



PRINTED: 09/06/2016
FORM APPROVED

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 08/19/2016
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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 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on August 17-19, 2016.	{D 000}	Disclaimer Statement	
{D 273}	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION</p> <p>Based on these findings, the previous Type B Violation was not abated.</p> <p>Based on observations, interviews, and record reviews, the facility failed to obtain required weekly laboratory work for the administration of Clozaril for 1 of 2 sampled residents (Resident #6).</p> <p>The findings are:</p> <p>Review of Resident #6's current FL-2 dated 05/31/16 revealed:</p> <ul style="list-style-type: none"> -Diagnosis of chronic paranoid schizophrenia. -Physician's orders for Clozaril 225 mg every night. (Clozaril is an antipsychotic and is only available through a restricted program because of the severity of risks associated with the medication, particularly bone marrow suppression, causing dangerous lowering of white blood cell count and increased vulnerability to infection. Prescribing physicians and dispensing pharmacists are required to be registered and trained through the program and 	{D 273}	<p>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</p>	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE
Administrator

(X6) DATE
9-16-16

STATE FORM

473S12

If continuation sheet 1 of 38

*2nd and accepted
Ammore
9/26/16*

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{D 273}	Continued From page 1 ensure laboratory studies are completed as determined by the program.) Review of the Resident Register revealed Resident #6 was admitted to the facility on 05/31/16. Interview on 08/18/16 at at 10:13 am with the facility's contracted pharmacist revealed: -When the pharmacy began new service for a resident on Clozaril, the pharmacy staff was required to enroll the resident online with the manufacturer of the medication. The manufacturer determined how often laboratory studies needed to be completed for that particular resident and communicated that information to the pharmacy and to the resident's physician, who was also required to be registered with the program. -The dispensing pharmacy was required to have documentation of the laboratory studies prior to dispensing the medication. -Resident #6 was required to have weekly laboratory studies. -When the facility contacted the pharmacy for a refill of Clozaril, if the required lab work had not been sent, the pharmacy informed the facility of the inability to fill the medication until the lab work was completed. -There were gaps in Resident #6's Clozaril dispensing records because the required weekly laboratory studies had not been received from the facility. -The facility sent lab results on 06/10/16 (drawn on 06/10/16), duplicates on 06/19/16 (drawn on 06/10/16), on 06/24/16 (drawn on 06/23/16), duplicates on 06/30/16 (drawn on 06/23/16), on 07/07/16 (drawn on 07/07/16), on 07/21/16 (drawn on 07/21/16), on 08/06/16 (drawn 08/06/16).	{D 273}	Health Care 10 A BCAC 13F .0902 Medication Administration 10A NCAC 13F.1004 On 8/19/16m, an audit was completed by the facility Lab auditor for each resident receiving Clozaril ensuring their labs are up to date and that the medication is available. On 8/19/16, a questionnaire was completed on all interviewable residents. Questions were: Have you ever been out of medication? If yes, explain. Do you know who to tell if you are told by a Med Tech you are out of medication? After 8/19/16, questionnaires will be completed on 10% of interviewable residents weekly for 8 weeks then monthly ongoing. Starting 8/18/16, the administrator began in-servicing 100% of Med Techs, before beginning their next scheduled shift	

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{D 273}	<p>Continued From page 2</p> <ul style="list-style-type: none"> -A 7-day supply of Clozaril was dispensed on 06/10/16. -A 3-day supply of Clozaril was dispensed on 06/19/16. -A 3-day supply of Clozaril was dispensed on 06/25/16. -A 7-day supply of Clozaril was dispensed on 06/30/16. -A 3-day supply of Clozaril was dispensed on 07/06/16. -A 4-day supply of Clozaril was dispensed on 07/07/16. -A 7-day supply of Clozaril was dispensed on 07/22/16. -A 3-day supply of Clozaril was dispensed on 07/31/16. -A 7-day supply of Clozaril was dispensed on 08/07/16. <p>-(Based on the Clozaril dispensing records, there was no Clozaril available for administration for 30 of 74 days from 06/10/16 through 08/18/16.)</p> <p>Interview on 08/18/16 at 10:58 am with the Assistant Resident Care Coordinator (ARCC) revealed:</p> <ul style="list-style-type: none"> -Resident #6 was "supposed to get weekly labs". -When the resident was at the previous facility, a nurse from a home health agency drew the weekly labs "as a courtesy" to the facility because the resident was not enrolled with the home health agency. -The facility staff contacted the home health agency when the resident was admitted to draw the resident's labs, but was informed the agency only drew them "as a courtesy" at the previous facility because the insurance would not pay for them to be drawn. -The home health nurse agreed to draw the first set of labs at this facility as a courtesy and the facility nurse was supposed to draw the labs 	{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. • 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 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 	

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(D 273)	<p>Continued From page 3 thereafter.</p> <ul style="list-style-type: none"> -The facility nurse quit working for the facility around 07/04/16. -The facility "kept asking" the home health staff person to draw the labs when the medication supply was depleted and the pharmacy required the labs. -The ARCC did not know the resident was running out of Clozaril that frequently or was missing that many doses. -The Resident Care Coordinator (RCC) was more involved with the labs and would have more information, but she was currently on vacation. <p>Interview on 08/19/16 at 9:19 am with the Administrator revealed:</p> <ul style="list-style-type: none"> -Residents on Clozaril were supposed to have laboratory studies completed weekly unless the physician ordered otherwise. -Because of the problem with Resident #6's insurance, the facility nurse was drawing his labs; however, the nurse quit on 07/08/16. -The Administrator thought the labs were being drawn weekly by a home health nurse and the results sent to the pharmacy. -On 07/20/16, the Administrator hired the home health nurse to take the facility nurse's place. <p>Interview on 08/19/16 at 9:30 am with the home health nurse revealed:</p> <ul style="list-style-type: none"> -He began working pm (as needed) at the facility about three weeks ago to fill in until the facility could hire another full time nurse. -Typically, laboratory studies were done by an outpatient laboratory company; however, if a resident (such as Resident #6) had no insurance, the facility called him to draw the labs. -There were currently no residents in the facility, that he was aware of, for whom he was supposed to draw labs every week on a routine basis. 	(D 273)	<p>Starting 8/19/16 the administrator began in-servicing the Med Techs at 100% and before beginning their next scheduled shift</p> <ul style="list-style-type: none"> • When a medication is not given as ordered you must initial the MAR and circle your initials and then document reasoning for medication not being given on the back of MAR. • Each resident receiving clozaril will have a count sheet for this medication and the Med Tech giving the medication will sign it out on the count sheet at the time it was given • Clozaril will be counted each shift at change of shift. <p>On 8/19/16, the administrator began in-servicing the RCC, assistant RCC, and lab auditor before there next scheduled shift on completing:</p> <ul style="list-style-type: none"> • When a medication requires labs to be drawn it is your 	

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{D 273}	<p>Continued From page 4</p> <p>-He relied on the facility staff to notify him when a lab needed to be drawn.</p> <p>Interview on 08/19/16 at 9:05 am with Resident #6's psychiatric Nurse Practitioner (NP) revealed:</p> <p>-Resident #6 was supposed to have laboratory studies done weekly and the results provided to the pharmacy in order for the Clozaril to be dispensed.</p> <p>-The pharmacy would not dispense the Clozaril without the required lab work; their motto was "No blood, No drugs".</p> <p>-It was "very important!" for the required laboratory studies to be done and Clozaril to be administered consistently as ordered by the physician.</p> <p>-Every time there was a change in Clozaril dosage, they had "to go back to weekly" labs.</p> <p>-After a resident was stable, the frequency of laboratory studies could be decreased to monthly or every 6 months.</p> <p>-The NP was not aware the facility was not obtaining the labs on a weekly basis or that the resident was not receiving the Clozaril as ordered.</p> <p>Interview on 08/17/16 at 8:42 am with Resident #6 revealed:</p> <p>-His Clozaril "frequently" ran out, meaning he would be out for 3 days, the facility would order the medication, then he would be out for 5 days and the facility would order the medication "back and forth".</p> <p>-"I don't know why they're checking my blood work if I ain't getting my meds."</p> <p>-The resident liked the Clozaril because it kept him from having bad dreams about a deceased family member.</p> <p>-He had complained twice to facility management as well as to the people who drew his blood about</p>	{D 273}	<p>responsibility to ensure that labs have been drawn, results received and faxed to pharmacy.</p> <ul style="list-style-type: none"> • Call pharmacy to ensure that the fax was received and that the medication will be delivered with the next delivery. • The labs need to be obtained prior to resident being out of medication. <p>On 8/19/16, the Administrator, ARCC, and/or Lab Auditor did a complete Medication Cart to MAR audit to ensure all medications were available as ordered by the Nurse Practitioner/Doctor. Any issues were addressed immediately.</p> <p>On 8/19/16, the Administrator\RCC\Lab Auditor 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. The administrator\RCC\ARCC will complete a 100% audit of all carts to ensure medications are being given as ordered. These audits will be completed</p>	

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{D 273}	<p>Continued From page 5</p> <p>running out of Clozaril.</p> <p>On 08/19/16, the Administrator submitted a Plan of Protection as follows:</p> <ul style="list-style-type: none"> -An audit was completed for each resident receiving Clozaril to ensure laboratory studies were up to date and the medication available. -An audit was completed for each resident record to identify any health care issues requiring follow up. All identified issues will be addressed immediately. -A Clozaril audit tool was developed to ensure laboratory studies were obtained and Clozaril was administered as ordered. The audit tool will be completed 5 times weekly for 8 weeks, then monthly thereafter. -The RCC, ARCC, and lab coordinator would be inserviced before their next scheduled shift regarding the process for ensuring required laboratory testing was completed. -The Administrator or designee will ensure ongoing compliance by auditing and initialing the audit tools weekly for 8 weeks, then monthly thereafter. <p>The Administrator submitted a correction date of August 26, 2016 for the Unabated B Violation.</p>	{D 273}	<p>immediately by 8/26/16 using Medication Monitoring form audit tool.</p> <p>On 8/24/16, the Pharmacy Consultant did an in service "Putting it on Paper" and "Controlled Substance Documentation" for all Med Techs.</p> <p>The RCC/ARCC and/or lab auditor will audit all count sheets of residents receiving Clozapril to ensure medication is being given as ordered. The RCC/ARCC and/or Lab auditor will begin auditing all labs including resident's receiving Clozapril to ensure all labs are drawn as ordered and faxed to pharmacy as indicated. Audits will be completed 5x/week x 8 weeks then monthly ongoing using the Clozapril audit tool.</p>	
{D 358}	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <ol style="list-style-type: none"> (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 	{D 358}	<p>Administrator/designee will audit the Clozapril audit tool 5x/week x 8 week then monthly ongoing. Any concerns will be taken to the QI Committee for further review monthly for three months and then quarterly.</p>	8-26-15 Amm

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{D 358}	<p>Continued From page 6 and procedures.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION</p> <p>The Type A2 Violation is abated. Non-compliance continues.</p> <p>THIS IS A TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medications (Mobic, Depakote, Klonopin, and Clozaril) were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #5 and #6).</p> <p>The findings are:</p> <p>A. Review of Resident #6's current FL-2 dated 05/31/16 revealed: -The resident's listed diagnosis was chronic paranoid schizophrenia. -A physician's order for Clozaril 100 mg, two tablets every night and Clozaril 25 mg every night for a total dosage of 225 mg nightly. (Clozaril is an antipsychotic and is only available through a restricted program because of the severity of risks associated with the medication, particularly bone marrow suppression, causing dangerous lowering of white blood cell count and increased vulnerability to infection. Prescribing physicians and dispensing pharmacists are required to be registered and trained through the program and ensure laboratory studies are completed as determined by the program.)</p> <p>Review of the Resident Register revealed Resident #6 was admitted to the facility on 05/31/16.</p>	{D 358}	<p>Health Care 10 A BCAC 13F .0902 Medication Administration 10A NCAC 13F.1004</p> <p>On 8/19/16m, an audit was completed by the facility Lab auditor for each resident receiving Clozaril ensuring their labs are up to date and that the medication is available.</p> <p>On 8/19/16, a questionnaire was completed on all interviewable residents. Questions were: Have you ever been out of medication? If yes, explain. Do you know who to tell if you are told by a Med Tech you are out of medication? After 8/19/16, questionnaires will be completed on 10% of Interviewable residents weekly for 8 weeks then monthly ongoing.</p> <p>Starting 8/18/16, the administrator began in-servicing 100% of Med Techs, before beginning their next scheduled shift</p>		

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{D 358}	<p>Continued From page 7</p> <p>Review of Resident #8's June 2016 Medication Administration Record (MAR) revealed: -An entry for Clozaril 225 mg (total dosage) and scheduled for administration daily at 9:00 pm. -The Clozaril was circled as not administered for five consecutive days from 06/06/16 through 06/10/16. -The Clozaril was circled as not administered on 06/25/16. -Documentation on the back of the MAR revealed the Clozaril was not administered on 06/06/16 and 06/25/16 because there were "no meds". -No further information was documented to indicate the reason for the other omissions.</p> <p>Review of Resident #6's July 2016 MAR revealed: -An entry for Clozaril 225 mg (total dosage) and scheduled for administration daily at 9:00 pm. -From 07/01/16 through 07/04/16, "LOA" (leave of absence) was documented in the spaces provided for documentation of administration. -The Clozaril 200 mg was documented as administered from 07/05/16 through 07/31/16. -The Clozaril 25 mg was documented as administered from 07/05/16 through 07/30/16. -The Clozaril 25 mg was circled as not administered on 07/31/16. -There was no further information documented on the back of the MAR.</p> <p>Review of Resident #6's August 2016 MAR revealed: -An entry for Clozaril 225 mg (total dosage) and scheduled for administration daily at 9:00 pm. -The Clozaril 200 mg was circled as not administered on 08/06/16, 08/07/16, 08/14/16, 08/15/16, and 08/17/16, for a total of 5 doses. -The space for documentation on 08/16/16 was blank.</p>	{D 358}	<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. • Medication Availability, discontinued meds are to be removed from the med cart. Medication that is not in med cart, look in med room. <p>Medication not in the med cart or med room must be obtained contacting Neil Medical pharmacy. Neil Medical 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> <p>Starting 8/19/16 the administrator began in-servicing the Med Techs at 100% and before beginning their next scheduled shift</p>	

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{D 358}	<p>Continued From page 8</p> <ul style="list-style-type: none"> -The Clozaril 25 mg was circled as not administered from 08/04/16 through 08/07/16, 08/15/16, and 08/17/16 for a total of 6 doses. -The space for documentation on 08/16/16 was blank. -Documentation on the back of the MAR revealed the Clozaril was not administered on 08/04/16 due to "no meds". -There was no further documentation to indicate the reason for the other omissions. <p>Observation on 08/18/16 at 11:45 am of Resident #6's medications on hand revealed there was no Clozaril available for administration.</p> <p>Interview on 08/18/16 at 10:13 am with the facility's contracted pharmacist revealed:</p> <ul style="list-style-type: none"> -A 7-day supply of Clozaril was dispensed on 06/10/16. -A 3-day supply of Clozaril was dispensed on 06/19/16. -A 3-day supply of Clozaril was dispensed on 06/25/16. -A 7-day supply of Clozaril was dispensed on 06/30/16. -A 3-day supply of Clozaril was dispensed on 07/06/16. -A 4-day supply of Clozaril was dispensed on 07/07/16. -A 7-day supply of Clozaril was dispensed on 07/22/16. -A 3-day supply of Clozaril was dispensed on 07/31/16. -A 7-day supply of Clozaril was dispensed on 08/07/16. <p>-(Based on the Clozaril dispensing records, there was no Clozaril available for administration for 30 of 74 days from from 06/10/16 through 08/18/16.)</p> <ul style="list-style-type: none"> -When the pharmacy began new service for a resident on Clozaril, the pharmacy staff was 	{D 358}	<ul style="list-style-type: none"> • When a medication is not given as ordered you must initial the MAR and circle your initials and then document reasoning for medication not being given on the back of MAR. • Each resident receiving clozaril will have a count sheet for this medication and the Med Tech giving the medication will sign it out on the count sheet at the time it was given • Clozaril will be counted each shift at change of shift. <p>On 8/19/16, the administrator began in-servicing the RCC, assistant RCC, and lab auditor before there next scheduled shift on completing:</p> <ul style="list-style-type: none"> • When a medication requires labs to be drawn it is your responsibility to ensure that labs have been drawn, results received and faxed to pharmacy. 	

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{D 358}	<p>Continued From page 9</p> <p>required to enroll the resident online with the manufacturer of the medication. The manufacturer determined how often laboratory studies needed to be completed for that particular resident and communicated that information to the pharmacy and to the resident's physician, who was also required to be registered with the program.</p> <p>-The dispensing pharmacy was required to have documentation of the laboratory studies prior to dispensing the medication.</p> <p>-Resident #6 was required to have weekly laboratory studies, so "the most" the pharmacy will fill at a time for Resident #6 was 7 days supply.</p> <p>-The gaps in Resident #6's Clozaril dispensing records were because the required laboratory studies had not been received from the facility.</p> <p>-The facility sent lab results on 06/10/16 (drawn on 06/10/16), duplicates on 06/19/16 (drawn on 06/10/16), on 06/24/16 (drawn on 06/23/16), duplicates on 06/30/16 (drawn on 06/23/16), on 07/07/16 (drawn on 07/07/16), on 07/21/16 (drawn on 07/21/16), on 08/06/16 (drawn 08/06/16).</p> <p>Interview on 08/18/16 at 10:58 am with the Assistant Resident Care Coordinator (ARCC) revealed:</p> <p>-Resident #6 was "supposed to get weekly labs".</p> <p>-When the resident was at the previous facility, a nurse from a home health agency drew the weekly labs "as a courtesy" to the facility because the resident was not enrolled with the home health agency.</p> <p>-The facility staff contacted the home health agency when the resident was admitted to draw the resident's labs, but was informed the agency only drew them "as a courtesy" at the previous facility because the insurance would not pay for</p>	{D 358}	<ul style="list-style-type: none"> Call pharmacy to ensure that the fax was received and that the medication will be delivered with the next delivery. The labs need to be obtained prior to resident being out of medication. <p>On 8/19/16, the Administrator, ARCC, and/or Lab Auditor did a complete Medication Cart to MAR audit to ensure all medications were available as ordered by the Nurse Practitioner/Doctor. Any issues were addressed immediately.</p> <p>On 8/19/16, the Administrator\RCC\Lab Auditor 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. The administrator\RCC\ARCC will complete a 100% audit of all carts to ensure medications are being given as ordered. These audits will be completed immediately by 8/26/16 using</p>	

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	<p>Continued From page 10</p> <p>them to be drawn.</p> <ul style="list-style-type: none"> -The home health nurse agreed to draw the first set of labs at this facility as a courtesy and the facility nurse was supposed to draw the labs thereafter. -The facility nurse quit working for the facility on 07/04/16. -The facility "kept asking" the home health staff person to draw the labs when the medication supply was depleted and the pharmacy required labs. -The ARCC did not know the resident was running out of Clozaril that frequently or was missing that many doses. -The facility did not routinely count non-narcotic medications, so if medications were documented as administered when they were actually unavailable, there would be no way of knowing. <p>Interview on 08/18/16 at 11:50 am with an evening shift Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -The procedure for ordering Clozaril from the pharmacy was not the same as with other medications, because Resident #6 "got so many days" of Clozaril and then he had to have laboratory work completed. -When the Clozaril supply was depleted, the MA "just waited" for the medication to come in from the facility. -The MA did not call the pharmacy or request refills for Clozaril; "they (pharmacy) keep up with that". <p>Interview on 08/18/16 at 3:50 pm with a second evening shift MA revealed:</p> <ul style="list-style-type: none"> -He just became a MA at the facility about a month ago. -If the Clozaril was not available for administration, he was supposed to leave a note for the RCC or the ARCC to order. 	{D 358}	<p>Medication Monitoring form audit tool.</p> <p>On 8/24/16, the Pharmacy Consultant did an in service "Putting it on Paper" and "Controlled Substance Documentation" for all Med Techs.</p> <p>The RCC/ARCC and/or lab auditor will audit all count sheets of residents receiving Clozapril to ensure medication is being given as ordered. The RCC/ARCC and/or Lab auditor will begin auditing all labs including resident's receiving Clozapril to ensure all labs are drawn as ordered and faxed to pharmacy as indicated. Audits will be completed 5x/week x 8 weeks then monthly ongoing using the Clozapril audit tool. Administrator/designee will audit the Clozapril audit tool 5x/week x 8 week then monthly ongoing. Any concerns will be taken to the QI Committee for further review monthly for three months and then quarterly.</p>	

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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 11</p> <ul style="list-style-type: none"> -For medications that required laboratory studies, he was supposed to "notify management" if the medication was unavailable. -He routinely circled medications that were not available for administration, but "sometimes" forgot to go back and document reason for the omission on the back of the MAR. <p>Interview on 08/19/16 at 9:05 am with Resident #6's psychiatric Nurse Practitioner (NP) revealed:</p> <ul style="list-style-type: none"> -Resident #6 was supposed to have laboratory studies done weekly and the results provided to the pharmacy in order for the Clozaril to be dispensed. -The pharmacy would not dispense the Clozaril without the required lab work; their motto was "No blood, No drugs". -It was "very important" for the required laboratory studies to be done and Clozaril to be administered consistently as ordered by the physician. -Every time there was a change in Clozaril dosage, they had "to go back to weekly" labs. -After a resident was stable, the frequency of laboratory studies could be decreased to monthly or every 6 months. -The NP was not aware Resident #6 was not receiving the Clozaril as ordered. -The NP was in the facility on a weekly basis and routinely reviewed what medications the residents were currently taking, but did not look for documentation of missed medications. -The NP would "invest time to re-educate staff" regarding the importance of Clozaril administration and the required laboratory studies. <p>Interview on 08/19/16 at 9:19 am with the Administrator revealed:</p> <ul style="list-style-type: none"> -Residents on Clozaril were supposed to have 	{D 358}		

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{D 358}	<p>Continued From page 12</p> <p>laboratory studies completed weekly unless the physician ordered otherwise.</p> <p>-Because of the problem with Resident #6's insurance, the facility nurse was drawing his labs; however, the nurse quit on 07/08/16.</p> <p>-The Administrator was not aware of the gaps in Resident #6's Clozaril administration.</p> <p>-The Administrator thought the labs were being drawn weekly by a home health nurse and the results sent to the pharmacy.</p> <p>-On 07/20/16, the Administrator hired the home health nurse to take the facility nurse's place.</p> <p>Interview on 08/19/16 at 9:30 am with the home health nurse revealed:</p> <p>-He began working prn (as needed) at the facility about three weeks ago to fill in until the facility could hire another full time nurse.</p> <p>-Typically, laboratory studies were done by an outpatient laboratory company; however, if a resident (such as Resident #6) had no insurance, the facility called him to draw the labs.</p> <p>-There was currently no residents in the facility, that he was aware of, for whom he was supposed to draw labs every week.</p> <p>-He relied on the facility to notify him if a lab needed to be drawn.</p> <p>Interview on 08/17/16 at 8:42 am with Resident #6 revealed:</p> <p>-His Clozaril "frequently" ran out, meaning he would be out for 3 days, the facility would order the medication, then he would be out for 5 days and the facility would order the medication "back and forth".</p> <p>-"I don't know why they're checking my blood work if I ain't getting my meds."</p> <p>-The resident liked the Clozaril because it kept him from having bad dreams about a deceased family member.</p>	{D 358}			

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{D 358}	<p>Continued From page 13</p> <p>-He had complained twice to facility management as well as to the people who drew his blood about running out of Clozaril.</p> <p>B. Review of Resident #5's current FL-2 dated 05/31/16 revealed diagnoses included bipolar and Schizoaffective personality disorder.</p> <p>1. Review of the 05/31/16 FL-2 revealed: -A physician's order for Depakote ER 500 mg, 2 tablets twice daily. -A physician's order for Depakote DR 125 mg daily. (Depakote is an anticonvulsant often used to manage manic episodes related to bipolar disorder. ER is the extended-release formulation, while DR is the delayed-release formulation.)</p> <p>Review of the Resident Register revealed Resident #5 was admitted on 05/31/16.</p> <p>Review of Resident #5's June 2016 Medication Administration Record (MAR) revealed: -The MAR was handwritten and included entries for Depakote DR 125 mg to be administered daily at 9:00 am and Depakote ER 500 mg, 2 tablets to be administered twice daily at 9:00 am and 9:00 pm. -Depakote DR 125 mg was documented as administered daily from 06/01/16 through 06/30/16 at 9:00 am. -The 9:00 am dose of Depakote ER 1000 mg was circled as not administered on 06/28/16 and 06/29/16. -The 9:00 pm dose of Depakote ER 1000 mg was documented as administered daily from 06/01/16 through 06/30/16. -Documentation on the back of the MAR revealed the 9:00 am dose of Depakote ER 1000 mg was not administered on 06/28/16 due to "no meds". -There was no further information regarding</p>	{D 358}		

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{D 358}	<p>Continued From page 14</p> <p>Depakote omissions on the back of the June 2016 MAR.</p> <p>Review of Resident #5's July 2016 MAR revealed:</p> <ul style="list-style-type: none"> -The MAR was pharmacy generated and included entries for Depakote DR 125 mg to be administered daily at 9:00 am and Depakote ER 500 mg, 2 tablets to be administered daily at 9:00 am. -There was no entry for Depakote ER 500 mg; 2 tablets to be administered at 9:00 pm on the MAR. -The Depakote DR 125 mg was circled as not administered for four consecutive doses from 07/11/16 through 07/14/16. -The Depakote ER 1000 mg was circled as not administered for two consecutive doses on 07/22/16 and 07/23/16. -Documentation on the back of the MAR revealed the Depakote DR 125 mg was not administered on 07/11/16 and 07/12/16 due to "no meds". -Documentation on the back of the MAR revealed the Depakote ER 500 mg tablets (2) was not administered on 07/22/16 due to "no meds". -There was no further information regarding Depakote omissions on the back of the July 2016 MAR. <p>Review of Resident #5's August 2016 MAR revealed:</p> <ul style="list-style-type: none"> -The MAR was pharmacy generated and included entries for Depakote DR 125 mg to be administered daily at 9:00 am and Depakote ER 500 mg, 2 tablets to be administered daily at 9:00 am. -The Depakote DR 125 mg and Depakote ER 1000 mg was documented as administered daily at 9:00 am from 08/01/16 through 08/17/16. -There was no entry for Depakote ER 500 mg, 2 tablets to be administered at 9:00 pm on the 	{D 358}			

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{D 358}	<p>Continued From page 15</p> <p>MAR.</p> <p>Review on 08/18/16 at 11:55 am of Resident #5's medications on hand revealed:</p> <ul style="list-style-type: none"> -Depakote DR 125 mg was available for administration. -Depakote ER 500 mg tablets were available for administration. -The Depakote ER pharmacy label included instructions to administer 2 tablets along with 125 mg to equal 1125 mg daily. The label did not include instructions to administer 2 tablets twice daily as ordered by the physician. <p>Interview on 08/17/16 at 3:00 pm with the facility's contracted pharmacist revealed:</p> <ul style="list-style-type: none"> -The facility did not send a copy of the 05/31/16 FL-2 to the pharmacy. -The first orders the pharmacy received for Resident #5 was a copy of the handwritten MAR on 06/02/16. -The pharmacy routinely accepted the MAR copies as physician orders, but they were usually accompanied by the FL-2. -The pharmacy did not have a subsequent physician's order to discontinue the evening dose of Depakote ER. -Upon review of the physician orders, the pharmacist determined the Depakote ER order was incorrectly entered into the pharmacy's computer system as once daily instead of twice daily as ordered. <p>Interview on 08/17/16 at 2:30 pm with the facility's Nurse Practitioner (NP) revealed:</p> <ul style="list-style-type: none"> -She was in the facility weekly to see residents. -The facility routinely gave her "everybody's (MARs) every month" for signature. -She tried to glance through the MARs but she relied on the facility staff to ensure the MARs 	{D 358}		

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{D 358}	<p>Continued From page 16</p> <p>were correct when they presented them to her for signature.</p> <p>-She did not manage any psychiatric medications but relied on psychiatry to manage those particular medications.</p> <p>Interview on 08/17/16 at 3:30 pm with the psychiatric Nurse Practitioner (NP) revealed:</p> <p>-The facility "generally" filled out a form each time a resident missed a dose of medication and gave the forms to her for review on a weekly basis.</p> <p>-She did not recall seeing any missed dosage forms for Resident #5's Depakote.</p> <p>-She was not aware Resident #5 had not been receiving the evening dosage of Depakote.</p> <p>-The resident had been doing very well since being admitted to this facility and had experienced no behavior issues, so she would probably go ahead and decrease the resident's dose of Depakote to match what he had been receiving since 07/01/16.</p> <p>Interview on 08/17/16 at 3:40 pm with the Assistant Resident Care Coordinator (ARCC) revealed:</p> <p>-The facility admitted "like 11" residents on 05/31/16 when Resident #5 was admitted.</p> <p>-The facility did not routinely fax FL-2s to the pharmacy, but faxed the MAR copies.</p> <p>-The facility completed MAR audits "at least weekly" looking for missing documentation or medications circled as not administered.</p> <p>-She did not recall seeing the circled doses of Depakote on Resident #5's June and July MAR.</p> <p>-At the end of each month, the new MARs were compared to the previous MARs by two different Medication Aides (MAs). If a discrepancy was noted, the MA would investigate to find out why they did not match.</p> <p>-The MARs were not routinely compared to</p>	{D 358}		

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{D 358}	<p>Continued From page 17</p> <p>physician orders unless there was a physician order that was received near the end of the month.</p> <p>-She did not know why the evening dose of Depakote was not discovered during the month-to-month MAR comparison at the end of June.</p> <p>-Regarding the process for ordering medications when the supply was depleted, the MAs were responsible for ordering before the current supply was completely depleted.</p> <p>-All MAs used to be responsible for auditing their own medication carts for supply of medications, but "stuff was still getting missed", so to improve the process, only 4 specific MAs were accountable for auditing medication carts to ensure available supply of medications.</p> <p>Interview on 08/17/16 at 4:26 pm with the Administrator revealed:</p> <p>-Medication was supposed to be reordered before the supply was completely depleted.</p> <p>-If a MA found a medication completely out, the MA should contact the pharmacy and get the medication sent from the back up pharmacy so the resident did not miss any doses.</p> <p>-The Administrator was aware there had been some issues with ordering medications timely, so two weeks ago she instituted a new system whereby 4 specific MAs were assigned the responsibility of auditing the medication supply in order to monitor the issue more closely and to improve accountability.</p> <p>Interview on 08/17/16 at 4:00 pm with Resident #5 revealed:</p> <p>-It had been "a couple of months" since he had received the night time dose of Depakote.</p> <p>-He had informed two (named) MAs and one nurse that he was supposed to be getting a night</p>	{D 358}		

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{D 358}	<p>Continued From page 18</p> <p>time dose, but they "argue" with him. -Since he has not been getting the correct dose of Depakote, he feels more sleepy and drowsy, but is unable to go to sleep at night and is sleepy "all day". -"They (facility) leave out a lot of pills." -When the facility runs out of a medication, they tell him, "We'll have to order some more-it may be a few days".</p> <p>Interviews at various times on 08/18/16 with the two MAs identified by Resident #5 as well as two additional MAs revealed none of the MAs recalled the resident telling them he was supposed to have an additional dose of Depakote administered at night.</p> <p>2. Review of Resident #5's 05/31/16 FL-2 revealed a physician's order for Mobic 15 mg daily. (Mobic is a nonsteroidal anti-inflammatory (NSAID) drug used to treat pain and/or inflammation.)</p> <p>Review of Resident #5's record revealed a physician's order dated 08/10/16 to discontinue Mobic and start a topical NSAID instead.</p> <p>Observation on 08/17/16 of the morning medication pass revealed: -At 9:11 am, the MA prepared Resident #5's morning medications, including Mobic 15 mg, for administration to the resident. -At 9:17 am, the MA administered the morning medications, including Mobic, to Resident #5.</p> <p>Review of Resident #5's August 2016 Medication Administration Record (MAR) revealed: -An entry for Mobic 15 mg and scheduled for administration daily at 9:00 am and was documented as administered daily from 08/01/16</p>	{D 358}		

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NAME OF PROVIDER OR SUPPLIER
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**1808 N CANNON BOULEVARD
KANNAPOLIS, NC 28083**

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{D 358}	<p>Continued From page 19</p> <p>through 08/17/16.</p> <ul style="list-style-type: none"> -The Mobic was not discontinued on 08/10/16 as ordered by the physician. -The topical NSAID ordered on 08/10/16 was transcribed to the MAR and documented as administered three times daily as ordered. -Resident #5 was receiving both medications. <p>Interview on 08/17/16 at 11:53 am with the Administrator revealed:</p> <ul style="list-style-type: none"> -All physician orders were checked by two different MAs to ensure completion and accuracy. -The 08/10/16 discontinuation of Mobic order was initialed as completed by the Assistant Resident Care Coordinator (ARCC) and the Resident Care Coordinator (RCC). -The RCC was currently on vacation. <p>Interview on 08/17/16 at 11:27 am with the ARCC revealed:</p> <ul style="list-style-type: none"> -She transcribed the 08/10/16 orders to the MAR but did not remember seeing the portion of the order to discontinue the Mobic. -Every order received by the facility was checked by two different MAs to ensure orders were not missed. -She did not know how the Mobic was missed on both checks. <p>Interview on 08/17/16 at 12:02 pm with the Nurse Practitioner (NP) revealed:</p> <ul style="list-style-type: none"> -Resident #5 had been on Mobic to manage complaints of knee and other joint pain. -The Mobic was not controlling the resident's pain, even at the maximum dosage, so the NP discontinued the Mobic and ordered a topical NSAID because the resident's pain was localized and there was less systemic absorption with the topical NSAID. -She was not aware the Mobic had not been 	{D 358}		

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KANNAPOLIS, NC 28083**

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{D 358}	<p>Continued From page 20</p> <p>discontinued and the resident was receiving both medications concurrently.</p> <p>Interview on 08/17/16 at 4:00 pm with Resident #5 revealed his joint pain was better since he was started on the (named) topical NSAID.</p> <p>3. Review of Resident #5's 05/31/16 FL-2 revealed an order for Klonopin 0.5 mg with no instructions regarding frequency. (Klonopin is a controlled sedative.)</p> <p>Review of Resident #5's record revealed the May 2016 Medication Administration Record (MAR) completed upon admission to the facility on 05/31/16 included instructions to administer Klonopin 0.5 mg, one-half tablet, three times daily.</p> <p>Review of Resident #5's June 2016 MAR revealed: -An entry for Klonopin 0.5 mg, one-half tablet three times daily and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm daily. -The Klonopin was documented as administered three times daily from 06/01/16 through 06/30/16.</p> <p>Review of Resident #5's July 2016 MAR revealed: -An entry for Klonopin 0.5 mg, one-half tablet three times daily and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm. -The Klonopin was documented as administered three times daily from 07/01/16 through 07/31/16.</p> <p>Review of Resident #5's August 2016 MAR revealed: -An entry for Klonopin 0.5 mg, one-half tablet three times daily and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm. -The Klonopin was documented as administered</p>	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HALD80003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/19/2016
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 21 three times daily from 08/01/16 through 08/17/16. Review of the Controlled Substance Count Sheets for June 2016 through August 2016 revealed: -The Klonopin was not signed out for administration on 13 occasions from June 2016 to August 2016. Examples included: -On 06/06/16, no Klonopin was signed out for the 3:00 pm dose. -On 06/17/16, no Klonopin was signed out for the 3:00 pm dose. -On 06/23/16, no Klonopin was signed out for the 9:00 pm dose. -On 07/01/16, no Klonopin was signed out for the 9:00 pm dose. -On 07/16/16, no Klonopin was signed out for the 9:00 pm dose. -On 07/21/16, no Klonopin was signed out for the 9:00 pm dose. Interview on 08/17/16 at 4:00 pm with Resident #5 revealed: -"They (facility staff) leave out a lot of pills." -When he informed staff he missed a pill, they say, "It's too late now". -He feels more irritable and paranoid when he misses the Klonopin. Interview on 08/18/16 at 1:40 pm with an evening shift Medication Aide (MA) revealed: -She made sure residents were awake because she did not like to waste medications. -There were a few days the resident would not wake up for his night time medications, but "I should have circled" them to indicate they were not administered. -"I know I've been giving it to him, so I don't know why it's not signed out and the count is right." -"I'm bad on forgetting to circle" medications not	{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 08/19/2016
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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 22</p> <p>administered.</p> <p>-Sometimes she initialed the medications as administered when she pulled them up and put them in the medication cup, so if the resident did not take the medications, she sometimes forgot to go back and circle them as not administered.</p> <p>Interview on 08/18/16 at 1:55 pm with a second evening shift MA revealed she did not know why she administered the Klonopin on that schedule (omitting the 3:00 pm dose).</p> <p>On 08/19/16, the Administrator submitted a Plan of Protection as follows:</p> <p>-An audit was completed on 08/19/16 to ensure each resident's medications were present on the medication cart as ordered on the MAR.</p> <p>-A resident questionnaire was developed to ask each resident if they ever run out of medications and if they know who to report to if they do. The questionnaire will be completed for 10% of the residents weekly for 8 weeks, then monthly thereafter.</p> <p>-All MAs would be inserviced prior to their next scheduled shift regarding medication availability, the process for reordering medications, and the process for obtaining laboratory studies for medications requiring labs.</p> <p>-Clozaril will be counted at each shift change.</p> <p>-A Clozaril audit tool was developed to ensure laboratory studies were obtained and Clozaril was administered as ordered. The audit tool will be completed 5 times weekly for 8 weeks, then monthly thereafter.</p> <p>-An audit to ensure each resident's medications are present on the medication cart will be completed weekly for 8 weeks, then monthly thereafter.</p> <p>-The Administrator or designee will ensure</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 23 ongoing compliance by auditing and initialing the audit tools weekly for 8 weeks, then monthly thereafter. -Any concerns would be discussed for further review by the QI Committee monthly for 3 months and then quarterly thereafter. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 3, 2016.	{D 358}	Health Care 10 A BCAC 13F .0902 Medication Administration 10A NCAC 13F.1004 On 8/19/16m, an audit was completed by the facility Lab auditor for each resident receiving Clozaril ensuring their labs are up to date and that the medication is available.	
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 observations, interviews, and record	D 367	On 8/19/16, a questionnaire was completed on all interviewable residents. Questions were: Have you ever been out of medication? If yes, explain. Do you know who to tell if you are told by a Med Tech you are out of medication? After 8/19/16, questionnaires will be completed on 10% of interviewable residents weekly for 8 weeks then monthly ongoing. Starting 8/18/16, the administrator began in-servicing 100% of Med Techs, before beginning their next scheduled shift	10-3-14 AW

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D 367	<p>Continued From page 24</p> <p>reviews, the facility failed to ensure the Medication Administration Record (MAR) was accurate and included the name, dosage and instructions for administration of one medication (Depakote) and documentation of omissions and the reason for the omissions of two medications (Klonopin and Clozaril) for 2 of 7 sampled residents (Residents #5 and #6).</p> <p>The findings are:</p> <p>A. Review of Resident #6's current FL-2 dated 05/31/16 revealed: -The diagnosis listed was chronic paranoid schizophrenia. -A physician's order for Clozaril 100 mg, two tablets every night and Clozaril 25 mg every night for a total dosage of 225 mg nightly. (Clozaril is an antipsychotic.)</p> <p>Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 05/31/16.</p> <p>Review of Resident #6's June 2016 Medication Administration Record (MAR) revealed: -An entry for Clozaril 225 mg (total dosage) and scheduled for administration daily at 9:00 pm. -The Clozaril was circled as not administered for five consecutive days from 06/06/16 through 06/10/16. -The Clozaril was circled as not administered on 06/25/16. -Documentation on the back of the MAR revealed the Clozaril was not administered on 06/06/16 and 06/25/16 because there were "no meds". -No further information was documented to indicate the reason for the other omissions.</p> <p>Review of Resident #6's July 2016 MAR revealed:</p>	D 367	<p>Medication not in the med cart or med room must be obtained contacting Neil Medical pharmacy. Neil Medical 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> <p>Starting 8/19/16 the administrator began in-servicing the Med Techs at 100% and before beginning their next scheduled shift</p> <ul style="list-style-type: none"> • When a medication is not given as ordered you must initial the MAR and circle your initials and then document reasoning for medication not being given on the back of MAR. • Each resident receiving clozaril will have a count sheet for this medication and the Med Tech giving the medication will sign it out on the count sheet at the 	

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D 367	<p>Continued From page 25</p> <p>-An entry for Clozaril 225 mg (total dosage) and scheduled for administration daily at 9:00 pm. -From 07/01/16 through 07/04/16, "LOA" (leave of absence) was documented in the spaces provided for documentation of administration. -The Clozaril 200 mg was documented as administered from 07/05/16 through 07/31/16. -The Clozaril 25 mg was documented as administered from 07/05/16 through 07/30/16. -The Clozaril 25 mg was circled as not administered on 07/31/16. -There was no further information documented on the back of the MAR.</p> <p>Review of Resident #6's August 2016 MAR revealed: -An entry for Clozaril 225 mg (total dosage) and scheduled for administration daily at 9:00 pm. -The Clozaril 200 mg was circled as not administered on 08/06/16, 08/07/16, 08/14/16, 08/15/16, and 08/17/16, for a total of 5 doses. -The space for documentation on 08/16/16 was blank. -The Clozaril 25 mg was circled as not administered from 08/04/16 through 08/07/16, 08/15/16, and 08/17/16 for a total of 6 doses. -The space for documentation on 08/16/16 was blank. -Documentation on the back of the MAR revealed the Clozaril was not administered on 08/04/16 due to "no meds". -There was no further documentation to indicate the reason for the other omissions.</p> <p>Observation on 08/18/16 at 11:45 am of Resident #6's medications on hand revealed there was no Clozaril available for administration.</p> <p>Interview on 08/18/16 at at 10:13 am with the facility's contracted pharmacist revealed:</p>	D 367	<p>time it was given</p> <ul style="list-style-type: none"> • Clozaril will be counted each shift at change of shift. <p>On 8/19/16, the administrator began in-servicing the RCC, assistant RCC, and lab auditor before there next scheduled shift on completing:</p> <ul style="list-style-type: none"> • When a medication requires labs to be drawn it is your responsibility to ensure that labs have been drawn, results received and faxed to pharmacy. • Call pharmacy to ensure that the fax was received and that the medication will be delivered with the next delivery. • The labs need to be obtained prior to resident being out of medication. <p>On 8/19/16, the Administrator, ARCC, and/or Lab Auditor did a complete Medication Cart to MAR audit to ensure all medications were available as ordered by the Nurse Practitioner/Doctor. Any issues were addressed immediately.</p>	

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D 367	<p>Continued From page 26</p> <p>-Based on the Clozaril dispensing records, there was no Clozaril available for administration for 30 of 74 days from from 06/10/16 through 08/18/16, although the medication was documented as administered on the MARs.</p> <p>-A 7-day supply of Clozaril was dispensed on 06/10/16.</p> <p>-A 3-day supply of Clozaril was dispensed on 06/19/16.</p> <p>-A 3-day supply of Clozaril was dispensed on 06/25/16.</p> <p>-A 7-day supply of Clozaril was dispensed on 06/30/16.</p> <p>-A 3-day supply of Clozaril was dispensed on 07/06/16.</p> <p>-A 4-day supply of Clozaril was dispensed on 07/07/16.</p> <p>-A 7-day supply of Clozaril was dispensed on 07/22/16.</p> <p>-A 3-day supply of Clozaril was dispensed on 07/31/16.</p> <p>-A 7-day supply of Clozaril was dispensed on 08/07/16.</p> <p>-The gaps in Resident #6's Clozaril dispensing records were because the required laboratory studies had not been received from the facility.</p> <p>Interview on 08/18/16 at 10:58 am with the Assistant Resident Care Coordinator (ARCC) revealed:</p> <p>-If a medication was not administered, staff should circle their initials to indicate it was not administered and document the reason for the omission on the back of the MAR.</p> <p>-The ARCC was not aware staff were documenting administration of Clozaril during times when none was available for administration.</p> <p>-The facility did not routinely count non-narcotic medications, so if medications were documented as administered when they were actually</p>	D 367	<p>The RCC/ARCC and/or lab auditor will audit all count sheets of residents receiving Clozapril to ensure medication is being given as ordered. The RCC/ARCC and/or Lab auditor will begin auditing all labs including resident's receiving Clozapril to ensure all labs are drawn as ordered and faxed to pharmacy as indicated. Audits will be completed 5x/week x 8 weeks then monthly ongoing using the Clozapril audit tool. Administrator/designee will audit the Clozapril audit tool 5x/week x 8 week then monthly ongoing. Any concerns will be taken to the QI Committee for further review monthly for three months and then quarterly.</p>	

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D 367	<p>Continued From page 27</p> <p>unavailable, there would be no way of knowing.</p> <p>Interview on 08/18/16 at 11:50 am with an evening shift Medication Aide (MA) revealed: -If the Clozaril was not available for administration when she was on duty, she would circle her initials to indicate it was not administered and document "waiting for labs" on the back of the MAR. -There had always been Clozaril available for administration when she worked.</p> <p>Interview on 08/18/16 at 3:50 pm with a second evening shift MA revealed: -He routinely circled medications that were not available for administration, but "sometimes" forgot to go back and document reason for the omission on the back of the MAR. -Sometimes he left the MAR blank if a medication was not available, intending to go back and document the medication was not available to administer, but forgot and left it blank. Then at the weekly staff meetings, the MAs are instructed to fill in the "holes" on the MAR, so if he forgot to go back and document a medication was not administered, he probably signed the blank as administered, not realizing he had left it blank on purpose.</p> <p>Interview on 08/19/16 at 9:19 am with the Administrator revealed she was not aware of the gaps in Resident #6's Clozaril administration or that the Clozaril was being documented as administered when it was not available.</p> <p>Interview on 08/17/16 at 8:42 am with Resident #6 revealed: -His Clozaril "frequently" ran out, meaning he would be out of medication for 3 days, the facility would order the medication, then he would be out</p>	D 367		

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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 367	<p>Continued From page 28</p> <p>of medication for 5 days and the facility would order the medication "back and forth". -"I don't know why they're checking my blood work if I ain't getting my meds." -The resident liked the Clozaril because it kept him from having bad dreams about a deceased family member. -He had complained twice to facility management as well as to the people who drew his blood about running out of Clozaril.</p> <p>B. Review of Resident #5's current FL-2 dated 05/31/16 revealed diagnoses included bipolar and Schizoaffective personality disorder.</p> <p>1. Review of the 05/31/16 FL-2 revealed: -A physician's order for Depakote ER 500 mg, 2 tablets twice daily. -A physician's order for Depakote DR 125 mg daily. (Depakote is an anticonvulsant often used to manage manic episodes related to bipolar disorder. ER is the extended-release formulation, while DR is the delayed-release formulation.)</p> <p>Review of Resident #5's Resident Register revealed the resident was admitted on 05/31/16.</p> <p>Review of Resident #5's June 2016 Medication Administration Record (MAR) revealed: -The MAR was handwritten and included entries for Depakote DR 125 mg to be administered daily at 9:00 am and Depakote ER 500 mg, 2 tablets to be administered twice daily at 9:00 am and 9:00 pm. -Depakote DR 125 mg was documented as administered daily from 06/01/16 through 06/30/16 at 9:00 am. -The 9:00 am dose of Depakote ER 1000 mg was circled as not administered on 06/28/16 and 06/29/16.</p>	D 367		

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D 367	<p>Continued From page 29</p> <ul style="list-style-type: none"> -The 9:00 pm dose of Depakote ER 1000 mg was documented as administered daily from 06/01/16 through 06/30/16. -Documentation on the back of the MAR revealed the 9:00 am dose of Depakote ER 1000 mg was not administered on 06/28/16 due to "no meds". -There was no further information regarding Depakote omissions on the back of the June 2016 MAR. <p>Review of Resident #5's July 2016 MAR revealed:</p> <ul style="list-style-type: none"> -The MAR was pharmacy generated and included entries for Depakote DR 125 mg to be administered daily at 9:00 am and Depakote ER 500 mg, 2 tablets to be administered daily at 9:00 am. -There was no entry for Depakote ER 500 mg, 2 tablets to be administered at 9:00 pm on the MAR. -The Depakote DR 125 mg was circled as not administered for four consecutive doses from 07/11/16 through 06/14/16. -The Depakote ER 1000 mg was circled as not administered for two consecutive doses on 07/22/16 and 07/23/16. -Documentation on the back of the MAR revealed the Depakote DR 125 mg was not administered on 07/11/16 and 07/12/16 due to "no meds". -Documentation on the back of the MAR revealed the Depakote ER 500 mg tablets (2) was not administered on 07/22/16 due to "no meds". -There was no further information regarding Depakote omissions on the back of the July 2016 MAR. <p>Review of Resident #5's August 2016 MAR revealed:</p> <ul style="list-style-type: none"> -The MAR was pharmacy generated and included entries for Depakote DR 125 mg to be administered daily at 9:00 am and Depakote ER 	D 367		

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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 367	<p>Continued From page 30</p> <p>500 mg, 2 tablets to be administered daily at 9:00 am.</p> <ul style="list-style-type: none"> -The Depakote DR 125 mg and Depakote ER 1000 mg was documented as administered daily at 9:00 am from 08/01/16 through 08/17/16. -There was no entry for Depakote ER 500 mg, 2 tablets to be administered at 9:00 pm on the MAR. <p>Interview on 08/17/16 at 3:00 pm with the facility's contracted pharmacist revealed:</p> <ul style="list-style-type: none"> -The facility did not send a copy of the 05/31/16 FL-2 to the pharmacy. -The first orders the pharmacy received for Resident #5 was a copy of the handwritten MAR on 06/02/16. -The pharmacy routinely accepted the MAR copies as physician orders, but they were usually accompanied by the FL-2. -The pharmacy did not have a subsequent physician's order to discontinue the evening dose of Depakote ER. -Upon review of the physician orders, the pharmacist determined the Depakote ER order was incorrectly entered into the pharmacy's computer system as once daily instead of twice daily as ordered. <p>Interview on 08/17/16 at 3:40 pm with the Assistant Resident Care Coordinator (ARCC) revealed:</p> <ul style="list-style-type: none"> -The facility admitted "like 11" residents on 05/31/16 when Resident #5 was admitted. -The facility did not routinely fax FL-2s to the pharmacy, but faxed the MAR copies. -The facility completed MAR audits "at least weekly" looking for missing documentation or medications circled as not administered. -She did not recall seeing the circled doses of Depakote on Resident #5's June and July MAR. 	D 367		

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D 367	<p>Continued From page 31</p> <ul style="list-style-type: none"> -At the end of each month, the new MARs were compared to the previous MARs by two different Medication Aides (MAs). If a discrepancy was noted, the MA would investigate to find out why they did not match. -The MARs were not routinely compared to physician orders unless orders the orders were received near the end of the month. -She did not know why the evening dose of Depakote was not discovered during the month-to-month MAR comparison at the end of June. <p>Interview on 08/17/16 at 2:30 pm with the facility's Nurse Practitioner (NP) revealed:</p> <ul style="list-style-type: none"> -She was in the facility weekly to see residents. -The facility routinely gave her "everybody's (MARs) every month" for signature. -She tried to glance through the MARs but she relied on the facility staff to ensure the MARs were correct when they presented them to her for signature. <p>Interview on 08/17/16 at 4:00 pm with Resident #5 revealed:</p> <ul style="list-style-type: none"> -It had been "a couple of months" since he had received the night time dose of Depakote. -He had informed two (named) MAs and one nurse that he was supposed to be getting a night time dose, but they "argue" with him. -Since he has not been getting the correct dose of Depakote, he feels more sleepy and drowsy, but is unable to go to sleep at night and is sleepy "all day". -"They (facility) leave out a lot of pills." <p>Interviews at various times on 08/18/16 with the two MAs identified by Resident #5 as well as two additional MAs revealed none of the MAs recalled the resident telling them he was supposed to</p>	D 367		

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D 367	<p>Continued From page 32</p> <p>have an additional dose of Depakote administered at night.</p> <p>2. Review of Resident #5's 05/31/16 FL-2 revealed a physician's order for Mobic 15 mg daily. (Mobic is a nonsteroidal anti-inflammatory (NSAID) drug used to treat pain and/or inflammation.)</p> <p>Review of Resident #5's record revealed a physician's order dated 08/10/16 to discontinue Mobic and start a topical NSAID instead.</p> <p>Observation on 08/17/16 of the morning medication pass revealed: -At 9:11 am, the MA prepared Resident #5's for morning medications, including Mobic 15 mg, for administration to the resident. -At 9:17 am, the MA administered the morning medications, including Mobic, to Resident #5.</p> <p>Review of Resident #5's August 2016 Medication Administration Record (MAR) revealed: -An entry for Mobic 15 mg and scheduled for administration daily at 9:00 am and was documented as administered daily from 08/01/16 through 08/17/16. -The Mobic was not discontinued on 08/10/16 as ordered by the physician. -The topical NSAID ordered on 08/10/16 was transcribed to the MAR and documented as administered three times daily as ordered.</p> <p>Interview on 08/17/16 at 11:53 am with the Administrator revealed: -All physician orders were checked by two different MAs to ensure completion and accuracy. -The 08/10/16 discontinuation of Mobic order was initialed as completed by the Assistant Resident Care Coordinator (ARCC) and the Resident Care</p>	D 367		

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D 367	<p>Continued From page 33</p> <p>Coordinator (RCC). -The RCC was currently on vacation. -She did not know how the order to discontinue the Mobic was missed and not transcribed to the MAR.</p> <p>Interview on 08/17/16 at 11:27 am with the ARCC revealed: -She transcribed the 08/10/16 orders to the MAR but did not remember seeing the portion of the order to discontinue the Mobic. -Every order received by the facility was checked by two different MAs to ensure orders were not missed. -She did not know how the Mobic was missed on both checks.</p> <p>Interview on 08/17/16 at 4:00 pm with Resident #5 revealed his joint pain was better since he was started on the (named) topical NSAID.</p> <p>3. Review of Resident #5's 05/31/16 FL-2 revealed an order for Klonopin 0.5 mg with no instructions regarding frequency. (Klonopin is a controlled sedative.)</p> <p>Review of Resident #5's record revealed the May 2016 Medication Administration Record (MAR) completed upon admission to the facility on 05/31/16 included instructions to administer Klonopin 0.5 mg, one-half tablet three times daily.</p> <p>Review of Resident #5's June 2016 MAR revealed: -An entry for Klonopin 0.5 mg, one-half tablet three times daily and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm daily. -The Klonopin was documented as administered three times daily from 06/01/16 through 06/30/16.</p>	D 367		

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D 367	<p>Continued From page 34</p> <p>Review of Resident #5's July 2016 MAR revealed: -An entry for Klonopin 0.5 mg, one-half tablet three times daily and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm. -The Klonopin was documented as administered three times daily from 07/01/16 through 07/31/16.</p> <p>Review of Resident #5's August 2016 MAR revealed: -An entry for Klonopin 0.5 mg, one-half tablet three times daily and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm. -The Klonopin was documented as administered three times daily from 08/01/16 through 08/17/16.</p> <p>Review of the Controlled Substance Count Sheets for June 2016 through August 2016 revealed: -The Klonopin was not signed out for administration on 13 occasions from June 2016 to August 2016, but was documented as administered on the MAR. Examples included: -On 06/06/16, no Klonopin was signed out for the 3:00 pm dose. -On 06/17/16, no Klonopin was signed out for the 3:00 pm dose. -On 06/23/16, no Klonopin was signed out for the 9:00 pm dose. -On 07/01/16, no Klonopin was signed out for the 9:00 pm dose. -On 07/16/16, no Klonopin was signed out for the 9:00 pm dose. -On 07/21/16, no Klonopin was signed out for the 9:00 pm dose.</p> <p>Interview on 08/17/16 at 4:00 pm with Resident #5 revealed: -"They (facility staff) leave out a lot of pills." -When he informs staff he missed a pill, they say,</p>	D 367		

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D 367	<p>Continued From page 35</p> <p>"It's too late now". -He feels more irritable and paranoid when he misses the Klonopin.</p> <p>Interview on 08/18/16 at 1:40 pm with an evening shift Medication Aide (MA) revealed: -She made sure residents were awake because she did not like to waste medications. -There was a few days the resident would not wake up for his night time medications, but "I should have circled" them to indicate they were not administered. -"I know I've been giving it to him, so I don't know why it's not signed out and the count is right." -"I'm bad on forgetting to circle" medications not administered. -Sometimes she initialed the medications as administered when she pulled them up and put them in the medication cup, so if the resident did not take the medications, she sometimes forgot to go back and circle them as not administered.</p> <p>Interview on 08/18/16 at 1:55 pm with a second evening shift MA revealed: -She did not know why she administered the Klonopin on that schedule (omitting the 3:00 pm dose). -She did not know why she documented administration of the medication on the MAR if none was signed out.</p> <p>Interview on 08/18/16 at 3:50 pm with a second evening night shift MA revealed: -He routinely circled medications that were not available for administration, but "sometimes" forgot to go back and document reason for the omission on the back of the MAR. -Sometimes he left the MAR blank if a medication was not available, intending to go back and document the medication was not available to</p>	D 367		

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D 367	Continued From page 36 administer, but forgot and left it blank. Then at the weekly staff meetings, the MAs are instructed to fill in the "holes" on the MAR, so if he forgot to go back and document a medication was not administered, he probably signed the blank as administered, not realizing he had left it blank on purpose. Interview on 08/19/16 at 9:19 am with the Administrator revealed she was not aware Klonopin was being documented as administered on the MAR on occasions when none had been signed out on the Controlled Count Sheets.	D 367		
(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 residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding medication administration and health care. The findings are: A. Based on observations, interviews, and record reviews, failed to obtain required weekly laboratory work for the administration of Clozaril	(D912)	131 D Resident's Rights On 8/19 8/19/16 Kannon Creek received a Residents' Rights deficiency related to Type B violation for Medication Administration, Type B Violation Healthcare Referral and Follow-up On 9/12/16 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	10-3-16 <i>AA</i>

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{D912}	Continued From page 37 for 1 of 2 sampled residents (Resident #6). [Refer to Tag 273, 10A NCAC 13F .0902(b) (Unabated Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to ensure medications (Mobic, Depakote, Klonopin, and Clozaril) were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #5 and #6). [Refer to Tag 358, 10A NCAC 13F .1004(a) (Type B Violation).]	{D912}	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. On 9/15/16 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 violations.	10-3-16 Anna