

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/14/2016
NAME OF PROVIDER OR SUPPLIER KANNON CREEK ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 N CANNON BOULEVARD KANNAPOLIS, NC 28083		
(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 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 4/13/16 and 4/14/16.	D 000	Disclaimer Statement Kannon Creek Assisted Living acknowledges the receipt of the Statement of Deficiencies and propose this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Kannon Creek Assisted Living response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute as admission that any deficiency is accurate. Further, Kannon Creek Assisted Living reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 1 of 5 sampled residents (Resident #7) regarding orders for IM (intramuscular) injections. Review of Resident #7's current, admission FL-2 dated 12/28/15 revealed: -Diagnoses included schizophrenia. -A physician's order for "Invega Sustenna 234 mg IM every 4 weeks. Due 01/25/16." (Invega is used to treat schizophrenia.) Review of the January 2016 Medication Administration Record (MAR) revealed: -A handwritten entry for Invega 234 mg IM every 4 weeks was transcribed to the MAR. -In the section of the MAR designated for scheduled administration times, there was a notation that the medication was to be administered by the (named) resident's mental health providers.	D 273		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

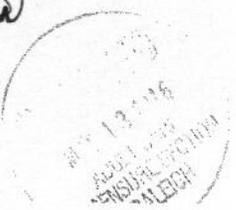
5-11-16

STATE FORM

6939

473S11

Reviewed & Accepted 5-16-16
[Handwritten Signature]



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D 273	<p>Continued From page 1</p> <p>-There was no further documentation on the MAR regarding the due date of the Invega or whether or not it had been administered in January 2016.</p> <p>Review of the February and March 2016 MARs revealed: -Computer-generated entries for "Invega 234 mg IM every four weeks due on the 25th of each month". -In the section of the MAR designated for scheduled administration times, there was a notation that the medication was to be administered by the (named) resident's mental health providers. -There was no further documentation on the MAR to indicate whether or not the Invega had been administered in February or March 2016.</p> <p>Review of Resident #7's record revealed there was no documentation the Invega was administered in January, February, or March 2016.</p> <p>Review of staff notes for Resident #7 revealed: -On 01/03/16 at 4:00 pm, Resident #7 called the police to report staff withholding (named) medication and urinary incontinence. Resident was "screaming in hallway saying somebody was on her". -On 01/03/16 at 6:30 pm, Resident #7 had gone in and out of both meal seatings "screaming and hollering" and "cursing other residents", demanding beverages, and "screaming out loud at the phone saying 'get off me'". -On 01/14/16 at 9:00 am, staff documented Resident #7 "still has loud outbursts yelling and cursing at staff. Accuses staff of stealing cigarettes. Takes all meds and eats meals with no problems". -On 02/18/16 at 9:45 (am or pm not designated),</p>	D 273	<p>Health Care 10A NCAC 13F.0902 - Medication Orders 10A NCAC 13F1002 - Medication Administration 10A NCAC 13F.1004</p> <p>On 4-13-16 the RCC called ACT team to clarify the order for Resident #7 injection. On 4-14-16 Dr. Douglas Smith faxed a letter to RCC that he would evaluate Resident #7 the next day. On 4-15-16 Dr. Smith discontinued the injection. Resident #3, #1, #4 and #6 revealed that orders were not clarified at admission. On 4-13-16 & 4-14-16 orders were clarified for Resident #3, #1, #4 and #6 by RCC\ARCC.</p> <p>On 4-15-16 Administrator\RCC\RN completed 100% audit of all in-house residents' charts back to the previous FL2 to ensure orders are completed, clarified, referral orders are completed and placed on MAR. A 100% audit of all carts to ensure medications are being given as ordered. These audit will be completed immediately by 4-</p>	

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D 273	<p>Continued From page 2</p> <p>staff documented Resident #7 "walks around cursing out staff and residents when she feels like it and really gets mad if she runs out of cigarettes".</p> <p>-On 02/18/16 at 9:15 p, staff documented Resident #7 "has been complaining with staff and residents".</p> <p>-On 03/16/16 at 10:00 am, staff documented Resident #7 was "argumentative with staff and other residents".</p> <p>Interview on 04/13/16 at 5:45 pm with the Resident Care Coordinator (RCC) revealed:</p> <p>-The mental health provider's nurse routinely administered the Invega injections for their residents.</p> <p>-She did not realize there was no documentation in Resident #7's record of the Invega injections.</p> <p>-She would obtain the documentation from the mental health provider's office.</p> <p>Subsequent interview on 04/14/16 at 2:30 pm with the RCC revealed:</p> <p>-She contacted Resident #7's mental health providers the previous evening for documentation of Invega administration and "found out she hadn't been getting it".</p> <p>-They (mental health provider) must have overlooked the order and did not know the resident was supposed to be receiving the Invega injections.</p> <p>-There was currently no system in place to ensure outside providers were administering injections as ordered by the physician.</p> <p>Attempts on 04/13/16 and 04/14/16 to interview Resident #7 were declined by the resident.</p> <p>A Plan of Protection was provided by the facility on 04/29/16:</p>	D 273	<p>22-16 using Medication Monitoring form audit tool, Administrator/RCC/RN will audit 10% of resident chart, MAR and med cart from correct orders, referrals, and medication availability using Medication Monitoring form audit tool. The weekly for 8 week and ongoing monthly.</p> <p>On 4-15-16 a questionnaire was completed on all interviewable resident. Questions' were "Have you ever been out of medication: yes or no. If yes, explain. Do you know who to tell if you are told by a Med Tech you are out of medication? Yes or no. Questionnaires will be completed for 10% of the interviewable residents weekly for 8 weeks then monthly ongoing.</p> <p>Starting 4/14/16, the corporate clinical director and the facility RN began in-servicing the Med Techs at 100% and before beginning their next scheduled shift</p>	

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D 273	Continued From page 3 -Effective immediately, the RCC, ARCC, RN and Administrator will audit all resident records at 100% to compare all referral orders and current medications to assure appropriate referral has been initiated and documented. -Any and all discrepancies will be reported immediately to the prescribing Practitioner and referral will be initiated as ordered and the RN will ensure continued follow up on all referrals. -Staff will be inserviced regarding policy on initiating referrals and ensuring appropriate follow up. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2016.	D 273	<ul style="list-style-type: none"> • Properly completing the front and back of the MAR using a dot first to signify the medication was pulled then sign after the medication is given. • Only sign for medications that are administered. If not administered do not sign off on; circle and document on the back. • Nebulizer machines are available at the nurse station. <p>On 4-14-16 RCC/RN in serviced all Med Techs at 100% and before there next scheduled shift on completing:</p> <ul style="list-style-type: none"> • Medication Availability, discontinued meds are to be removed from the med cart. Medication that is not in med cart, look in med room. Medication not in the med cart or med room must be obtained contacting Neil Medical pharmacy. Neil Medical 	<i>AW</i> 5-29-16
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION	D 344		

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D 344	<p>Continued From page 4</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for clarification of orders which were not dated and signed within 24 hours of admission to the facility for 2 of 7 sampled residents (Residents #1 and #3).</p> <p>The findings are:</p> <p>A. Review of Resident #3's Resident Register revealed an admission date of 2/02/16.</p> <p>Review of Resident #3's current FL2 dated 12/09/15 revealed: -Diagnoses included metabolic encephalopathy, pneumonia, secondary malignant neoplasm, liver cell carcinoma and dysphagia. -Physician orders for olanzapine 5mg - 2 tabs every morning and 3 tabs every evening (a medication used to manage psychosis), and lactulose 3 ml solution daily (a medication used to treat liver disease).</p> <p>Review of Resident #3's record revealed: -A physician's order dated 2/10/16 for oxycodone 5mg 1 tab every 6 hours as needed for pain. -A physician's order dated 2/26/16 for magnesium oxide 420 mg 1 tablet twice daily (a medication used to supplement magnesium in the blood).</p> <p>Review of Resident #3's February 2-29, 2016 Medication Administration Record (MAR) revealed: -Entries for olanzapine 5mg 2 tabs every morning and olanzapine 5mg 3 tabs every evening as ordered on the FL2 dated 12/09/15. -An entry for lactulose solution 30ml three times a day and documented as administered at 9:00 am, 3:00 pm and 9:00 pm on 2/03-2/29/16. -An entry for oxycodone 5mg 1 tab every 6 hours</p>	D 344	<p>pharmacy can call back up pharmacy. Inform RCC/ARCC if there is medication on the cart but not on the MAR. If medication is running low it is your responsibility to order the medication and make sure it is on the cart</p> <ul style="list-style-type: none"> Any new admission or readmission staff is to request prescriptions for all medications or a signed list of discharge medications or FL-2. Any conflicting orders will be immediately clarified and written out as telephone orders Orders for a new admission or readmission are to be written on new blank MAR. Med techs is to fill out the bottom of MAR completely and sign in the place marked Complete Entries Checked and date. A second med tech is to review all orders for new admissions or readmission making sure orders are transcribed correctly and matching. Med tech is then to sign on white copy of MAR in the 	

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D 344	<p>Continued From page 5</p> <p>as needed for pain with 26 as needed administrations documented on the February 2016 MAR which was not ordered.</p> <p>Interview with the Resident Care Coordinator on 4/13/16 at 11:30 am revealed:</p> <ul style="list-style-type: none"> -She did not notice that the FL2 had a different amount and frequency for lactulose solution than what she transcribed on the February 2016 MAR. -The entries that she transcribed onto the MAR were obtained from the MAR sent from a previous facility. -The orders were not clarified or verified with Resident #3's physician given Resident #3 was admitted 2/02/16 and the FL2 was dated 12/09/15. -They had been trained to use the latest medication list. -She did not know to clarify the orders if they were unclear or inconsistent. <p>Review of Resident #3's March 1-14, 2016 MAR revealed:</p> <ul style="list-style-type: none"> -Entries for olanzapine 5mg 2 tabs every morning and olanzapine 5mg 3 tabs every evening as ordered on the FL2 dated 12/09/15. -An entry for lactulose solution 30ml three times a day and documented as administered at 9:00 am, 3:00 pm and 9:00 pm on 3/01-3/14/16. -An entry for oxycodone 5mg 1 tab every 6 hours as needed for pain with 26 as needed administrations documented on the March 2016 MAR. <p>Review of Resident #3's Record revealed Resident #3 was admitted to the hospital for anemia and blood loss encephalopathy on 3/15/16 and discharged back to the facility on 3/17/16.</p>	D 344	<p>place marked Meds Reviewed by</p> <ul style="list-style-type: none"> • Once any and all orders are received they are to be transcribed onto the residents MAR and faxed to the appropriate pharmacy. Any orders that go to an outside pharmacy must be faxed also to NMG marked as profile only. • RCC/ARCC/RN will check all orders weekly for ongoing to verifying orders are correct, MAR, medications ordered from pharmacy, and medication in the med cart using Medication Monitoring audit tool. • Transportation Supervisor will place all orders and paperwork from outside doctor appointments in box hanging in RCC/ARCC office labeled "IN". All orders received will be placed in the "IN" box. • Each morning RCC/ARCC/RN will check all paperwork that is placed in the box labeled "OUT" within 72 hours and verify orders were transcribed onto MAR, clarified when unclear and medications. 	

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D 344	<p>Continued From page 6</p> <p>Review of Resident #3's discharge summary dated 3/17/16 from the hospital revealed:</p> <ul style="list-style-type: none"> -There were 2 different lists of medications on the discharge summary. -The discharge summary included a statement which read, "If you have already been taking a medication, and it has been renewed at this visit, it will be on this list a second time as "active"; please do not take it twice." <p>Further review of the discharge summary dated 3/17/16 revealed the following medications were included on one of the computer generated medications lists:</p> <ul style="list-style-type: none"> -Lactulose 10 gm/15ml oral solution 2 tablespoons daily. -Lactulose 10 gm/15ml oral solution 3 tablespoons daily. -Magnesium oxide 420 mg 1 tablet daily. -Magnesium oxide 420 mg 2 tablets twice daily. -Olanzapine 20mg 1/2 tablet daily. -Olanzapine 20mg 1/2 tablet in the morning. -Olanzapine 7.5mg tablet 2 tablets at bedtime. -Oxycodone 5mg tablet 1 tablet every 6 hours as needed. -Oxycodone 5mg tablet 1 tablet twice daily. -Oxycodone C-R 10mg tablet 1 tablet every 12 hours. <p>Review of Resident #3's hand-written March 17-31, 2016 MAR revealed:</p> <ul style="list-style-type: none"> -An entry for lactulose 10 gm/15ml oral solution 75 ml three times daily documented as administered 3/17/16 at 9:00 pm and 3/18 - 3/31/16 at 9:00 am, 3:00 pm and 9:00 pm. -An entry for magnesium oxide 420 mg 1 tablet daily and documented as administered 3/17-3/31/16 at 9:00 pm. -An entry for magnesium oxide 420 mg 2 tablets twice daily and documented as administered 	D 344	<p>ordered. Then orders are to be placed into filing or chart.</p> <p>On 5-6-16 RCC in serviced Med Tech at 100% and before their next scheduled shift</p> <ul style="list-style-type: none"> • referral's will be initiated as ordered • prescribing practitioner will be called for all unclear orders • then place in RCC/ARCC's box in the 100 hall nurses station • RCC/ARCC will place all referral in box on Transportation's Desk • RN/designee will assure follow up on all referral <p>On 5-6-16 Administrator in serviced RCC/ARCC on putting referrals in the box on the Transportation desk after reviewing all orders and referrals</p> <p>On 5-10-16 before working her shift Administrator in serviced RN</p>	

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D 344	<p>Continued From page 7</p> <p>3/17/16 at 9:00 pm and 3/18 - 3/31/16 at 9:00 am and 9:00 pm.</p> <p>-An entry for olanzapine 20mg 1/2 tablet daily and documented as administered at 9:00 am from 3/18-3/31/16.</p> <p>-An entry for olanzapine 20mg 1/2 tablet daily and documented as administered at 3:00 pm from 3/18-3/31/16.</p> <p>-An entry for olanzapine 7.5mg 2 tablets at bedtime and documented as administered at 9:00 pm from 3/17-3/31/16.</p> <p>-An entry for oxycodone 5mg tablet 1 tablet every 6 hours as needed with 3 administrations documented on the March 2016 MAR.</p> <p>-An entry for oxycodone 5mg tablet 1 tablet twice daily and documented as administered 3/17/16 at 5:00 pm and 3/18 - 3/31/16 at 1:00 pm and 5:00 pm.</p> <p>-An entry for oxycodone C-R 10mg tablet 1 tablet every 12 hours and documented as administered 3/17/16 at 9:00 pm and 3/18 - 3/31/16 at 9:00 am and 9:00 pm.</p> <p>Interview with the Assistant Resident Care Coordinator on 4/14/16 at 10:15 am revealed:</p> <p>-She obtained Resident #3's medication list from the discharge summary and used the medication list that was on the first page.</p> <p>-She did not read the sentence that stated, "If you have already been taking a medication, and it has been renewed at this visit, it will be on this list a second time as "active"; please do not take it twice."</p> <p>-She did not obtain clarification or verification from the prescribing physician or Resident #3's primary care physician.</p> <p>-She utilized this list because it was the most recent medication list for Resident #3.</p> <p>-She was not aware she was supposed to clarify orders that were unclear or inconsistent.</p>	D 344	<p>to check the referral box on the top of the file cabinet on the left side of her desk. Using the Health Care audit tool weekly to follow up on all referrals for 8 weeks and monthly ongoing.</p> <p>On 5-9-16 before working her shift Administrator in serviced Transportation Supv once she receive the referral out of her box on her desk to document the appointment on the referral and place it in the box on top of the file cabinet on the left side of the RN's desk</p> <p>RCC/ARCC/RN will audit all orders on each residents that had a doctor's appointment or has been out to the hospital and re admitted five days a week ongoing. Also, when the RN completes her quarterly LHPS ongoing. Checking to make sure all orders match, all referrals and any new medications are ordered. Any clarification of orders and referrals will be addressed immediately.</p>	

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D 344	Continued From page 8 Interview with the Resident Care Coordinator on 4/14/16 at 4:48 pm revealed: -She thought the olanzapine dose should have been given three times a day as it was on the discharge summary. -She did not clarify the discharge summary orders with the hospital physician, the primary care physician or the visiting psychiatric physicians. -She would typically fax prescriptions along with the hand written medication list that was a carbon copy of the list that was created when they wrote the MAR. -She did not realize if the orders on a medication list, discharge summary or FL2 were different that she was supposed to seek clarification of the orders. -She was trained to take the latest copy of the medication list and utilize that as the current list for an admission or re-admission. Interview with Resident #3's Primary Care Physician on 4/14/16 at 9:32 am revealed: -He did not write the orders that were on the hospital discharge summary. -He would refer the resident to a psychiatrist to adjust the olanzapine orders and did not change them. -The dose of olanzapine administered was excessive. -The orders that were on the discharge summary were not generated by the hospital rather they were generated from a medication list that was acquired upon admission through written or verbal sources. Interview with a pharmacist from the contracted pharmacy on 4/14/16 at 9:26 am revealed: -The orders they used to generate the April 2016 MAR were obtained from the carbon copy that	D 344	Administrator/designee will audit using Administrators Double Signature audit tool, Administrator's Dot system audit tool, Administrator's Neb Machine audit tool, Administrator Health Care audit tool for 8 weeks weekly then ongoing monthly. Any concerns will be taken to the QI Committee for further review monthly for three months and then quarterly.	

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D 344	<p>Continued From page 9</p> <p>was faxed to the pharmacy by the facility.</p> <ul style="list-style-type: none"> -This medication list was not signed by a physician. -There was no FL2, discharge summary or other hard copy orders faxed along with the hand written medication list generated by the facility. -The pharmacy usually would require a physician's signature on medication orders or medication lists. -The last orders they received that did have a doctor's signature for olanzapine was 10mg in the morning and 15mg at night dated 12/09/15. -The last orders they received that did have a doctor's signature for oxycodone C-R was 10mg and dated 3/08/15. <p>Interview with the facility's Medical Director on 4/14/16 at 3:01 pm revealed:</p> <ul style="list-style-type: none"> -He saw Resident #3 that morning and discontinued one of the oxycodone orders because he was concerned the dose Resident #3 was taking was excessive and Resident #3 did not present with pain. -He did not change the olanzapine dose because he was not aware that Resident #3 was taking 35 mg daily and 35mg daily was an excessive dose. -He was not aware Resident #3 was taking 75 ml of lactulose three times daily and that was an excessive dose. -They (he and his team) expected the nurse or the supervisor at the facility to review the medication list before he signs off on them. -He and his team expected the staff to notify them if there were any duplications or if any clarifications were needed. <p>Resident #3 was unavailable for interview on 4/14/16.</p>	D 344		

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NAME OF PROVIDER OR SUPPLIER KANNON CREEK ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 N CANNON BOULEVARD KANNAPOLIS, NC 28083		
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D 344	<p>Continued From page 10</p> <p>B. Review of Resident #1's current FL-2 dated 2/15/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses entered as code numbers only. -Medication orders included Clonazepam 0.5 mg twice daily (used to treat anxiety and panic disorders), vitamin D3 1000 units twice daily (a supplement for muscle, bone, teeth and immune health), Ferrous Sulfate 325 mg 3 times daily (used to treat iron deficiency anemia), Cetirizine 10 mg at bedtime (an antihistamine for allergy symptoms), Docusate 100 mg twice daily as needed (prn) (a stool softener), Loperamide 2 mg every 4 hours prn (used to treat diarrhea), Humalog 4 units at lunch (a short acting insulin), Humalog 6 units twice daily, Lantus 15 units twice daily (a long acting insulin), Humalog (no dose or times specified), and Hydroxyzine 25 mg every 4 hours prn (used to treat anxiety and pain). <p>Review of Resident #1's Discharge Summary from a rehabilitation center dated 2/23/16 revealed:</p> <ul style="list-style-type: none"> -It had two signatures at the bottom of the Care Management Discharge Summary and Guide Medication page. It was not clear if either signature was a physician's signature (later investigation discovered the signatures were a wound nurse and a facility transporter's signature). -The Discharge Summary included an admission record with diagnoses and codes that matched Resident #1's FL-2 diagnoses codes. -Diagnoses included Diabetes type 2, major depressive disorder, bipolar disorder, chronic pain syndrome, anxiety disorder, Opioid abuse, panic disorder, iron deficiency anemia, vitamin D deficiency -The Medication Discharge Summary page included Lantus 15 units twice a day at 6:00 am and 4:00 pm, and Humalog SSI before meals and 	D 344		

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D 344	<p>Continued From page 11</p> <p>at bedtime with a sliding scale written out, Depakote 250 mg 3 times daily (used to treat bipolar disorder), Flexeril 10 mg 3 times daily (a muscle relaxer), Fentanyl patch 100 mcg change every 3 days (for pain control), Toradol 10 mg every 4 hours prn pain (an anti-inflammatory used to treat pain), and Oxycodone 10 mg every 4 hours prn pain (a narcotic used to treat moderate to severe pain).</p> <p>-The Medication Discharge Summary page did not include an order for Vitamin D3.</p> <p>Further review of Resident #1's rehabilitation center Medication Discharge Summary page dated 2/23/16 revealed:</p> <p>-The medications listed did not match the current FL-2 dated 2/15/16.</p> <p>-The medications not listed on the Medication Discharge Summary page were: Clonazepam 0.5 mg twice daily, Ferrous Sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily, and Vitamin D3 1000 unit twice daily.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 2/25/16.</p> <p>Review of Resident #1's February 2016 MAR from 2/25/16 to 2/29/16 revealed:</p> <p>-It was a handwritten MAR.</p> <p>-The medications listed did not match the current FL-2 dated 2/15/16.</p> <p>-The following medications were not transcribed onto the MAR: Clonazepam 0.5 mg twice daily, Ferrous Sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units</p>	D 344		

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D 344	<p>Continued From page 12</p> <p>twice daily.</p> <p>-The insulins documented as administered were Lantus 15 units twice a day at 6:00 am and 4:00 pm, and Humalog SSI before meals and at bedtime with a sliding scale written out.</p> <p>Review of Resident #1's March 2016 MAR revealed:</p> <p>-It was a handwritten MAR for the dates 3/01/16 to 3/31/16.</p> <p>-The following medications were not transcribed onto the MAR: Clonazepam 0.5 mg twice daily, Ferrous Sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 100 6 units twice daily.</p> <p>-The insulins documented as administered were Lantus 15 units twice a day at 6:00 am and 4:00 pm, and Humalog SSI before meals and at bedtime with a sliding scale written out.</p> <p>Review of Resident #1's April 2016 MAR revealed:</p> <p>-The MAR was pre-printed from the facility's contracted pharmacy.</p> <p>-The following medications were not transcribed onto the MAR: Clonazepam 0.5 mg twice daily, Ferrous Sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily.</p> <p>-The insulins documented as administered were Lantus 15 units twice a day at 6:00 am and 4:00 pm, and Humalog SSI before meals and at bedtime with a sliding scale written out.</p> <p>Review of Resident #1's record revealed:</p> <p>-A handwritten "Physician's orders" medication</p>	D 344		

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D 344	<p>Continued From page 13</p> <p>page for the period from 2/25/16 to 2/29/16, and signed by a Nurse Practitioner (NP) on 3/01/16 that included an entry for Humalog insulin with a sliding scale four times daily.</p> <p>-There was no documentation that the following medications from the current FL-2 were discontinued or changed: Clonazepam 0.5 mg twice daily, Ferrous Sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily.</p> <p>-There was an entry for Vitamin D3 1000 units twice daily that was on the FL-2, not on the Discharge summary, but was transcribed onto the handwritten "physicians orders" (dated 2/25/16 to 2/29/16 and signed by the NP on 3/01/16), the February, March and April 2016 MARs. There was no separate order found in Resident #1's record for Vitamin D3.</p> <p>-Documentation of a pharmacy review was not found in Resident #1's record.</p> <p>Interview on 4/13/16 at 3:35 pm with the Assistant Resident Care Coordinator (ARCC) revealed:</p> <p>-If a resident was admitted from another facility, "the staff would look at the discharge summary, the FL-2, and use the most current date as the resident's orders".</p> <p>-She "did not usually compare the FL-2 and the discharge summary" for discrepancies.</p> <p>-She called the physician to get an order clarified if she could not read the order.</p> <p>-Resident #1's initial medication list was from the discharge summary from a rehabilitation center dated 2/15/16.</p> <p>-She had not noticed that the medications for Resident #1 were different on the FL-2 and the discharge summary.</p>	D 344		

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D 344	Continued From page 14 Interview on 4/14/16 at 9:00 am with the facility's contract pharmacy's Manager revealed: -The pharmacy printed the MARs for the facility. -There was no copy of an FL-2 dated 2/15/16 in the pharmacy's system. -There was no copy of a discharge summary dated 2/23/16 in the pharmacy's system. -The facility faxed Resident #1's handwritten "physician's order" sheet for 2/25/16 to 2/29/16 on 2/27/16. It was not signed by a physician or NP. The pharmacy entered the orders into the computer system to generate the MARs. -Usually the physician's order sheets had physician or NP signatures on them. -There was no record that the pharmacy had contacted the facility or the physician for signatures to the orders received. Interviews on 4/14/16 at 10:50 am and 4/16/16 at 4:25 pm with Resident #1 revealed: -"I take what meds I'm given. I was on several medications including Zyrtec (Cetirizine) before I came here. I don't know why I am not getting it here." -"I do not know why my Klonopin was stopped. I was taking it at the rehab, but for some reason it was stopped here. I have not asked why." -She had not admitted to any side effects from not taking the missed medicines. Interviews on 4/14/16 at 11:40 am and 4/14/16 at 4:10 pm with Resident #1's NP revealed: -She "expected the facility to contact the physician or the discharging facility if the orders did not match the FL-2 orders, and especially if medications were omitted". -She expected the facility to contact her if an order needed to be clarified or if there were any questions.	D 344		

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D 344	<p>Continued From page 15</p> <p>-She was not aware Resident #1 was not started on Clonazepam, Ferrous Sulfate, Cetirizine, Docusate or Imodium, but she could not comment of the psych or anxiety meds as Resident #1 was being seen by another physician who could address those medications.</p> <p>-She had discontinued the Humalog at lunch and twice a day since she had ordered Lantus and SSI. (No discontinue order found in Resident #1's record).</p> <p>-She glanced at the "physician orders flimsies but trusted the facility to have them right" when they transcribed the medications listed. She was not always careful to check the orders before she signed what the facility asked her to sign.</p> <p>-She visited the facility weekly with an assistant who checked the MARs in the facility computer system to verify if any changes or orders were made from a visit with the Resident. If those changes were not on the resident's MAR, they "picked it up" and were able to correct it.</p> <p>-She would address those medications at her next visit on 4/19/16.</p> <p>Interview on 4/14/16 at 2:25 pm with the discharging rehabilitation center representative for Resident #1 revealed:</p> <p>-Details of orders after the FL-2 was written on 2/15/16 and the Resident #1 was discharged from rehab on 2/25/16 was not available as the medical records staff was not available.</p> <p>-The Rehab's staff member matching the name of the signature at the bottom of the discharge summary paperwork was a wound care nurse.</p> <p>Interview on 4/14/16 at 3:45 pm with the RCC revealed:</p> <p>-The facility's ARCC, the RCC or Medication Aide (MA) re-wrote a resident's discharge orders onto a "physician's orders page" and faxed it to the</p>	D 344		

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D 344	<p>Continued From page 16</p> <p>pharmacy, but they did not send the original discharge summary with the handwritten orders page.</p> <ul style="list-style-type: none"> -The pharmacy had never requested the facility to fax orders differently (to include the original order, not the facility's transcribed order). -They used the most recent order whether it was a discharge summary, FL-2 or an office order. -She was not aware Resident #1's discharge summary signature was a staff nurse and not a physician or NP. -The second signature on the discharge summary paperwork she recognized as the facility's transportation staff. -The ARCC and the RCC transcribed and clarified orders during the week. After hours and on weekends the MAs performed this task. -There was no process in place to double-check orders and MARs for accuracy. No staff was responsible for monitoring transcription of orders for accuracy. (No policy and procedure was available to be reviewed for who was responsible for this task). <p>Interview on 4/14/16 at 4:45 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -The staff had been instructed to use the last signed orders as the most recent. The orders should be signed by the physician or NP. -Prescriptions and medication lists signed by the physician or NP were to be faxed to the pharmacy. -The RCC and ARCC wrote out new MARs and should clarify any conflicting orders. When they were not here, the MAs performed that task. -A new system would be put in place to double check the orders and MARs for accuracy and prompt staff to have orders clarified as needed. <p>Interview on 4/14/16 at 4:55 pm with Resident</p>	D 344		

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D 344	<p>Continued From page 17</p> <p>#1's Psychiatrist revealed: -The dose of Clonazepam Resident #1 was to receive per the FL-2 was not a strong enough dose to be worried about withdrawals. -"We try to reduce medications if possible". -She would expect the facility to call and clarify orders if there were conflicting orders and the discharge summary and FL-2 did not match. -She was not aware the resident had been on Clonazepam and not receiving it at this facility. -She had not been contacted by the facility about clarifying orders for Resident #1. -The physician's service has had problems with the facility staff regarding clarification of orders and had a recent meeting with the facility about this. She could not remember the date of the meeting.</p> <p>Interview on 4/14/16 at 5:00 pm with a MA revealed: -The ARCC or the RCC transcribed orders and were to clarify orders as necessary. -The MAs clarified orders and transcribed orders after hours and on weekends. -She had worked at the facility for 9 months and never had to admit or receive anyone after hours, so had never needed to clarify or transcribe orders.</p> <p>A Plan of Protection was provided by the facility on 4/14/16: -Effective immediately, the RCC, ARCC, RN and Administrator will audit all resident records at 100% to compare all orders and current medications to assure they are being administered correctly. -Any and all discrepancies will be immediately clarified with the physician. -Staff will be inserviced prior to the next scheduled shift on medication clarification of</p>	D 344		

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D 344	Continued From page 18 orders as it relates to admission, re-admissions and unclear or incomplete orders. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED, MAY 29, 2015.	D 344		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 4 of 7 sampled residents (Residents #1, #4, #6 and #7). The findings are: A. Review of Resident #4's current FL2 dated 01/13/16 revealed: -The diagnosis section with the words "see attached". -The medication section with the words "see attached". -The attached form was a Report from a Veteran's Medical Center with a 47 item list of	D 358		

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5-29-16

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D 358	<p>Continued From page 19</p> <p>past and current diagnoses which included: hypoxemia, pulmonary emphysema, multiple nodules of the lung, tobacco use disorder and history of pneumothorax. -The attached form did not have any medications listed.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 02/07/16.</p> <p>Interview with the Resident Care Coordinator (RCC) on 4/13/16 at 11:30 am revealed they obtained Resident #4's initial medication list from a discharge summary from a local hospital dated 11/20/15.</p> <p>Review of the Discharge Summary from a local hospital dated 11/20/15 revealed a medication list that included an albuterol multi-dose inhaler 2 puffs every four hours for wheezing.</p> <p>Review of Resident #4's Record revealed: -A physician order dated 1/19/16 which discontinued several medications that were included on the 11/20/15 discharge summary and an order for "May keep albuterol at bedside, may self-administer."</p> <p>Review of the January 2016 Medication Administration Record (MAR) revealed a hand written entry for albuterol 2 puffs every 4 hours as needed for wheezing with no documented administrations.</p> <p>Review of the February 2016 MAR revealed a computer generated entry for albuterol 2 puffs every 4 hours as needed for wheezing and may keep at bedside with no documented administrations.</p>	D 358		

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D 358	<p>Continued From page 20</p> <p>Further review of Resident #4's records revealed:</p> <ul style="list-style-type: none"> -A physician order dated 3/01/16 for fluticasone 1 squirt each nare daily (a medication used to treat allergies), azithromycin 250mg as directed on package (an antibiotic used to treat bacterial infections) and Mucinex 600mg 1 twice daily for 5 days (a medication used to thin mucus). -Emergency Room (ER) discharge instructions dated 3/04/16 with orders to take methylprednisolone 4mg as directed on package (a medication used to treat inflammation) and tramadol 50mg 1 tablet every 4-6 hours as needed for pain (a medication used to treat pain). -A physician order dated 3/15/16 for Symbicort 1 puff twice daily (a medication used to treat chronic obstructive pulmonary disease), albuterol-ipratropium three times a day for 5 days (a medication used to treat chronic obstructive pulmonary disease), levofloxacin 500mg 1 tablet daily for 10 days (an antibiotic used to treat bacterial infections) and "Please make sure patient has Flonase (fluticasone) as prescribed last week." -A physician order dated 3/19/15 for prednisone 20mg - 2 tablets by mouth for 3 days and azithromycin 250mg 5 days dose pack as directed. -A physician order for albuterol-ipratropium via nebulizer three times a day for 5 days "IT WAS NOT STARTED LAST WEEK.) <p>Review of the March 2016 MAR revealed:</p> <ul style="list-style-type: none"> -An entry for azithromycin 250mg 2 tablets on first day and 1 tablet for four days with 2 tabs documented as administered at 9:00 am on 3/02/16 and one tab documented as administered from 3/03/16 through 3/06/16. -An entry for guaifenesin ER 600mg 1 tab by mouth twice daily and documented as 	D 358		

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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 358	Continued From page 21 administered at 9:00am from 3/03/16 to 3/22/16 and 8:00pm from 3/02/16 to 3/22/16. There were circled initials at 9:00 am on 3/11, 3/12, 3/13, 3/14, 3/16 and 3/17 and at 8:00 pm on 3/12 and 3/14/16. There was one exception documented on the back of the MAR dated 3/16/16 at 9:00 am "Mucinex, zero meds, needs refill." -An entry for fluticasone 1 spray in each nostril everyday and documented as administered at 9:00 am from 3/03/16 to 3/31/16. -An entry for methylprednisolone 4mg dose pack documented as administered as ordered from 3/06/16 to 3/11/16. -An entry for levofloxacin 500mg 1 tab daily for 10 days and documented as administered at 6:00pm from 3/16/16 to 3/25/16. -An entry for Symbicort 1 puff twice daily and documented as administered at 9:00 am from 3/17/16 to 3/31/16 and 8:00 pm from 3/16/16 to 3/31/16. -An entry for prednisone 20mg 2 tabs daily for three days and documented as administered at 8:00 am from 3/20/16 to 3/22/16. -An entry for azithromycin 250mg 2 tablets on first day and 1 tablet for four days with 2 tabs documented as administered at 8:00 am on 3/24/16 and one tab documented as administered from 3/03/16 through 3/06/16. -An entry for albuterol-ipratropium 1 via nebulizer three times daily for 5 days and documented as administered at 9:00am, 3:00 pm from 3/16/16 to 3/22/16 and 10:00 pm from 3/16/16 to 3/21/16 and a handwritten comment "see new". -An entry for albuterol-ipratropium 1 via nebulizer three times daily for 5 days and documented as administered at 9:00am, 3:00 pm from 3/22/16 to 3/31/16 and 10:00 pm from 3/22/16 to 3/31/16. -An entry for albuterol 2 puffs every 4 hours as needed for wheezing with no documented administrations.	D 358		

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D 358	<p>Continued From page 22</p> <p>Observation of medications on hand on 4/13/16 at 12:42 pm revealed: -One box of Symbicort that was unopened with 120 inhalations and dispensed on 3/15/16. -One box of albuterol-ipratropium with a total of 30 vials dispensed on 3/15/16 and two unopened vial packs containing 5 vials each (a total of 10 vials) left in the box.</p> <p>Observation of Resident #4's room on 4/14/16 revealed: -One nebulizer machine sitting on nightstand. -Sitting next to Resident #4's nebulizer machine there was one unopened albuterol-ipratropium vial pack (5 vials) with 2 vials of albuterol-ipratropium sitting on top of the unopened pack (total of 7 vials). -One box of fluticasone labeled with Resident #4's name and 120 metered sprays dispensed on 3/01/16 with a bottle that was approximately 75% full.</p> <p>Interview with a Pharmacist from the contracting pharmacy on 4/14/16 at 11:30 am revealed: -One multi-dose inhaler of Symbicort containing 120 inhalations was filled only once on 3/15/16 and provided to the facility on 3/16/16. -One box of albuterol-ipratropium containing 30 vials was filled only once on 3/15/16 and provided to the facility on 3/16/16.</p> <p>Out of 30 vials of albuterol-ipratropium provided by the pharmacy there were 17 vials remaining.</p> <p>Observation of the Symbicort on hand on the medication cart on 4/14/16 at 11:20 am revealed the box was opened and there were approximately 4 doses used out of 120 that were provided to the facility on 3/16/16.</p>	D 358		

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D 358	Continued From page 23 Interview with Resident #4 on 4/14/16 at 10:54 am revealed: -Resident #4 started coughing and had a runny nose around the end of February. -She went to the ER because she was having some difficulty breathing, was coughing and just "felt sick". -The ER physician gave her some medication and the Physician Assistant (PA) that comes to the facility also prescribed some medication for her in the beginning of March 2016. -The PA ordered a nasal spray that Resident #4 did not get for at least two weeks after it was ordered. -There were Medications Aides (MA) that got "wrote up" for signing that they administered this nasal spray when they did not and after that it was just left in my room. -Resident #4 continued to feel sick and started to get worse. -In mid-March the PA ordered Resident #4 some breathing treatments (nebulizer) that Resident #4 did not get for another a week after they were ordered. -Resident #4 was given prednisone and antibiotics, but continued to decline. -Resident #4 started to feel terrible and was having a very difficult time breathing and became very sick. -Right before they sent Resident #4 to the hospital the evening of April 5, 2016, Resident #4 was gasping for air and was having an extremely difficult time breathing. -Staff never gave her a dose of Symbicort until yesterday and Resident #4 was administered the Symbicort around 1:00 or 2:00 pm and then again last night and this morning, but that was the first time Resident #4 had ever seen or used the inhaler.	D 358		

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D 358	Continued From page 24 Review of a History and Physical report from the local hospital dated 4/08/16 revealed: -Resident #4 was persistently wheezing despite multiple courses of nebulizers and steroids. -Resident #4 was drowsy, woke only to verbal stimuli and then fell right back asleep. -Resident was hypoxemia (an abnormally low level of oxygen in the blood) with an oxygen saturation of 94% while on 3 liters of oxygen. Review of a hospital discharge summary dated 04/08/16 revealed: -Resident #4 was discharged from the local hospital on 04/08/16. -Discharge diagnoses included: chronic obstructive pulmonary disease exacerbation and acute respiratory failure. A second interview with Resident #4 on 4/14/16 at 1:30 pm revealed: -Resident #4 was using the nebulizer machine on her nightstand. -The albuterol-ipratropium vial pack and the 2 albuterol-ipratropium vials were hers and given to her by one of the MAs. -She used the albuterol-ipratropium when she got short of breath or felt like she needed it. -The MAs would put the medicine in the nebulizer if they were asked, but Resident #4 never asked because Resident #4 said she knew how to use the machine. -The MAs did not observe her using or remind her to use the nebulizer treatments. -It took about a week for the facility to provide Resident #4 with a nebulizer machine so she could take her treatments. -The nebulizer machine was used and belonged to the facility.	D 358		

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D 358	<p>Continued From page 25</p> <p>Interview with a first shift MA on 4/14/16 at 11:08 am revealed:</p> <ul style="list-style-type: none"> -She opened the inhaler yesterday and administered the Symbicort after it was clarified with her supervisor that there were two different inhalers. -She also administered the Symbicort this morning. -She got the Symbicort inhaler confused with the albuterol inhaler and thought the Symbicort inhaler was the one she kept at her bed side and self-administered. -She had not administered the Symbicort prior to yesterday. -She helped Resident #4 with her nebulizer treatments in the past and did not leave the albuterol-ipratropium vials with Resident #4. -She thought that Resident #4 could have her nasal spray and would just sign it out because she knew that Resident #4 had it at her bedside. <p>Interview with a second MA on 4/14/16 at 5:40 pm revealed:</p> <ul style="list-style-type: none"> -She thought that the Symbicort inhaler was the one that Resident #4 kept at her bedside. -She had made a mistake, but did gave it last night for the first time and observed Resident #4 inhale the medication. -She helped Resident #4 with her nebulizer treatments in the past and did not leave the albuterol-ipratropium vials with Resident #4. <p>Interview with the Resident Care Coordinator revealed:</p> <ul style="list-style-type: none"> -She was aware that the Symbicort was just opened on 4/13/16. -It was not intentional, but the MAs may have been administering the medication and then going back and signing out the medications in the MARs without looking at each individual 	D 358		

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D 358	<p>Continued From page 26</p> <p>medication for the administration time.</p> <ul style="list-style-type: none"> -Sometimes they did have difficulty getting nebulizer machines. -Resident #4 probably did not get her own nebulizer machine because it was a temporary order only. -She did not know why it took so long to get the nebulizer machine and it could have been that they did not hunt a nebulizer down. -No one notified her the resident did not have a machine and that the staff could not give the medication. -She did not know who got Resident #4 the nebulizer. -She did not know why there was so much extra fluticisone left in Resident #4's nasal spray bottle other than it was not being administered. <p>Interview with the PA on 4/14/16 at 11:44 am revealed:</p> <ul style="list-style-type: none"> -She saw Resident #4 on 3/15/16, Resident #4 was not feeling well and was coughing and wheezing. -At that time she ordered Symbicort, albuterol-ipratropium 3 times a day for 5 days and levofloxacin 500mg daily for 10 days. -At the next visit Resident #4 told her the nebulizer treatments had not been started. -She would expect that the facility initiate the Symbicort the day it was ordered because it was something that they could easily obtain from the pharmacy. -She did give them some leeway with the nebulizer treatments because it can be difficult to obtain a machine. -Symbicort was for those people with chronic airway problems and was not intended to be used like a rescue inhaler. -It was possible if the staff had started the Symbicort and the nebulizer treatments as 	D 358		

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D 358	<p>Continued From page 27</p> <p>ordered it could have prevented the hospitalization depending on whether or not there were other contributing factors.</p> <p>-Resident #4 was very alert and not one to forget things.</p> <p>B. Review of Resident #6's current FL2 dated 01/07/16 revealed:</p> <p>-Diagnoses included dementia, restlessness and agitation, human immunodeficiency virus, and anemia in kidney disease.</p> <p>-A physician's order for tamsulosin 0.4 mg daily. (Tamsulosin is used to treat difficulty with urination.)</p> <p>Review of a urology physician progress note dated 03/14/16 revealed:</p> <p>-Resident #6 complained of daytime urinary frequency and enuresis (involuntary urination at night).</p> <p>-The resident was unable to void at the physician's office.</p> <p>-The physician would increase the resident's tamsulosin from once daily to twice daily to see if there would be any improvement.</p> <p>Review of Resident #6's record revealed a physician's order dated 03/14/16 which included instructions to increase the tamsulosin to one (capsule) in the morning and one in the evening.</p> <p>Review of the March 2016 Medication Administration Record (MAR) revealed:</p> <p>-Tamsulosin 0.4 mg was scheduled for administration once daily at 9:00 am.</p> <p>-The tamsulosin was documented as administered at 9:00 am from 03/01/16 through 03/31/16.</p> <p>-The 03/14/16 physician's order to increase to</p>	D 358		

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D 358	<p>Continued From page 28</p> <p>twice daily was not transcribed to the March 2016 MAR.</p> <p>Review of the April 2016 MAR revealed:</p> <ul style="list-style-type: none"> -Tamulosin 0.4 mg was scheduled for administration once daily at 9:00 am. -The tamulosin was documented as administered at 9:00 am from 04/01/16 through 04/13/16. -The 03/14/16 physician's order to increase to twice daily was not transcribed to the April 2016 MAR. <p>Interview on 04/13/16 at 5:08 pm with a representative from the facility's contracted pharmacy revealed:</p> <ul style="list-style-type: none"> -The pharmacy did not receive a copy of the 03/14/16 order to increase the tamulosin to twice daily. -The pharmacy's computer system currently showed the ordered dosage at once daily. <p>Interview on 04/13/16 at 5:45 pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -She was unaware of the 03/14/16 order to increase the tamulosin to twice daily. -When a resident returned from a physician's visit, the transportation aide (TA) routinely gave any physician's orders to the RCC, the Assistant Resident Care Coordinator (ARCC), or the Medication Aide (MA) on duty. -It was the responsibility of "whoever she (TA) hands it to" to fax the order to the pharmacy and transcribe the order to the MAR. <p>Interview on 04/14/16 at 9:20 am with the TA revealed:</p> <ul style="list-style-type: none"> -It was the TA's routine to bring any physician orders back to the facility, scan them into the computer so the RCC had a copy, and then give the order to the RCC, ARCC, or the MA on duty. 	D 358		

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D 358	<p>Continued From page 29</p> <p>-The TA remembered scanning the 03/14/16 orders into the computer and then giving them to the ARCC.</p> <p>Interview on 04/14/16 at 9:30 am with the ARCC revealed: -She did not recall receiving the 03/14/16 order to increase the tamulosin. -The TA may have given the order to her and it may have been misplaced among other paperwork on her desk.</p> <p>Interview on 04/13/16 at 6:00 pm with Resident #6 revealed: -He had a problem with urinary frequency because he drank a lot of fluids. -The resident stated he needed to urinate "about every 20 minutes". -He knew he was currently prescribed tamulosin, but did not realize the physician increased his dosage on 03/14/16. -He had been taking the tamulosin once daily for "a few months" but did not recall the medication being of much help. -Sometimes he did not "make it" to the bathroom on time, so he routinely wears a "diaper".</p> <p>D. Review of Resident #1's current FL-2 dated 2/15/16 revealed: -Diagnoses entered as code numbers only. -Medications included Clonazepam (Klonopin) 0.5 mg twice daily (used to treat anxiety and panic disorders), vitamin D3 1000 units twice daily (a supplement for muscle, bone, teeth and immune health), ferrous sulfate 325 mg 3 times daily (used to treat iron deficiency anemia), Cetirizine 10 mg at bedtime (an antihistamine for allergy symptoms), Docusate 100 mg twice daily as needed (prn) [a stool softener], Loperamide 2 mg every 4 hours prn (used to treat diarrhea),</p>	D 358		

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D 358	<p>Continued From page 30</p> <p>Humalog 4 units at lunch (a short acting insulin), Humalog 6 units twice daily, Lantus 15 units twice daily (a long acting insulin), Humalog (no dose or times specified), and Hydroxyzine 25 mg every 4 hours prn (used to treat anxiety and pain).</p> <p>Review of Resident #1's Discharge Summary from a rehab facility dated 2/23/16 revealed: -It had two signatures at the bottom of the Care Management Discharge Summary and Guide Medication page. It was not clear if either signature was a physician's signature. (Further investigation revealed the signatures were a wound nurse and a facility transporter's.) -It included an admission record with diagnoses and codes that matched Resident #1's FL2 diagnoses codes. -Diagnoses included diabetes type 2, major depressive disorder, bipolar disorder, chronic pain syndrome, anxiety disorder, Opioid abuse, panic disorder, iron deficiency anemia, and vitamin D deficiency. -The Medication Discharge Summary page listed medications included Lantus 15 units twice a day at 6:00 am and 4:00 pm and Humalog SSI before meals and at bedtime with a sliding scale written out, Depakote 250 mg 3 times daily (used to treat bipolar disorder), Flexeril 10 mg 3 times daily (a muscle relaxer), Fentanyl patch 100 mcg change every 3 days (for pain control), Toradol 10 mg every 4 hours prn pain (an anti-inflammatory used to treat pain), and Oxycodone 10 mg every 4 hours prn pain (a narcotic used to treat moderate to severe pain).</p> <p>Further review of Resident #1's rehabilitation center Medication Discharge Summary page dated 2/23/16 revealed: -The medications listed did not match the current FL2 dated 2/15/16.</p>	D 358		

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D 358	<p>Continued From page 31</p> <p>-The medications omitted on the Medication Discharge Summary page were: Clonazepam 0.5 mg twice daily, ferrous sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 2/25/16.</p> <p>Review of Resident #1's initial MAR for the period of 2/25/16 to 2/29/16 revealed: -It was a handwritten MAR. -The medications listed did not match up to the current FL-2 dated 2/15/16. -The following medications were not transcribed onto the MAR: Clonazepam 0.5 mg twice daily, ferrous sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily.</p> <p>Review of Resident #1's March 2016 MAR revealed: -The MAR was handwritten for the dates of 3/01/16 to 3/31/16. -The following medications were not transcribed onto the MAR: Clonazepam 0.5 mg twice daily, ferrous sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily.</p> <p>Review of Resident #1's April 2016 MAR revealed: -The MAR was a pre-printed MAR from the facility's contracted pharmacy. -The following medications were not transcribed onto the MAR: Clonazepam 0.5 mg twice daily,</p>	D 358		

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NAME OF PROVIDER OR SUPPLIER KANNON CREEK ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 N CANNON BOULEVARD KANNAPOLIS, NC 28083		
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D 358	<p>Continued From page 32</p> <p>ferrous sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily.</p> <p>Review of Resident #1's record revealed: -A handwritten "Physician's orders" medication page from 2/25/16 to 2/29/16, and signed by a Nurse Practitioner (NP) on 3/01/16 that included an entry for Humalog insulin with a sliding scale four times daily. -There was no documentation that the following medications from the current FL2 were discontinued or changed: Clonazepam 0.5 mg twice daily, ferrous sulfate 325 mg 3 times daily, Cetirizine 10 mg at bedtime, Docusate 100 mg twice daily prn, Loperamide 2 mg every 4 hours prn, Humalog 4 units at lunch, and Humalog 6 units twice daily. -Documentation of a pharmacy review was not found in Resident #1's record.</p> <p>Interview on 4/13/16 at 3:35 pm with the Assistant Resident Care Coordinator (ARCC) revealed: -If a resident was admitted from another facility, "the staff would look at the discharge summary and the FL-2, and use the most current date as the resident's orders". -She "did not usually compare the FL-2 and the discharge summary." -Resident #1's initial medication list was from the discharge summary from a rehabilitation center dated 2/23/16.</p> <p>Interview on 4/14/16 at 9:00 am with the facility's contract pharmacy's Manager revealed: -The pharmacy printed the MARs for the facility. -There was no copy of an FL2 dated 2/15/16 in the pharmacy's system. -There was no copy of a discharge summary</p>	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/14/2016
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NAME OF PROVIDER OR SUPPLIER KANNON CREEK ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 N CANNON BOULEVARD KANNAPOLIS, NC 28083
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D 358	<p>Continued From page 33</p> <p>dated 2/23/16 in the pharmacy's system.</p> <p>-The facility faxed Resident #1's handwritten "physician's order" sheet for 2/25/16 to 2/29/16 on 2/27/16. It was not signed by a physician or NP. The pharmacy entered the orders into the computer system to generate the MARs.</p> <p>-Usually the physician's order sheets had physician or NP signatures on them.</p> <p>-There was no record that the pharmacy had contacted the facility or the physician for signatures to the orders received.</p> <p>Interviews on 4/14/16 at 10:50 am and 4/16/16 at 4:25 pm with Resident #1 revealed:</p> <p>-"I take what meds I'm given. I was on several medications including Zyrtec (Cetirizine) before I came here. I don't know why I am not getting it here."</p> <p>-"I do not know why my Klonopin was stopped. I was taking it at the rehab, but for some reason it was stopped here. I have not asked why."</p> <p>-She had not admitted to any side effects from not taking the missed medicines.</p> <p>Interviews on 4/14/16 at 11:40 am and 4/14/16 at 4:10 pm with Resident #1's NP revealed:</p> <p>-She "expected the facility to contact the physician or the discharging facility if the orders did not match the FL-2 orders, and especially if medications were omitted".</p> <p>-She was not aware Resident #1 was not started on Clonazepam, ferrous sulfate, Cetirizine, Docusate or Loperamide, but she could not comment of the psych or anxiety meds as Resident #1 was being seen by another physician who could address those medications.</p> <p>-She had discontinued the Humalog at lunch and twice a day since she had ordered Lantus and SSI. (No discontinue order found in Resident #1's</p>	D 358		

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NAME OF PROVIDER OR SUPPLIER KANNON CREEK ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 N CANNON BOULEVARD KANNAPOLIS, NC 28083		
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D 358	Continued From page 34 record). -She glanced at the "physician orders flimsies but trusted the facility to have them right" with the transcribed the medications listed. She was not always careful to check the orders before she signed what the facility asked her to sign. -She visited the facility weekly with an assistant who checked the MAR in their computer system to verify if any changes or orders were made from a visit with residents. If those changes were not on the resident's MAR, they "picked it up" and were able to correct it. -She would address those medications at her next visit on 4/19/16. Interview on 4/14/16 at 2:25 pm with the discharging rehabilitation center representative for Resident #1 revealed: -Details of orders after the FL-2 was written on 2/15/16 and the Resident #1 was discharged from rehab on 2/25/16 was not available as the medical records staff was not available. -The Rehab's staff member matching the name of the signature at the bottom of the discharge summary paperwork was a wound nurse. Interview on 4/14/16 at 3:45 pm with the RCC revealed: -The facility's ARCC, the RCC or Medication Aide (MA) re-wrote a resident's discharge orders onto a "physician's orders page" and faxed it to the pharmacy, but they did not send the original discharge summary with the handwritten orders page. -The pharmacy had never requested the facility to fax orders differently (to include the original order, not the facility's transcribed order). -They used the most recent order whether it was a discharge summary, FL2 or an office order. -She was not aware Resident #1's discharge	D 358		

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NAME OF PROVIDER OR SUPPLIER
KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE
**1808 N CANNON BOULEVARD
KANNAPOLIS, NC 28083**

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D 358	<p>Continued From page 35</p> <p>summary signature was a staff nurse and not a physician or NP. -The second signature on the discharge summary paperwork she recognized as the facility's transportation staff. -There was no process in place to double-check orders and MARs for accuracy. No staff was responsible for monitoring transcription of orders for accuracy. (No policy and procedure was available to be reviewed for who was responsible for this task).</p> <p>Interview on 4/14/16 at 4:45 pm with the Administrator revealed: -The staff had been instructed to use the last signed orders as the most recent. The orders should be signed by the physician or NP. -Prescriptions and medication lists signed by the physician or NP were to be faxed.</p> <p>Interview on 4/14/16 at 4:55 pm with Resident #1's Psychiatrist revealed: -The dose of Klonopin Resident #1 was to receive per the FL2 was not a strong enough dose to be worried about withdrawals. -"We try to reduce medications if possible". -She would expect the facility to call and clarify orders if there were conflicting orders and the discharge summary and FL2 did not match.</p> <p>A Plan of Protection was provided by the facility on 04/14/16: -Effective immediately, the RCC, ARCC, RN and Administrator will audit all resident records at 100% to compare all orders and current medications to assure they are being administered correctly. -Any and all discrepancies will be clarified immediately with the physician. -Staff will be inserviced prior to their next</p>	D 358		

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D 358	Continued From page 36 scheduled shift regarding ensuring medications are administered according to current active physician orders. DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2016.	D 358		<i>Alan</i> <i>5-13-16</i>	
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 observations, interviews, and record reviews, the facility failed to ensure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as they relate to medication administration and clarification of medication orders. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 4 of 7 sampled residents (Residents #1, #4, #6 and #7). [Refer to Tag 0358, 10A NCAC 13F .1004(a) (Type A2 Violation).] B. Based on observations, interviews, and record	D912	131 D Resident's Rights On 4/14/16 Kannon Creek received a Residents' Rights deficiency related to Type A2 violation for Medication Administration, Type B Violation Healthcare Referral and Follow-up and Medication Orders On 5/4/16 Administrator in serviced Payroll and AR Bookkeeper on the "Employee File Audit tool" to ensure all new employees have been educated on Residents' Rights upon hire on an ongoing basis. The Administrator will utilize a QI tool "Administrator's Employee File Audit" tool to monitor completion of the "Employee File Audit" tool weekly x 8 weeks, then monthly x 3 months. The administrator will present all findings at the monthly QI committee meeting for any further recommendations.		

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D912	Continued From page 37 reviews, the facility failed to ensure contact with the resident's physician for clarification of orders for medications which were not dated and signed within 24 hours of admission to the facility for 2 of 7 sampled residents (Residents #1 and #3). [Refer to Tag 344, 10A NCAC 13F .1002(a)(1) (Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 1 of 5 sampled residents (Resident #7) regarding orders for IM (intramuscular) injections. [Refer to Tag 273, 10A NCAC 13F .0902(b) (Type B Violation).]	D912	On 5/5/16 an in-service for staff at 100% or before working there next shift was initiated by the Administrator and Resident Care Coordinator (RCC) on the 131 D tag for Residents' Rights which was triggered by the Type B and Type A2 violations. The in-service titled "Resident Rights, Medication Rights" included that Residents have the right to: have staff clarify all unclear doctors' orders. Receive medication as order by their doctors. Have all referral and follow up as order by doctors.	<i>Ann</i> 5-13-16