

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/10/2016
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NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027
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{D 000}	Initial Comments	{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: (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.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION.</p> <p>The Type A2 Violation was abated. Non-compliance continues.</p> <p>Based on observations, record reviews and interviews, the facility failed to assure medication was administered as ordered for 3 of 7 sampled residents (Resident #2, #4, and #6) with physician orders for Protonix (Resident #2), Aspirin, Simethicone Chew, Pravastatin, and Trazadone (Resident #6) and Coumadin (Resident #4).</p> <p>The findings are:</p> <p>A. Review of Resident #6's current FL2 dated 5/26/16 revealed:</p>	{D 358}		

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{D 358}	<p>Continued From page 1</p> <p>-Diagnoses included chronic obstructive pulmonary disease, dyslipidemia, hypertension, circadian rhythm sleep disorder, osteoarthritis, hypokalemia, chronic kidney disease (Stage 3), esophageal reflux, transient ischemic attack, depression with anxiety, chronic pain syndrome.</p> <p>-A physician's orders for an order for Aspirin 325 mg daily (a medication used to prevent recurrent heart attack or ischemic stroke).</p> <p>-A physician's order for Simethicone Chew 80 mg daily as needed (a medication used to used to reduce bloating, discomfort or pain caused by excessive gas).</p> <p>-A physician's order for Pravastatin 10 mg every night (a medication used to treat high cholesterol and triglyceride levels),</p> <p>Review of Resident #6's Resident Register revealed an admission date of 3/20/10.</p> <p>Review of Resident #6's record revealed a subsequent clarification order in Resident #6's record dated 4/28/16 for Trazodone 50 mg every night (a medication used to treat depression).</p> <p>Review of Resident #6's June 2016 Medication Administration Record (MAR) revealed:</p> <p>-An entry for aspirin 325 mg daily, scheduled for administration at 6:00 am.</p> <p>-An entry for Simethicone chew 80 mg daily as needed.</p> <p>-No documentation of administration of Simethicone Chew on MAR.</p> <p>-An entry for Pravastatin 10 mg every night scheduled for administration at 8:00 pm.</p> <p>-An entry for Trazodone 50 mg every night scheduled for administration at 8:00 pm.</p> <p>-Documentation of administration of the above medications as ordered 6/1/16 - 6/30/16.</p>	{D 358}		

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{D 358}	<p>Continued From page 2</p> <p>Review of Resident #6's July 2016 MAR revealed: -An entry for aspirin 325 mg daily, scheduled for administration at 6:00 am. -An entry for Simethicone chew 80 mg daily as needed. -An entry for Pravastatin 10 mg every night, scheduled for administration at 8:00 pm. -An entry for Trazodone 50 mg every night, scheduled for administration 8:00 pm. -Documentation of administration of the above medications as ordered 7/1/16 - 7/31/16.</p> <p>Review of Resident #6's August 2016 MAR revealed: -No entry for Aspirin, Simethicone Chew, Pravastatin, and the Trazodone on the MAR. -There were no documentation for administration of the Aspirin, Simethicone Chew, Pravastatin, or the Trazodone available for review from 8/1/16 - 8/9/16.</p> <p>Interview on 8/10/16 at 11:19 am with Quality Control Aide (QCA) revealed: -The aspirin and the Trazodone had been discontinued starting in August. -She was unable to give a discontinue order for the aspirin or the Trazodone. -She was the second person that checked the MARs for accuracy and for new or discontinued orders after receiving them from the pharmacy. -She was not aware that the aspirin, Simethicone, Pravastatin or the Trazodone had been left off of the August 2016 MAR.</p> <p>Interview on 8/10/16 at 1:25 pm with the Administrator revealed: -She was not aware that the aspirin, Simethicone, Pravastatin, and the Trazodone had been left off of the MAR until it had been brought to her attention.</p>	{D 358}		

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{D 358}	<p>Continued From page 3</p> <ul style="list-style-type: none"> -There were no side effects or adverse reactions to Resident #6 not receiving the medications. -She had called the primary Doctor's office on 8/10/16 at 1:00 pm to get an order for the medications to be held from 8/1/16 - 8/9/16. <p>Interview on 8/10/16 at 2:15 with a second QCA revealed:</p> <ul style="list-style-type: none"> -The MARs come in from the pharmacy and were checked by a QCA along with the MAR from the previous month. -The new MAR was checked for accuracy and new orders are verified and for orders that were left off. -If there was a clarification/discrepancy noted then the medication order is written on the MAR and the carbon copy was faxed to the pharmacy for revision or correction. -There was a second check done by another QCA or a Medication Aide once the corrected MAR is returned from the pharmacy. -If there was any other clarification needed then the doctor would be called. -The revisions and corrections were usually returned from the pharmacy within 24 hours after faxing the carbon copy to them. -She was not aware that the aspirin, Simethicone, Pravastatin or the Trazadone had been left off of the August 2016 MAR. <p>Interview on 8/10/16 at 4:20 pm with the pharmacist revealed:</p> <ul style="list-style-type: none"> -Resident #6's MAR's had been printed on 7/22/16 and there was a software setup issue which prevented the Aspirin, Simethicone, Pravastatin and the Trazadone from being entered on the MAR. -Any discrepancies that are noted by the facility are faxed to the pharmacy on the corrected carbon copy for clarification and a reprint of the 	{D 358}		

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{D 358}	<p>Continued From page 4</p> <p>MAR.</p> <ul style="list-style-type: none"> -The reprinted MAR would then be sent out by delivery personnel that day. - The carbon copy had not been faxed back to the pharmacy. -The clarification carbon copy should have been faxed back to pharmacy by 8/1/16 for clarification and reprint. <p>Interview on 8/10/16 at 4:30 pm with Resident #6 revealed:</p> <ul style="list-style-type: none"> -She has resided at the facility for 6 years. -She did not feel she had been getting all of her medications lately. <p>Interview on 8/10/16 at 5:00 pm with Resident #6's primary care physician's office Licensed Practical Nurse revealed:</p> <ul style="list-style-type: none"> -The resident had not been seen since 11/12/15. -The FL2 dated 5/26/16 containing the orders for Aspirin, Simethicone, and the Pravastatin was signed by their Nurse Practitioner (NP), but there was not a note in Resident #6's record that the NP had seen the resident. -There was a written order dated 4/28/16 in Resident #6's record for the Trazodone signed by their another NP. -She was unsure if there would be any issues if the resident did not receive those medications since Resident #6 had been seeing another primary doctor. <p>Review of Resident #6's record on 8/10/16 revealed that there was no order to hold Aspirin 325 mg daily, Simethicone Chew 80 mg daily as needed, Pravastatin 10 mg every night, or Trazodone 50 mg every night.</p> <p>Observation on 8/10/16 at 11:19 am with a QCA, of medications on hand revealed:</p>	{D 358}		

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{D 358}	<p>Continued From page 5</p> <p>-The medications on hand were checked and Aspirin and Trazodone were not present and were not listed on the August 2016 MAR. -A full pack of Simethicone Chews and the Pravastatin were in Resident #6's bin but not listed on August 2016 MAR.</p> <p>B. Review of Resident #4's current FL 2 dated 5/31/16 revealed: -Diagnoses included non-operative hip fracture, history of deep vein thrombosis (DVT), chronic anti-coagulation, anemia, and hypertension. -An order for Coumadin (a blood thinner) 4.5 mg daily except Mondays and Fridays. -An order for Coumadin 3 mg on Mondays and Fridays.</p> <p>Review of Resident #4's record revealed: -A physician's order dated 6/24/16 for Coumadin 6mg today (6/24/16), and to start Coumadin 4.5 mg daily except 3mg on Monday, Wednesday, and Friday for an International Normalized Ratio (INR) level of 1.1. -INR values ranged from 1.1 to 3.4 in June 2016, 1.8 to 2.0 in July 2016, and was not due to be checked in August 2016 until 8/12/16.</p> <p>Review of Resident #4's June 2016 Medication Administration Record (MAR) revealed: -A pre-printed entry for Coumadin 3mg Monday and Friday and scheduled for 8:00 pm. There was a handwritten "discontinued 6/08/16" marking across the entry. Coumadin 3 mg was documented as administered on Wednesday, 6/01/16 and Friday, 6/03/16. No dose was documented as administered on Monday, 6/06/16 and no documentation for the reason it was not administered. -A second pre-printed entry for Coumadin 4.5 mg</p>	{D 358}		

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{D 358}	<p>Continued From page 6</p> <p>daily except Monday and Friday and scheduled for 8:00 pm. There was a handwritten "discontinued 6/08/16" marking across the entry. Coumadin 4.5 mg was documented as administered on 6/01, 6/02, 6/04, 6/05, and 6/07/16.</p> <p>-A handwritten entry to hold Coumadin for one day and marked "hold" on 6/08/16. No Coumadin was administered on this day.</p> <p>-A handwritten entry for "Coumadin 3 mg on Monday, Wednesday and Friday to start 6/10/16" and scheduled at 8:00 pm. There was a "hold" notation on 6/24/16. Coumadin 3 mg was documented as administered on Mondays, Wednesdays and Fridays as ordered from 6/10/16 to 6/30/16 and was held on 6/24/16.</p> <p>-A handwritten entry for Coumadin 6 mg today only and scheduled on 6/24/16 at 8:00 pm. Coumadin 6 mg was documented as administered on 6/24/16.</p> <p>-An entry for "Coumadin 4.5 mg daily except 3mg on Monday, Wednesday and Friday to start 6/09/16" and scheduled for 8:00 pm. Coumadin 4.5 mg was documented as administered daily except Mondays, Wednesdays and Fridays as ordered from 6/11/16 to 6/30/16 except it was not administered on Thursday, 6/09/16 or Sunday, 6/12/16. There was no documentation for the reason Coumadin 4.5 mg was not administered on 6/09/16 or 6/12/16.</p> <p>-Coumadin was not administered on 3 scheduled days in June: 6/06, 6/09 and 6/12/16. There was no documentation for the reason the doses were not administered.</p> <p>-Coumadin 3mg and Coumadin 4.5 mg were documented as administered on Wednesday, 6/01/16 for a total dose of 7.5 mg at 8:00 pm.</p> <p>Review of Resident #4's record revealed no physician's order to hold the Coumadin dose on</p>	{D 358}		
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{D 358}	<p>Continued From page 7</p> <p>6/08/16 and to change the Coumadin dose schedule.</p> <p>Review of Resident #4's July 2016 MAR revealed: -An entry for Coumadin 3 mg on Monday, Wednesday and Friday and scheduled to be administered at 5:00 pm. -Coumadin 3 mg was documented as administered on Mondays, Wednesdays and Fridays from 7/01 to 7/29/16 except for on 7/13, 7/15 and 7/20/16. There was no documentation for the reason Coumadin 3 mg was not administered on those 3 days. -An entry for Coumadin 4.5 mg daily except Monday, Wednesday and Friday and scheduled to be administered at 5:00 pm. -Coumadin 4.5 mg was documented as administered daily except Mondays, Wednesdays and Fridays except for 7/10/16. There was no documentation for the reason Coumadin 4.5 mg was not administered on 7/10/16.</p> <p>Review of Resident #4's August 2016 MAR revealed: -An entry for Coumadin 3 mg on Monday, Wednesday and Friday and scheduled to be administered at 8:00 pm. -Coumadin 3 mg was documented as administered every Monday, Wednesday and Friday from 8/01 to 8/08/16. -An entry for Coumadin 4.5 mg daily except Monday, Wednesday and Friday and scheduled to be administered at 8:00 pm. -Coumadin 4.5 mg was documented as administered daily except Mondays, Wednesdays and Fridays from 8/01 to 8/08/16.</p> <p>Review of medications on hand on 8/10/16 at 3:00 pm for Resident #4 revealed: -Two Coumadin 4.5 mg cards dispensed on</p>	{D 358}		

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{D 358}	<p>Continued From page 8</p> <p>7/28/16 and 8/03/16. -One Coumadin 3 mg card with doses left.</p> <p>Interview on 8/09/16 at 4:35 pm with a Medication Aide (MA) revealed: -The Quality Control Aides (QCAs) verified the MARs for accuracy when the new MARs came in. -The QCAs or the MAs were responsible to transcribing physician orders onto the MAR. -The MAs were to initial entries on the front of the MAR to document that a medication was administered. If a medication was not administered, documentation and the reason should be written on the back of the MAR. -Any errors or omissions should be reported to the QCA and the physician.</p> <p>Interview on 8/09/16 at 4:36 pm with a QCA revealed: -She verified resident MARs , "usually" with another QCA, when the next month's batch of MARs were received from the pharmacy. -The current MAR was compared to the new month's MAR for accuracy. -She was not aware there was no copy of the physician's order in Resident #4's record to hold the Coumadin dose on 6/08/16 and to change the Coumadin dose schedule. "She would call to obtain one from the Coumadin clinic."</p> <p>Interview on 8/10/16 at 11:30 am with Resident #4's physician's office nurse revealed: -The "Coumadin clinic" managed Coumadin dose orders for Resident #4 when INRs were obtained. -There was a physician's order dated 6/08/16 in their files to hold the Coumadin dosage on 6/08/16 and to start Coumadin 4.5 mg daily except 3mg on Monday, Wednesday, and Friday for an INR level of 3.4. -There was no record in the office files that the</p>	{D 358}		

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{D 358}	<p>Continued From page 9</p> <p>facility had notified the clinic or the physician that Coumadin doses were missed or given incorrectly to Resident #4 on 6/01, 6/06, 6/09, 6/12, 7/10, 7/13, 7/15 or 7/20/16.</p> <p>-The physician expected the facility to administer Coumadin as ordered by the Coumadin clinic.</p> <p>Interview on 8/10/16 at 11:50 am with Resident #4's Coumadin clinic representative revealed:</p> <p>-There was no documentation in the clinic files that the facility had notified them that Coumadin doses were missed or given incorrectly to Resident #4 on 6/01, 6/06, 6/09, 6/12, 7/10, 7/13, 7/15 or 7/20/16.</p> <p>-There was a physician's order dated 6/08/16 in their files to hold the Coumadin dosage on 6/08/16 and to start Coumadin 4.5 mg daily except 3mg on Monday, Wednesday, and Friday for an INR level of 3.4.</p> <p>-They expected the facility to administer Coumadin as ordered by the Coumadin clinic and to contact them if clarification of orders were needed.</p> <p>-They wanted Resident #4's INR to be between 2.0 and 3.0.</p> <p>Interview on 8/10/16 at 1:40 pm with another QCA revealed:</p> <p>-The MAs were to report medication omissions and errors to the physician.</p> <p>-She was not aware Resident #4 had missed or received incorrect Coumadin doses in June or July 2016, so had not notified the physician.</p> <p>Interview on 8/10/16 at 2:20 pm with the Executive Director revealed:</p> <p>-The MAs and the QCAs were responsible to verify new MARs every month.</p> <p>-The Coumadin clinic made lab and medication orders for Resident #4.</p>	{D 358}		

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{D 358}	<p>Continued From page 10</p> <p>-The MAs or the QCAs were responsible for transcribing any physician orders onto Resident's MARs.</p> <p>Interview on 8/10/16 at 2:10 with Resident #4 revealed:</p> <p>-The Coumadin clinic staff ordered his labwork to be checked and ordered his Coumadin. -He was not aware when the labwork was scheduled "until they showed up to draw it". -He thought the facility administered his medication as ordered by his physician. -He was not aware if he had missed any doses of Coumadin. -He did not have any bleeding problems and thought he was "pretty well controlled". -He did not have any current bruises.</p> <p>C. Review of Resident #2's current FL2 dated 12/22/15 revealed:</p> <p>-Diagnoses included diabetes, anemia, anxiety, coronary artery disease, hypertension, renal insufficiency and irritable bowel syndrome. -A physician's order for Protonix 40 mg every 48 hours (a proton pump inhibitor used to decrease the amount of acid produced in the stomach).</p> <p>Review of Resident #2's June 2016 Medication Administration Record (MAR) revealed:</p> <p>-An entry for Protonix 40 mg every other day and scheduled for 8:00 am. -There were handwritten markings that crossed out the odd days on the MAR. -Protonix 40 mg was documented as administered every other day on even days as ordered from 6/01 to 6/30/16.</p> <p>Review of Resident #2's July 2016 MAR revealed:</p> <p>-An entry for Protonix 40 mg every other day and scheduled for 8:00 am.</p>	{D 358}		

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{D 358}	<p>Continued From page 11</p> <p>-At the Protonix entry there were handwritten markings that crossed out the even days of the MAR from 7/04/16 to 7/31/16, and also thru 7/29/16.</p> <p>-Protonix 40 mg was documented as administered every other day on the odd days from 7/01 to 7/25/16 except for 7/19, 7/27, and 7/29/16, and was documented as administered on 7/02 and 7/30/16.</p> <p>-There was no documentation on the front or back of the MAR for the reason Protonix 40 mg was not administered as ordered on 7/19, 7/27, and 7/29/16, or the reason it was administered on 7/02 and 7/30/16.</p> <p>Review of Resident #2's August 2016 MAR on 8/09/16 at 2:00 pm revealed:</p> <p>-An entry for Protonix 40 mg every other day and scheduled for 8:00 am.</p> <p>-Protonix 40 mg was documented as administered daily from 8/01 to 8/09/16.</p> <p>-There were no markings on the Protonix entry to guide staff to administer medications every other day on odd days from 8/01 to 8/31/16.</p> <p>Review of medications on hand on 8/09/16 at 4:00 pm for Resident #2 revealed:</p> <p>-A Protonix 40 mg punch card with labeled instructions to administer every other day. A dispense date of 8/01/16 for 15 tablets. There were 13 tablets remaining.</p> <p>-It could not be determined if Protonix 40 mg was administered daily or every other day by reviewing Resident #2's medication card.</p> <p>Interview on 8/09/16 at 4:35 pm with a MA revealed:</p> <p>-A medication card was used until empty, then a new medication card was started. The facility did not start a new card at the start of each month.</p>	{D 358}		

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{D 358}	<p>Continued From page 12</p> <p>-Resident #2 was to receive Protonix 40 mg every other day. She did not know why "we are administering it daily". "The MAR was not marked off as usual" to guide in which day to administer it. She would mark it so staff administered the medication as ordered.</p> <p>-The Quality Control Aide (QCA) verified the MARs for accuracy when the new MARs came in.</p> <p>-The QCA or the MA were responsible for transcribing physician orders onto the MAR.</p> <p>-The MAs were to initial entries on the front of the MAR to document that a medication was administered.</p> <p>Further review of Resident #2's August 2016 MAR on 8/10/16 at 8:30 am revealed there were handwritten markings at the Protonix entry that crossed out the even days of the MAR from 8/10 to 8/30/16.</p> <p>Interview on 8/09/16 at 4:36 pm with a QCA revealed:</p> <p>-She verified resident MARs ,"usually" with another QCA, when the next month's batch of MARs were received from the pharmacy.</p> <p>-The current MAR was compared to the new month's MAR for accuracy.</p> <p>Attempted telephone interview on 8/10/16 with Resident #2's physician or office nurse was unsuccessful.</p> <p>Interview on 8/10/16 at 10:00 am with Resident #2 revealed:</p> <p>-She thought the facility staff administered her medication as ordered by her physician.</p> <p>-She did not know how often she was ordered to take Protonix.</p> <p>Interview on 8/10/16 at 2:20 pm with the</p>	{D 358}		

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{D 358}	Continued From page 13 Executive Director revealed: -The MA and the QCA were responsible to verify new MARs every month. -The clinic provided Coumadin lab and medication orders for Resident #2. -The MA or the QCA were responsible for transcribing any physician orders onto residents' MARs.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to assure the Medication Administration Records (MARs) were accurate, related to	{D 367}		

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{D 367}	<p>Continued From page 14</p> <p>documentation of medications administered as needed (prn), for 2 of 7 sampled residents (Resident #5, and #6) with orders for hydrocodone/ APAP (#5), and Dilaudid (#6).</p> <p>The findings are:</p> <p>A. Review of Resident #6's current FL2 dated 05/26/16 revealed: -Diagnoses included chronic obstructive pulmonary disease, dyslipidemia, hypertension, circadian rhythm sleep disorder, osteoarthritis, hypokalemia, chronic kidney disease (Stage 3), esophageal reflux, transient ischemic attack, depression with anxiety, and chronic pain syndrome. -A physician's order for Dilaudid 2 mg every 6 hours as needed (prn). (Dilaudid is a narcotic medication used for chronic pain.)</p> <p>Review of Resident #6's Controlled Substance Sheet (CSS) revealed: -CSS dated 05/25/16 with a received count of 30 tablets to administer, dispensed on 05/25/16. -Nine tablets were documented as administered from 07/1/16 to 07/6/16 at 2:00 pm. -CSS dated 07/6/16 with a received count of 60 tablets to administer, dispensed on 07/6/16. -Twenty five tablets were documented as administered from 07/16/16 at 8:00 pm to 07/31/16 at 8:00 pm. -Thirty six doses of Dilaudid 2mg were documented as administered on the CSS from 07/01/16 to 07/31/16.</p> <p>Review of Resident #6's July 2016 Medication Administration Record (MAR) revealed: -An entry for 1 tablet administered from 07/01/16 to 07/06/16 on 07/03/16 at 2:00pm. -Five tablets documented as administered on the</p>	{D 367}		

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{D 367}	<p>Continued From page 15</p> <p>July 2016 MAR from 7/06/16 to 7/31/16 at 8:00 pm -There was no entry for effectiveness of medication noted on MAR.</p> <p>Comparison of Resident #6's CSS for 05/25/16 and 07/06/16 to Resident #6's July 2016 MAR revealed: -Documentation for Dilaudid 2 mg on the MAR was blank on 30 of 36 occasions. -The medication was documented as administered on the CSS for the 36 occasions. -The reason the medication was administered, and the outcome/effectiveness of the medication was not documented for the 30 occasions.</p> <p>Examples of administration logged on Resident #6's CSS but not documented on the July 2016 MAR were as follows: -On 07/07/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/11/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/12/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/13/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR.</p> <p>Review of Resident #6's CSS sheet revealed: -CSS dated 07/06/16 with a received count of 60 tablets to administer, dispensed 07/06/16. -Twelve tablets were documented as administered from 08/01/16 at 8:00 pm to 08/09/16 at 8:00 pm.</p> <p>Review of Resident #6's August 2016 MAR</p>	{D 367}		

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{D 367}	<p>Continued From page 16</p> <p>revealed:</p> <ul style="list-style-type: none"> -Four tablets were documented as administered on the August 2016 MAR from 08/01/16 to 08/09/16 at 8:00 pm. -All entries documented as given did not include time, reason or effectiveness of medication. <p>Comparison of Resident #6's CSS for 07/06/16 to Resident #6's August 2016 MAR revealed:</p> <ul style="list-style-type: none"> -Documentation for Dilaudid 2 mg on the MAR was blank on 8 of 12 occasions. -The medication was documented as administered on the CSS for the 12 occasions. -The reason the medication was administered, and the outcome/effectiveness of the medication was not documented for the 8 occasions. <p>Examples of administration logged on Resident #6's CSS but not documented on the August 2016 MAR were as follows:</p> <ul style="list-style-type: none"> -On 08/01/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/02/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/03//16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/09/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. <p>Interview with Resident #6 on 08/10/16 at 4:30 pm revealed that when she needed pain medicine, and she felt that the Medication Aides gave it to her every time.</p> <p>Interview with a day shift Medication Aide (MA) on 08/10/16/at 3:03 pm revealed:</p>	{D 367}		

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{D 367}	<p>Continued From page 17</p> <ul style="list-style-type: none"> -All "prn" medications were supposed to be documented on the front of the MAR, and on the back of the MAR for reason administered. MA staff should come back later and document on the back of the MAR if the medication was effective. -The MA staff documented removal of controlled substance from the locked drawer on the corresponding CSS. -She concentrated on making sure each controlled substance was signed out on the CSS when it was removed form the lock drawer. -She used the CSS to determine if the proper time had passed before administering another dose of the medication. -She stated sometimes MAs may be interrupted during the documentation of the "prn" and overlook documenting on the MAR. -Each floor of the facility had a Quality Control Aide (QCA) that was responsible for monitoring medication orders and supervising MAs. -The QCA would be responsible for auditing for accuracy of the MARs compared to the CSS documentation. -She did not know if the QCA was conducting routine audits of the "prn" controlled substances. <p>B. Review of Resident #5's current FL-2 dated 03/29/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included cardiomyopathy, atrial fibrillation, depression, urinary retention, and hypothyroidism. -Hydrocodone/acetaminophen 7.5-325 (a narcotic pain reliever used to treat moderate to severe pain) three times a day was ordered. <p>Review of Resident #5's record revealed physician's orders dated 06/23/16 and 07/28/16 for hydrocodone/acetaminophen 10/325 one tablet every 6 hours as needed (prn) for pain.</p>	{D 367}		

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{D 367}	<p>Continued From page 18</p> <p>Telephone interview on 08/10/16 at 4:30 pm with a representative for the contract pharmacy revealed:</p> <ul style="list-style-type: none"> -Resident #5 was dispensed 120 hydrocodone/acetaminophen 10/325 through the back-up pharmacy on 06/24/16. -Resident #5 was dispensed 30 hydrocodone/acetaminophen 10/325 on 07/30/16. -Resident #5 was dispensed 30 hydrocodone/acetaminophen 10/325 on 08/05/16. <p>-Controlled Substance Sheets (CSS) were included with each dispensing of a controlled substance for tracking the administration of the controlled substance.</p> <p>Review of Resident #5's hydrocodone/acetaminophen CSS for 06/24/16 revealed documentation of administration of 99 tablets from 07/01/16 to 7/30/16.</p> <p>Review of Resident #5's hydrocodone/acetaminophen CSS for 07/30/16 revealed documentation for administration of 4 tablets on 07/31/16.</p> <p>Review of Resident #5's Medication Administration Record (MAR) for July 2016 revealed:</p> <ul style="list-style-type: none"> - Hydrocodone/acetaminophen 10/325 one tablet every 6 hours as needed (prn) for pain was transcribed on the MAR. -Administration of "prn" hydrocodone/acetaminophen 10/325 was documented 42 times from 07/01/16 to 07/31/16. <p>Comparison of Resident #5's CSS for 06/24/16 and 07/31/16 to Resident #5's July 2016 MAR revealed:</p> <ul style="list-style-type: none"> -Documentation for hydrocodone/acetaminophen 	{D 367}		

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{D 367}	<p>Continued From page 19</p> <p>10/325 on the MAR was blank on 61 of 103 occasions.</p> <p>-The medication was documented as administered on the CSS for the 61 occasions.</p> <p>-The reason the medication was administered, and the outcome/effectiveness of the medication was not documented for the 61 occasions.</p> <p>Examples of administration logged on Resident #5's CSS but not documented on the July 2016 MAR were as follows:</p> <p>-On 07/02/16, CSS had a dose signed out at 2:00 am, 8:40 am, 3:30 pm and 11:00 pm with one dose at 2:00 am documented as administered on the MAR.</p> <p>-On 07/13/16, CSS had a dose signed out at 4:30 am, 1:15 pm, and 7:15 pm with no doses documented as administered on the MAR.</p> <p>-On 07/19/16, CSS had a dose signed out at 1:00 am, 9:15 am, 3:15 pm, and 10:30 pm with no doses documented as administered on the MAR.</p> <p>-On 07/29/16, CSS had a dose signed out at 5:30 am, 12:10 pm, and 6:00 pm with no doses documented as administered on the MAR.</p> <p>Review of Resident #5's hydrocodone/acetaminophen CSS for 07/30/16 and 08/05/16 revealed 32 tablets were signed out from 08/01/16 to 08/10/16 at 1:30 pm.</p> <p>Review of Resident #5's MAR for August 2016 revealed:</p> <p>-Hydrocodone/acetaminophen 10/325 one tablet every 6 hours as needed (prn) for pain was transcribed on the MAR.</p> <p>-Administration of "prn" hydrocodone/acetaminophen 10/325 was documented 10 times from 08/01/16 to 08/10/16.</p> <p>Comparison of Resident #5's CSS for 07/30/16</p>	{D 367}		

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{D 367}	<p>Continued From page 20</p> <p>and 08/05/16 to Resident #5's August 2016 MAR revealed:</p> <ul style="list-style-type: none"> -Documentation for hydrocodone/acetaminophen 10/325 on the MAR was blank on 22 of 32 occasions. -The medication was documented as administered on the CSS for the 22 occasions. -The reason the medication was administered, and the outcome/effectiveness of the medication was not documented for the 22 occasions. <p>Examples of administration recorded on Resident #5's CSS but not documented on the August 2016 MAR were as follows:</p> <ul style="list-style-type: none"> -On 08/01/16, CSS had a dose signed out at 2:00 am, 9:00 am, 4:45 pm and 11:00 pm with no doses documented as administered on the MAR. -On 08/02/16, CSS had a dose signed out at 5:00 am, 1:40 pm, and 7:40 pm with one dose documented as administered on the MAR. -On 08/05/16, CSS had a dose signed out at 5:40 am, 1:40 pm, and 7:40 pm with no doses documented as administered on the MAR. -On 08/07/16, CSS had a dose signed out at 2:00 am, 8:35 am, 3:35 pm, and 10:40 pm with one dose documented as administered on the MAR. <p>Interview with Resident #5 on 08/10/16 at 1:35 pm revealed:</p> <ul style="list-style-type: none"> -She was aware she had pain medication ordered as needed. -She had discomfort in her back and knees. -She requested her pain medication several times every day. -She had not been out of her pain medication. <p>Interview with a day shift Medication Aide (MA) on 08/10/16/at 3:03 pm revealed:</p> <ul style="list-style-type: none"> -All "prn" medications were supposed to be documented on the front of the MAR, and on the 	{D 367}		

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{D 367}	<p>Continued From page 21</p> <p>back of the MAR for reason administered. MA staff should come back later and document on the back of the MAR if the medication was effective.</p> <ul style="list-style-type: none"> -The MA staff documented removal of controlled substance from the locked drawer on the corresponding CSS. -She concentrated on making sure each controlled substance was signed out on the CSS when it was removed form the lock drawer. -She used the CSS to determine if the proper time had passed before administering another dose of the medication. -She stated sometimes MAs may be interrupted during the documentation of the "prn" and overlook documenting on the MAR. -Each floor of the facility had a Quality Control Aide (QCA) that was responsible for monitoring medication orders and supervising MAs. -The QCA would be responsible for auditing for accuracy of the MARs compared to the CSS documentation. -She did not know if the QCA was conducting routine audits of the "prn" controlled substances. <p>Interview with an evening shift MA on 08/10/16 at 3:05 pm revealed:</p> <ul style="list-style-type: none"> -MAs were supposed to document all controlled substances that were removed from the medication cart on the corresponding CSS. -She always documented popping a controlled substance from the bubble pack immediately on the corresponding CSS. -MAs were supposed to document administration of all "prn" medications, including controlled drugs, on the front and back of the residents' MARs. -She had overlooked documenting the "prn" on the MAR sometimes due to interruptions or distractions, but always made certain she 	{D 367}		

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{D 367}	<p>Continued From page 22</p> <p>documented the controlled substance on the CSS, otherwise the count would not be right for end of shift for controlled substances.</p> <p>Interview with the Executive Director on 08/10/16 at 2:20 pm and 4:05 pm revealed:</p> <ul style="list-style-type: none"> -Documentation for medications administered to residents "as needed (prn)" should include notation for the administration, reason for administration, and effectiveness/outcome for each dose administered. -It was the MAs' and the QCAs' responsibility to verify new MARs every month. -The MAs had multiple in-services for medication administration and documentation. -The facility had an in-service earlier this week (week of 8/07/16) for documenting medication administration that would have included controlled substances. -She expected MAs to be documenting "prn" medications as trained. -She was not aware QCAs were not monitoring the CSS logs compared to the residents' MARs for completeness. -The QCAs would be responsible for auditing the accuracy of the residents' MARs compared to the CSS going forward. <p>Interviews with a QCA on 08/10/16 at 5:45 pm revealed:</p> <ul style="list-style-type: none"> -MAs were supposed to look over the MARs before the end of their shift for completeness of documentation. -The MAs were expected to follow the procedure for proper documentation of "prn" medications. -She looked at the MARs (routinely at the end of the month) for omissions of documentation for scheduled medications. -She did not have a system in place to audit "prn" medications for completed documentation. 	{D 367}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/10/2016
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NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027
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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 367}	Continued From page 23 Interview with a second QCA on 08/10/16 at 5:50 pm revealed: -MAs should be documenting "prn" medications according to requirements. -She had not audited residents' MARs compared to the CSS for accuracy of "prn" controlled medications previously. -She would start auditing the administration of "prn" medications in the future.	{D 367}		