of medications that could not be crushed. <p>Interview with the Cottage Care Coordinator (CCC) on 04/06/16 at 5:50 p.m. revealed she had obtained a list of medications that could be crushed from the pharmacy and had put the list in a notebook on the medication cart.</p> <p>Review of a request to clarify the Depakote order dated 04/07/16 revealed:</p> <ul style="list-style-type: none"> - The CCC had requested the physician to change the Depakote order since the current tablet could not be crushed. - The physician order to discontinue crushing the medication; home care RN to visit to draw Depakote level. <p>Review of a physician's order dated 04/08/16 revealed to change the Depakote 250mg to an alternative formulation, open and sprinkle on a spoon of applesauce three times daily.</p> <p>B. Review of Resident #7's current FL-2 dated 8/20/15 revealed diagnoses included dementia, chronic obstructive pulmonary disease,</p>	D 358		

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D 358	<p>Continued From page 3</p> <p>dermatitis, atrial fibrillation, allergic rhinitis, gait dysfunction, and abnormal weight loss.</p> <p>Review of a physician's order dated 11/5/15 revealed:</p> <ul style="list-style-type: none"> - There was an order for Q-Tussin 100mg/5ml, take 4 teaspoons four times daily. (Q-Tussin is an expectorant and cough syrup used to treat colds and cough.) - There was an order for Duoneb 2.5/20mg/3ml, 1 vial four times daily. (Duoneb is a bronchodilator used to treat shortness of breath and wheezing.) - There was an order for Aquaphor thick emollient cream (provided by family member), apply to areas of dry skin including back, neck, chest, and arms every morning. <p>Review of the April 2016 MAR revealed:</p> <ul style="list-style-type: none"> - Q-Tussin was scheduled to be administered four times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. - Duoneb was scheduled to be administered four times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. - Aquaphor was scheduled to be administered at 8:00 a.m. <p>Observation during the 8:00 a.m. medication pass on 04/07/16 revealed:</p> <ul style="list-style-type: none"> - The MA measured 5ml of Q-Tussin into a plastic measuring cup. - The MA retrieved one Duoneb from the medication cart. - The MA did not retrieve Aquaphor cream from the medication cart. - The Q-Tussin and Duoneb was taken by the MA into Resident #7's room. - Q-Tussin 5mls was administered to the resident instead of 4 teaspoons (20mls) as ordered. 	D 358		

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D 358	<p>Continued From page 4</p> <ul style="list-style-type: none"> - The MA put the contents of one 3.0 ml Duoneb vial into the nebulizer machine at 8:50 a.m. - The MA put the nebulizer mask on the resident, and turned on the nebulizer. - The MA stayed with Resident #7 for two minutes before walking back to the medication cart to prepare another resident's medications. - At 8:56 a.m., the MA went back into Resident #7's room. - Resident #7 was lying down in bed. - The MA assisted the resident back to a sitting position, checked to see how much of the medication was left in the nebulizer, and left the room. - The MA prepared another resident's medication and entered that resident's room. - At 9:12 a.m., the MA asked a Personal Care Aide (PCA) to "cut off" Resident #7's nebulizer. - The MA did not check to see if all of the Duoneb had been used. <p>Interview with the MA on 04/07/16 at 10:55 a.m. revealed:</p> <ul style="list-style-type: none"> - The Aquaphor that was ordered for Resident #7 was supplied by Resident #7's family, and the facility was currently out of the Aquaphor. - The MA had not talked to the family since she "thought she left a message" with the family. - If the family did not bring in the cream, the pharmacy would not provide it until permission was received from Resident #7's family. - The MA did not recall having received training on administering nebulizer treatments. - The MA usually stayed in the room with the resident "if there was not a lot going on." - The MA had not had training on instructing residents to sit up during the nebulizer treatment and to take deep breaths. - The MA did not think Resident #7 would stay in a sitting position during the treatment, but 	D 358		

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D 358	<p>Continued From page 5</p> <p>Resident #7 would take breaths sometimes.</p> <ul style="list-style-type: none"> - Resident #7 would try to take the mask off if the MA did not stay in the room. - The MA did not know the resident was supposed to receive 20 mls (4 teaspoons) of Q-Tussin. - She had always administered 5mls to the resident because 5mls was printed on the label. - She pointed to the line on the medication label that had the name and strength of the medication which read, Q-tussin 100mg/5ml. - She had not noticed the instructions on the label were printed to give 4 teaspoons of the Q-tussin. - She did not realize she had been reading the label incorrectly. <p>Observation of the medication label for the Q-tussin revealed:</p> <ul style="list-style-type: none"> - The medication name and strength was labeled as Q-tussin 100mg/5ml. - The directions were labeled as take 4 teaspoons 4 times a day. <p>Interview with the CCC on 04/07/16 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - The CCC emailed Resident #7's family member on Monday, 04/04/16 that the Aquaphor was getting low, and the family member stated she would bring another jar. - The family did not want the facility to order the Aquaphor from the pharmacy. - At the time of the initial email, there was still some cream left in the jar. - The MAs were trained to stop and ask the CCC for clarification if there was something that did not match up or was confusing. - The MAs should stay with the residents during nebulizer treatments for the entire treatment, especially Resident #7 because she would lay 	D 358		

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D 358	<p>Continued From page 6</p> <p>down.</p> <ul style="list-style-type: none"> - The MAs had been taught to instruct the residents to take deep breaths, but it depended on the resident if they would understand to take deep breaths. <p>Review of Resident Care Notes for Resident #7 revealed on 04/04/16 at 9:00 p.m., staff left a message for the family member that the resident was out of Aquaphor.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/07/16 at 11:40 a.m. revealed the Licensed Health Professional Support nurse provided training on nebulizer treatments with each MA during clinical skills check-offs.</p> <p>C. Review of Resident #8's current FL-2 dated 12/29/15 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included congestive heart failure with edema, osteoarthritis, Alzheimer's dementia, hypertension, and diabetes mellitus type 2. - There was an order for Omega 3, two capsules daily. (Omega 3 also commonly referred to as Fish Oil is a supplement taken to provide the body with Omega 3 fatty acid since the body is unable to produce Omega 3.) <p>Review of the April 2016 MAR revealed Fish Oil was scheduled to be administered daily at 8:00 a.m.</p> <p>Observation during the 8:00 a.m. medication pass on 04/07/16 revealed:</p> <ul style="list-style-type: none"> - The MA retrieved the medications for Resident #8 and took the medications to the resident's room. - Resident #8 was seated in her recliner sleeping, and was drowsy during the medication 	D 358		

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D 358	<p>Continued From page 7</p> <p>pass.</p> <ul style="list-style-type: none"> - The MA attempted to encourage Resident #8 to wake up and take the medications. - The MA attempted to put the pills in Resident #8's hand. - One of the two Fish Oil capsules was dropped on the floor. - The MA picked up the capsule from the floor and tossed the capsule into the trash can in Resident #8's room. <p>Interview with the MA on 04/07/16 at 10:55 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #8 was not usually that sleepy. - She usually gave Resident #8 the bigger pills first. - Resident #8 would normally put the pills in her hand and take them with no problem. - The MA needed to put a note in the computer about the Fish Oil since she documented that two capsules were administered, and Resident #8 only received one capsule. - She would normally replace a pill or capsule if they were dropped on the floor. - She should not have disposed of the capsule in the resident's trash can. <p>Interview with the Resident Care Coordinator (RCC) on 04/07/16 at 11:40 a.m. revealed the MAs should be disposing of pills in the sharps containers and not in resident trash cans or flushing down toilets.</p> <p>2. Review of Resident #1's current FL-2 dated 06/19/15 revealed the resident's diagnoses included diabetes type II, missed hyperlipidemia, chronic depression, morbid obesity, osteoarthritis, and edema.</p> <p>Review of a physician's order dated 12/21/15</p>	D 358		

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D 358	<p>Continued From page 8</p> <p>revealed an order for Neurontin 300 mg capsule, take 1 capsule three times daily. (Neurontin is an anticonvulsant that is given to treat epilepsy and nerve pain).</p> <p>Review of subsequent physician's orders revealed an order dated 01/08/16 to "stop Neurontin."</p> <p>Review of the January 2016 - April 2016 medication administration records (MARs) revealed:</p> <ul style="list-style-type: none"> - There was an entry for Neurontin 300 mg, take 1 capsule three times daily and was scheduled at 8:00 a.m., 12:00 p.m., and 8:00 p.m. - Neurontin was documented as administered three times daily from 01/01/16 - 04/06/16. <p>Observation of medications on hand for Resident #1 on 04/07/16 at 11:20 a.m. revealed there were twenty four capsules of Neurontin in the medication cart.</p> <p>Interview with prescribing Physician Assistant (PA) on 04/07/16 at 11:15 a.m. revealed:</p> <ul style="list-style-type: none"> - The PA ordered the Neurontin to be stopped because the resident's family stated the resident had been hallucinating. - The PA was not aware that the medication had not been discontinued. - The PA had not seen Resident #1 in several months, but Resident #1 should be okay with having received the Neurontin despite its being stopped in January. - He had received a fax from the facility on 04/07/16 that the order was sent to the pharmacy but never discontinued. <p>Interview with Resident #1 on 04/07/16 at 12:15 p.m. revealed:</p>	D 358		

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D 358	<p>Continued From page 9</p> <ul style="list-style-type: none"> - The resident had pain in her legs if she stood too long. - They resident was "on top" of her medications. - The resident always looked at the medications she was given because she knew what the pills looked like. - The "bone" doctor prescribed Neurontin to help with the "sciatic nerve pain" in her legs. - She had been taking Neurontin three times a day for about 3 or 4 months. <p>Interview with the RCC on 04/07/16 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> - The RCC was unable to locate another order to restart Neurontin; the last order she saw was to stop Neurontin on 01/08/16. - The discontinue order was faxed to the pharmacy on 01/08/16, but the pharmacy said they did not receive the order. - An error report would be completed. - The primary physician and the ordering orthopedic physician had been contacted and the nurse was aware of the error in not discontinuing the Neurontin. - The order would be resent to the pharmacy and removed from the MAR. - When an order was faxed, the confirmation sheets were not saved because the chart would get too thick, so the staff had been instructed to "stamp the order faxed" when confirmation was received. - If the MAs received an order, they were to fax the order to the pharmacy, write the order on the dry erase board in the medication room for the next shift, and make a copy of the order for the RCC. - From now on, the RCC would go into the MAR and discontinue the order to prevent a medication error. 	D 358		

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D 358	<p>Continued From page 10</p> <p>Interview with a first shift MA on 04/07/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The MA remembered the discontinue order for Neurontin. - She knew the order was faxed to the pharmacy. - A lot of the facility's orders had been messed up lately. <p>Interview with the pharmacist on 04/07/16 at 3:15pm revealed that the pharmacy had not received a faxed order for the Neurontin to be discontinued.</p> <p>Interview with the RCC on 04/07/16 at 5:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The RCC had filled out a medication error report and notified Resident #1's family member. - The RCC faxed a communication to the physician. - Resident #1 would be upset about not getting the Neurontin. - The RCC had not witnessed Resident #1 have hallucinations nor had any been reported to her since taking the Neurontin. - She thought that the Neurontin had helped Resident #1's pain in her legs. <p>3. Review of Resident #5's current FL-2 dated 06/05/15 revealed the resident's diagnoses included Alzheimer's dementia, convulsions, high blood pressure, diabetes, and weakness of one side of the body.</p> <p>A. Review of a physician's order dated 11/24/15 for Resident #5 revealed an order for Ferrous Sulfate 220mg/5ml take 6.8mls (=300mg) by mouth once daily. (Ferrous sulfate is an iron supplement used to treat anemia.)</p> <p>Review of the February 2016 - April 2016</p>	D 358		

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D 358	<p>Continued From page 11</p> <p>medication administration records (MARs) revealed:</p> <ul style="list-style-type: none"> - There was an entry for Ferrous Sulfate 220mg/5ml take 6.8mls (=300mg) by mouth daily. - It was scheduled to be administered at 8:00 a.m. - It was documented as administered daily from 02/07/16 - 04/07/16. <p>Review of pharmacy dispensing records dated 01/01/16 - 04/08/16 for Resident #5 revealed one bottle (473mls) of Ferrous Sulfate was dispensed on 02/29/16.</p> <p>Observation of the medication cart and medications on hand for Resident #5 on 04/08/16 revealed:</p> <ul style="list-style-type: none"> - One bottle of Ferrous Sulfate dispensed on 02/29/16 with approximately 250mls of 473mls dispensed remaining in the bottle. - The instructions on the label were to take 6.8mls (=300mg) daily. - There was no measuring device stored with the Ferrous Sulfate. - There were 30ml plastic calibrated measuring cups stored in a compartment on the side of the medication cup. - The measurements on the cups started at 2.5ml increment and included 5ml, 7.5ml, 10ml, 15ml, 20ml, 25ml and 30ml increments. - There was no measuring device on hand to accurately measure 6.8mls. <p>Interview with the medication aide (MA) on 04/08/16 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - She had always administered 5mls to the resident because 5mls was printed on the label. - She pointed to the line on the medication label that had the name and strength of the medication which read, Ferrous Sulfate 220mg/5ml. 	D 358		

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NAME OF PROVIDER OR SUPPLIER SPRING ARBOR OF RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 NEW HOPE ROAD RALEIGH, NC 27604		
(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 358	<p>Continued From page 12</p> <ul style="list-style-type: none"> - She had not noticed the instructions on the label were printed to give 6.8mls of the Ferrous Sulfate. - She did not realize she had been reading the label incorrectly. - She did not have a device at the facility that would accurately measure 6.8mls. - She would have to estimate the dosage using the plastic measuring cup between the 5ml and 7.5ml increments. <p>Interview with the Cottage Care Coordinator (CCC) on 04/08/16 at 11:50 a.m. revealed:</p> <ul style="list-style-type: none"> - She had not noticed the order for Ferrous Sulfate was for 6.8ml dosage. - They do not have a device at the facility that would measure 6.8mls. - She would contact the pharmacy about getting an oral syringe that would accurately measure the 6.8mls. <p>B. Review of a physician's order dated 11/24/15 for Resident #5 revealed an order for Miralax Powder, mix 1 heaping tablespoon in 8 ounces of water and drink daily. (Miralax is for constipation.)</p> <p>Review of the February 2016 - April 2016 medication administration records (MARs) revealed:</p> <ul style="list-style-type: none"> - There was an entry for Miralax Powder, mix 1 heaping tablespoon in 8 ounces of water and drink by mouth daily. - It was scheduled to be administered at 8:00 a.m. - It was documented as administered daily from 02/07/16 - 04/07/16. <p>Review of pharmacy dispensing records dated 01/01/16 - 04/08/16 for Resident #5 revealed:</p>	D 358		

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D 358	<p>Continued From page 13</p> <ul style="list-style-type: none"> - One bottle (527 grams) of Miralax were dispensed on 02/01/16. - One bottle (527 grams) of Miralax were dispensed on 03/28/16. <p>Observation of the medication cart and medications on hand for Resident #5 on 04/08/16 revealed:</p> <ul style="list-style-type: none"> - One bottle of Miralax Powder dispensed on 03/28/16. - The instructions on the label were to mix 1 heaping tablespoon in 8 ounces of water and drink by mouth daily - There was a clear plastic calibrated lid on the Miralax bottle with a marked increment for 17 grams of Miralax. - There were 30ml plastic calibrated measuring cups stored in a compartment on the side of the medication cup. - The measurements on the cups started at 2.5ml increment and included 5ml, 7.5ml, 10ml, 15ml, 20ml, 25ml and 30ml increments. - There was small white plastic spoons stored in a compartment on the side of the medication cart. <p>Interview with the medication aide (MA) on 04/08/16 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - She was not sure what a heaping tablespoon meant so she had always used a small white plastic spoon to scoop out some Miralax powder and mix it in water. - She had not contacted the physician to clarify an exact dosage that should be administered to the resident. - The resident had not had any problems with constipation to her knowledge. <p>Interview with the Cottage Care Coordinator (CCC) on 04/08/16 at 11:50 a.m. revealed:</p> <ul style="list-style-type: none"> - She had not noticed the order for Miralax was 	D 358		

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D 358	<p>Continued From page 14</p> <p>for a heaping tablespoon.</p> <ul style="list-style-type: none"> - The order should have been clarified so staff would know how much to measure for the resident. - Staff should not be using spoons to measure medications. - She would contact the physician to clarify how much Miralax should be administered to the resident. <p>4. Review of Resident #4's current FL-2 dated 01/27/16 revealed the resident's diagnoses included unspecified dementia without behavioral disturbance, femur fracture, hypo-osmolality, and hyponatremia.</p> <p>A. Review of a physician's order dated 03/03/16 for Resident #4 revealed an order for Cipro 250mg twice a day for 7 days for suspected urinary tract infection. (Cipro is an antibiotic used to treat infections.)</p> <p>Review of a lab form with urinalysis result for Resident #4 revealed:</p> <ul style="list-style-type: none"> - The resident's urine was collected on 03/02/16 for a urinalysis. - The results of the urinalysis on 03/04/16 showed bacteria were present in the resident's urine. <p>Review of pharmacy dispensing records dated 01/01/16 - 04/07/16 revealed 14 Cipro 250mg tablets were dispensed on 03/03/16.</p> <p>Review of a resident care note dated 03/07/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Facility staff spoke with the pharmacy in regards to placing the Cipro order on the MAR. - Pharmacy stated the order would be posted that day. 	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2016
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D 358	<p>Continued From page 15</p> <ul style="list-style-type: none"> - Facility staff called pharmacy again about the Cipro order. - Facility staff documented, "the medication is here to be given but not placed on the MAR". - The pharmacy staff stated a temporary order should have been placed by facility staff but the pharmacy would call the electronic software provider. <p>Review of the March 2016 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - There was an entry for Cipro 250mg take 1 tablet 2 times a day for 7 days for suspected urinary tract infection and it was scheduled for 8:00 a.m. and 8:00 p.m. - The date of the order was noted at 03/07/16. - There was only 2 doses documented as administered, one on 03/07/16 at 8:00 p.m. and one on 03/08/16 at 8:00 a.m. - The order was noted to be discontinued on 03/08/16. <p>Review of a physician's visit form dated 03/08/16 for Resident #4 revealed the physician discontinued Cipro and started a new antibiotic.</p> <p>Interview with a medication aide on 04/08/16 at 2:48 p.m. revealed:</p> <ul style="list-style-type: none"> - She recalled Resident #4 getting Cipro at one time but then the medication got switched to something different. - She did not recall how long the resident got the Cipro. - She did not recall if the Cipro order was coming up on the electronic MAR. - She thought the resident had 3 or 4 Cipro tablets left over and she thought it was sent back to the pharmacy. <p>Interview with the Cottage Care Coordinator</p>	D 358		

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D 358	<p>Continued From page 16</p> <p>(CCC) on 04/07/16 at 4:45 p.m. revealed:</p> <ul style="list-style-type: none"> - The medication aide (MA) on duty was responsible for faxing new orders to the pharmacy. - The pharmacy staff would enter the new orders into the electronic MARs on the same day they received the order. - A pending order will come up on the electronic MAR screen and the medication staff on duty would have to approve the order for it to be active on the MAR. - She did not know why the Cipro order did not appear on the MAR until 03/07/16. - She thought staff was giving the Cipro even though it was not listed on the MAR. - She could not recall if any Cipro was returned to the pharmacy or disposed at the facility. - She would check on it. <p>Review of a handwritten note provided by the CCC on 04/08/16 revealed:</p> <ul style="list-style-type: none"> - The first name of Resident #4 was written in the margin of the paper. - There was a handwritten note indicating on 03/08/16 at 9am, a medication aide and the CCC destroyed 4 pills of Cipro. - There was no reason for the destruction indicated and no other information related to the Cipro. <p>Telephone interviews with a pharmacist at the primary pharmacy on 04/08/16 at 12:45 p.m. and 4:03 p.m. revealed:</p> <ul style="list-style-type: none"> - During normal business hours, the pharmacy will enter new orders received from the facility into the electronic MAR system. - After hours and on weekends, the facility staff can enter temporary entries for new orders. - The pharmacy received the Cipro order on 03/03/16 at 12:09 p.m. and it was dispensed that 	D 358		

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D 358	<p>Continued From page 17</p> <p>day.</p> <ul style="list-style-type: none"> - When a medication was dispensed, it was usually profiled and goes into the electronic MAR system. - She did not know why there was a delay in the Cipro order appearing on the MAR. - She would contact the software company to find out what may have caused the Cipro order not to appear on the MAR. - No Cipro was returned to the pharmacy. <p>B. Review of physician's orders for Resident #4 revealed:</p> <ul style="list-style-type: none"> - There was an order dated 02/05/16 for Lasix 20mg daily. (Lasix is a diuretic.) - There was a subsequent order dated 03/01/16 for Lasix 40mg daily for 7 days for edema. <p>Review of the February 2016 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - There was an entry for Lasix 20mg 1 tablet daily and it was scheduled to be administered at 8:00 a.m. - Lasix 20mg was documented as administered daily from 02/06/16 - 02/29/16 except one refusal on 02/13/16. <p>Review of the March 2016 MAR revealed:</p> <ul style="list-style-type: none"> - There was an entry for Lasix 20mg 1 tablet daily and it was scheduled to be administered at 8:00 a.m. - Lasix 20mg was documented as administered daily from 03/01/16 - 03/03/16 and it was noted to be discontinued on 03/04/16. - There was an entry for Lasix 40mg 1 tablet daily for 7 days for edema and it was administered at 8:00 a.m. from 03/05/16 - 03/11/16. - No Lasix was documented as administered from 03/12/16 - 03/21/16. 	D 358		

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D 358	<p>Continued From page 18</p> <ul style="list-style-type: none"> - There was another entry for Lasix 20mg 1 tablet daily at 8:00 a.m. started on 03/22/16 and administered through 03/31/16. <p>Review of pharmacy dispensing records dated 01/01/16 - 04/07/16 revealed:</p> <ul style="list-style-type: none"> - Twenty-nine Lasix 20mg tablets were dispensed on 02/05/16. - Thirty Lasix 20mg tablets were dispensed on 03/02/16. - Seven Lasix 40mg tablets were dispensed on 03/04/16. -Thirty Lasix 40mg tablets were dispensed on 03/31/16. <p>Review of a physician's visit form dated 04/06/16 revealed Resident #4's edema in her lower extremities was stable but the resident needed to continue elevation and compression stockings daily.</p> <p>Interview with the Cottage Care Coordinator (CCC) on 04/07/16 at 4:45 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not know why Lasix 20mg was not administered from 03/12/16 - 03/21/16. - She would contact the physician regarding the Lasix. <p>Review of a physician's note dated 04/08/16 revealed:</p> <ul style="list-style-type: none"> - Resident #4 should have received Lasix 20mg from 03/12/16 - 03/21/16. - The 20mg dose should have been resumed after the 7 days of Lasix 40mg. - There was no harm to the resident and her edema remained stable, if not improved, during this time. - The resident was currently receiving Lasix 20mg daily. 	D 358		

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D 358	Continued From page 19 Review of the facility's plan of protection dated 04/08/16 revealed: - The Resident Care Coordinator (RCC) and Cottage Care Coordinator (CCC) will audit 10 charts per week looking at orders, medication administration records (MARs), and medications in the cart. - RCC/CCC will develop tracking system with new orders and attach order to tracking form. - RCC/CCC will monitor to make sure order is on the electronic MAR, medications are on hand, follow-up if needed, and they will complete and sign off, and put form in RCC/CCC box to follow-up. - Medication aide training has been scheduled for 04/12/16. - The facility will report all medication errors to the physician and the Executive Director. - The pharmacy will supply appropriate measuring devices for appropriate medication administration. - RCC and CCC will audit charts and orders to check behind each other to assure orders are in place and accurate. - The facility will have continuous training with staff of medication administration by pharmacy and monthly meetings of training as needed. - Random observations of medication passes will be done by the RCC, CCC, and/or Registered Nurse (RN). CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 23, 2016.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

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D912	<p>Continued From page 20</p> <p>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.</p> <p>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 administration. The findings are:</p> <p>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 7 residents (#6, #7, #8) observed during the medication passes, including errors with an anticonvulsant (#6), medications for nebulizer treatments, a cough syrup, and a skin care ointment (#7), and a supplement (#8) and 3 of 5 residents (#1, #4, #5) sampled for record review including errors with an anticonvulsant used for nerve pain (#1), errors with medications for constipation and iron deficiency anemia (#5), and errors with an antibiotic and a diuretic (#4). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]</p>	D912		