STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE COURTYARDS AT BERNE VILLAGE	2701 AMHURST BOULEVARD NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up, and complaint investigation survey on March 17 - 20, 2015.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to have door alarm sounding devices on 2 of 2 exit doors and failed to ensure door alarm sounding devices were activated upon doors opening for 3 of 4 sampled exit doors to prevent 3 of 3 sampled residents (Residents #6, #7, #8) from exiting the building who were known to be wanderers and noted to be disoriented, and had exited the facility without staff knowledge. The findings are:	D 067		

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D 067	Continued From page 1 Observation during initial tour of the facility on 03/17/15 at 11:20 a.m. revealed: -Exit door at the end of 100 hall would not open when the metal bar was pushed by surveyor. -Green button on wall to the left of the door had "push to exit" imprinted on the button. -A sign on the wall above the green button noted, "the alarm will sound if exit button is pushed". -The green exit button was pushed but no alarm was heard. -The exit door opened when the green button and the metal bar on the door were pushed at the same time. -No alarm was heard when the door was opened. -The door opened to a parking lot on the side of the building. -No staff responded when the exit door was opened. Observation during initial tour of the facility on 03/17/15 at 12:14 p.m. revealed: -Exit door midway down 100 hall was opened by surveyor but no alarm was heard. -Green button on wall to the left of the door had "push to exit" imprinted on the button. -A sign on the wall above the green button noted, "the alarm will sound if exit button is pushed". -The exit door led into an enclosed courtyard with a locked gate. -No staff responded when the exit door was opened. Observation of the facility on 03/17/15 at 5:00 p.m. revealed: -Exit door midway down 300 hall was opened by surveyor but no alarm was heard. -The exit door led into an enclosed courtyard with a locked gate. -No staff responded when the exit door was opened.	D 067		

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D 067	Continued From page 2 Observation of the facility on 03/17/15 at 5:10 p.m. revealed: -Exit door at the end the 300 hall was opened by surveyor but no alarm was heard. -Green button on wall to the left of the door had "push to exit" imprinted on the button. -A sign on the wall above the green button noted, "the alarm will sound if exit button is pushed". -The exit door opened to a parking lot on the side of the building. -No staff responded when the exit door was opened. 1. Review of Resident #8's current FL-2 dated 12/26 (no year documented) revealed: -Diagnoses included febrile illness, obesity, urinary incontinence, and alzheimer's disease. -Resident #8 was ambulatory. -Resident #8 was identified as intermittently disoriented. Review of an FL-2 dated 04/29/2014 for Resident #8 revealed: -Diagnoses included Alzheimers Dementia and Psychosis with Dementia. -The current level of care checked as "other" with "SCU" [Special Care Unit] handwritten on the line below the area where "other" was checked. -The recommended level of care checked as "domiciliary". Review of a Licensed Health Professional Support (LHPS) review dated 04/30/14 revealed Resident #8 was transferred from the Memory Care to the Assisted Living area at the facility. Review of Elopement Risk Evaluations for Resident #8 revealed: -On 01/09/15, the evaluation score for Resident	D 067		

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#8 was 16 (score of 9 - 18 = moderate risk according to scoring scale printed on the Elopement Risk Evaluation form).
-On 01/19/15, the evaluation score for Resident #8 was 31 (score of 18+ = high risk according to scoring scale printed on the Elopement Risk Evaluation form).

Review of Resident Care Notes revealed Resident #8 moved into the Assisted Living facility on 03/27/2014.

Interview with a medication aide (MA) on 03/17/15 at 5:18 p.m. revealed:
-Exit doors at the ends of the halls are usually kept locked and security or housekeeping has to unlock them if needed.
-MA thought door alarms would sound if the door was opened.

Interview with the Administrator on 03/17/15 at 5:33 p.m. revealed:
-Resident #8 eloped from the facility about 2 months ago.
-He had gone down to the end of the road beside the facility and turned to the right onto the next highway (4 lane highway).
-He got past the gas station on the 4 lane highway and was seen by staff who worked at another facility.

Refer to interview and observation with the Resident Care Coordinator (RCC) on 03/17/15 at 5:20 p.m.

Refer to interview and observation with the Administrator on 03/17/15 at 5:33 p.m.

Refer to interview with the Personal Care Aide (PCA) 03/17/15 at 6:15 p.m.

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D 067	Continued From page 4 Refer to interview and observation with a facility security staff person on 03/17/15 at 6:40 p.m. Refer to interview with the Maintenance Supervisor on 03/19/15 at 9:00 a.m. Refer to interview with a family member on 03/20/15 at 8:20 a.m.. 2. Review of Resident #6's current hospital generated FL-2 dated 08/08/14 revealed: -Diagnoses included unresponsive at dialysis/syncope, altered mental status, chronic kidney, diabetes, hypertension, and depression. -Resident #6 was semi-ambulatory. Review of a hospital generated FL-2 dated 04/29/2014 for Resident #6 revealed: -Diagnoses included altered mental status, encephalopathy, urinary retention, hypertension, diabetes mellitus type II, chronic anemia, coronary artery disease, and end stage renal disease. -The recommended level of care checked as "domiciliary". -Resident #6 was identified as intermittently disoriented. -Resident #6's ambulatory status was semi-ambulatory with assistance. Review of Elopement Risk Evaluations for Resident #6 revealed: -On 01/07/15, the evaluation score for Resident #6 was 4 (score of 0 - 9 = minimal risk according to scoring scale printed on the Elopement Risk Evaluation form). -On 01/09/15, the evaluation score for Resident #6 was 4. -There was no scoring in the mental status	D 067		

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section of the elopement risk evaluation tool.
-There were no further elopement risk evaluations completed for Resident #6.

Observation of Resident #6 on 03/17/15 at 5:15 p.m. revealed:
-Resident #6 was in her wheelchair with her hand to the sliding glass door on the 300 hall.
-Resident #6 asked the surveyor to help her get out the sliding glass exit door because the resident could not open the door.
-The medication aide (MA) sitting behind the nurses station was advised Resident #6 needed assistance.
-Resident #6 was assisted away from the exit door by the MA.

Interview with a medication aide (MA) on 03/17/15 at 5:18 p.m. revealed:
-Resident #6 started trying to leave the facility about 2 weeks ago.
-Resident #6 went out the side sliding door today and MA heard the resident say something about a physician's appointment.
-Exit doors at the ends of the halls are usually kept locked and security or housekeeping has to unlock them if needed.
-MA thought door alarms would sound if the door was opened.

Refer to interview and observation with the Resident Care Coordinator (RCC) on 03/17/15 at 5:20 p.m.

Refer to interview and observation with the Administrator on 03/17/15 at 5:33 p.m.

Refer to interview with the Personal Care Aide (PCA) 03/17/15 at 6:15 p.m.

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D 067	Continued From page 6 Refer to interview and observation with a facility security staff person on 03/17/15 at 6:40 p.m. Refer to interview with the Maintenance Supervisor on 03/19/15 at 9:00 a.m. Refer to interview with a family member on 03/20/15 8:20 a.m. 3. Review of Resident #7's current FL-2 dated 11/05/14 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease, hypothyroidism, and osteoporosis. -Resident #7 was identified as constantly disoriented. -Resident #7 was identified as a wanderer. -Resident #7 was identified as ambulatory. Review of Elopement Risk Evaluations for Resident #7 revealed: -On 12/10/14, the evaluation score for Resident #7 was 4 (score of 0 - 9 = minimal risk according to scoring scale printed on the Elopement Risk Evaluation form). -On 03/12/15, the evaluation score for Resident #7 totaled 4. -There were no further elopement risk evaluations completed for Resident #7. Interview with a medication aide (MA) on 03/17/15 at 5:18 p.m. revealed: -Exit doors at the ends of the halls are usually kept locked and security or housekeeping has to unlock them if needed. -MA thought door alarms would sound if the door was opened. Observations of Resident #7 at different intervals during the survey revealed:	D 067		

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D 067	Continued From page 7 -Resident #7 walked up and down the 100 hall and 200 hall. -Staff was observed walking with Resident #7 in the halls on occasions. Refer to interview and observation with the Resident Care Coordinator (RCC) on 03/17/15 at 5:20 p.m. Refer to interview and observation with the Administrator on 03/17/15 at 5:33 p.m. Refer to interview with the Personal Care Aide (PCA) 03/17/15 at 6:15 p.m. Refer to interview and observation with a facility security staff person on 03/17/15 at 6:40 p.m. Refer to interview with the Maintenance Supervisor on 03/19/15 at 9:00 a.m. Refer to interview with a family member on 03/20/15 at 8:20 a.m. _____ Interview and observation with the Resident Care Coordinator (RCC) on 03/17/15 at 5:20 p.m. revealed: -Exit door at the end of 300 hall was locked when the metal bar on the door was pushed. -RCC stated she thought an alarm would sound if the key beside the green exit button was turned and the button was pushed. -RCC tried turning the key and pressing the button but no alarm sounded. -RCC then pushed the green button and pushed the metal bar on the door and the door opened but no alarm sounded. -RCC was unaware no alarm sounded when the	D 067		

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exit door was opened.
-RCC reported their security personnel usually dealt with any exit doors issues.
-RCC identified Residents #6, #7, and #8 as being wanderers and disoriented.
-RCC reported to her knowledge there were no alarms on the sliding doors at the front of the building or on the side sliding door entrance.

Interview and observation with the Administrator on 03/17/15 at 5:33 p.m. revealed:
-Exit door at the end of 300 hall was locked when the metal bar on the door was pushed.
-Administrator stated the key in the wall had to be turned to unlock the door.
-She also thought the key turned off the alarm.
-She tried the key in both positions but the door did not unlock and no alarm sounded.
-The door opened when the green exit button and metal bar were pushed at the same time.
-No alarm sounded.
-Administrator had been employed by the facility for 4 years and she was unaware of any problems with the exit door alarms.
-Administrator stated she would get alarms to go on doors and have staff to monitor the exit doors until the alarms are installed.
-There was currently no system to monitor the exit doors and anyone could go in and out.
-The 3 sliding exit doors (front, back, and side) were usually locked around 8:00 p.m. and unlocked at 6:30 a.m. when staff start arriving for shift change.

Interview and observation with a facility security staff person on 03/17/15 at 6:40 p.m. revealed:
-She thought an alarm would sound when the exit door was opened.
-She turned the key in different positions and tried opening the exit door at the end of 300 hall but

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D 067	Continued From page 9	D 067		

the door was locked.
-She pushed the green exit button and the metal bar on the door at the same time and the exit door opened but no alarm sounded.
-She did not ever recall hearing a door alarm in the facility.

Interview with a personal care aide (PCA) on 03/17/15 at 6:15 p.m. revealed:
-He thought if an exit door was opened, it would show up on the computer screen on the desk at the nurses' station.
-He thought the person at the nurses' desk would announce on the intercom system which door to check.
-The PCA identified Residents #6, #7, and #8 as wanderers.
-The PCA had personally redirected Residents #6, #7, and #8 away from the exit doors on several occasions.

Interview with the Resident Care Coordinator on 03/17/15 at 6:25 p.m. revealed when the exit doors were opened, it would not show up on the computer system.

Interview with the Maintenance Supervisor on 03/19/15 at 9:00 a.m. revealed:
-The Maintenance Supervisor checked the alarms monthly but had not documented the montly checks.
-The Maintenance Supervisor was not aware of any elopement issues at the facility.
-The exit doors at the end of the 100 hall and 300 hall did not have sounding alarms when doors opened until 03/17/15 when the alarms were installed due to surveyor notification to facility staff of need for door alarms because of residents noted to be disoriented and with exit seeking behaviors.

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-The exit door midway down the 100 hall and the exit door to the gated area on the 300 hall had alarms attached to the doors but were not alarming until new batteries were installed on 03/17/15.
-The Maintenance Supervisor knew the green exit button only needed to be pressed to open the exit doors at the end of 100 and 300 halls and the exit doors would open without turning the key. -The keys to the exit doors were left in the doors because the Maintenance Supervisor understood the keys always needed to be available to staff.

Interview with a family member on 03/20/15 revealed the door alarms did not alarm before 03/17/15.

Observation on 03/18/15 at 8:00 a.m. revealed a chiming sound was heard when the sliding door to the front entrance opened.

Interview with the Administrator on 03/18/15 at 8:05 a.m. revealed they installed door chimes from a local retail store the previous night and installed them on the exit doors.

Observation on 03/18/15 at 8:10 a.m. revealed a chiming sound was heard when the sliding door to the back entrance opened.

Observation on 03/18/15 at 12:40 p.m. revealed a chiming sound was heard when the 300 hall exit door was opened, but no staff responded.

Observation on 03/18/15 at 12:45 p.m. revealed a chiming sound was heard when the 100 hall exit door was opened, but no staff responded.

Observation on 03/18/15 at 12:48 p.m. revealed a chiming sound was heard when the side exit door

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D 067	Continued From page 11 on the 100 hall was opened, but no staff responded. Observation on 03/18/15 at 9:45 a.m. revealed a chiming sound was heard when the side exit door on the 100 hall was opened, but no staff responded. Observation on 03/20/15 at 9:50 a.m. revealed a chiming sound was heard when the 100 hall exit door was opened, but no staff responded. Interview with the Administrator on 03/20/15 at 7:00 p.m. revealed: -Facility staff was supposed to check the doors when the alarms sounded. -She would in-service staff again to make sure they know to check the doors when the alarms sound. _____ Review of the Plan of Protection provided by the facility dated 03/17/2015 revealed: -A door alarm system was purchased and being installed on 03/17/2015. -Staff are monitoring the doors until the system can be put in place to ensure residents are unable to get out. -Staff will be inserviced on reacting to the alarms. -A camera will be installed to monitor the door where there is not constant supervision. -The facility will continue to do 15 and 30 minute checks on those identified as wanderers. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 19, 2015.	D 067		

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D 131	Continued From page 12	D 131		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis	D 131		

10A NCAC 13F .0406 Test For Tuberculosis
(a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 2 of 6 sampled staff (Staff B, C) had the second step of the tuberculosis (TB) skin test.

The findings are:
1. Review of Staff B's personnel record revealed:
-A hire date of 06/18/14.
-Staff B was hired as a Medication Aide.
-A TB skin test was placed on 09/09/14 and read as "negative" on 09/11/14.
-There was no documentation of a second TB skin test.

Interview with the Administrator on 03/20/15 at 4:40 PM revealed:
-She could not locate documentation of a second TB skin test for Staff B.
-She was not completely sure if a second TB skin test was done for Staff B.
-A newly hired Business Office Manager was handling the TB skin test for employees and she was in the process of reviewing employee records.

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D 131	Continued From page 13 -The Business Office Manager had left for the day. -The Administrator will notify the Business Office Manager who will schedule the needed TB skin tests. Staff B was not available for interview. 2. Review of Staff C's personnel record revealed: -A hire date of10/15/14. -Staff C was hired as a Medication Aide. -A TB skin test placed 10/19/14 and read as "negative" on 10/21/14. -There was no documentation of a second TB skin test. Interview with the Administrator on 03/20/15 at 4:40 PM revealed: -She could not locate documentation of a second TB skin test for Staff C. -She was not completely sure if a second TB skin test for Staff C had been done. -The newly hired Business Office Manager was ensuring that TB skin testing was completed for Staff. -The Business Office Manager was not available. -The Administrator will notify the Business Office Manager who will schedule the needed TB skin tests. Staff C was not available for interview.	D 131		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to	D 164		

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D 164	Continued From page 14 unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 3 of 3 medication aides (A, B, C) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin. The findings are: 1. Review of Staff A's personnel file revealed: -A hire date of 01/28/15 as a medication aide. -A Medication Clinical Skills Validation Checklist completed on 02/05/15. -A written Medication Aide Exam passed on 02/12/15. -Documentation of the 5 hour Medication Training completed on 02/12/15. -No documentation of required diabetic training.	D 164		

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D 164	Continued From page 15 Review of the facility's medication administration records (MAR) revealed Staff A administered insulin during March 2015. Staff A was not available for interview. Refer to interview with the Administrator on 03/20/15 at 6:40 p.m. 2. Review of Staff B's personnel file revealed: -A hire date of 06/18/14 as a medication aide. -A Medication Clinical Skills Validation Checklist completed on 06/25/14. -Documentation of the Medication Administration Test being passed on 07/22/05. -Documentation of the Medication Administration Testing verification on 10/08/14. -No documentation of required diabetic training. Review of the facility's Medication Administration Records (MARs) revealed Staff B administered insulin during January, February, and March of 2015. Staff B was not available for interview. Refer to interview with the Administrator on 03/20/15 at 6:40 p.m. 3. Review of Staff C's personnel file revealed: -A hire date of 10/15/14 as a medication aide. -Verification of being listed on the Nurse Aide I registry as of 05/12/2000. -Documentation of the Medication Clinical Skills Validation Checklist completed on 02/10/15. -Documentation of the Medication Administration Test being passed. -No documentation of required diabetic training. Review of facility's MARs revealed that Staff C	D 164		

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D 164	Continued From page 16 had administrated insulin during February and March 2015. Staff C was not available for interview. Interview with Administrator on 03/20/15 at 6:40 p.m. revealed she thought the State approved infection control curriculum was the diabetic training course and did not require any additional course.	D 164		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 3 of 5 residents (#1, #2, #5) residing in the facility were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 07/31/14 revealed diagnoses included diabetes, dementia, hypertension, microvascular ischemia, gastroesophageal reflux disease, metabolic	D 234		

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encephalopathy caused by urinary tract infection, spinal stenosis, anemia, and folic acid deficiency.

Review of Resident #1's Resident Register revealed an admission date of 07/11/13.

Review of Resident #1's record revealed:
-One tuberculosis (TB) skin test placed on 07/09/13 and read as negative on 07/11/13.
-No documentation of any other tuberculosis (TB) skin test.

Refer to interviews with the Resident Care Coordinator on 03/18/15 at 5:25 p.m. and the Wellness Director on 03/19/15 11:45 a.m.

2. Review of Resident #2's current FL-2 dated 04/22/14 revealed diagnoses included dementia, insulin dependent diabetes mellitus, pernicious anemia, hypertension, cervical arthritis, hyperlipidemia, coronary artery disease, and chronic gastritis.

Review of Resident #2's Resident Register revealed an admission date of 04/22/14.

Review of Resident #2's record revealed:
-One tuberculosis (TB) skin test placed on 04/22/14 and read as negative on 04/25/14.
-No documentation of any other tuberculosis (TB) skin test.

Refer to interviews with the Resident Care Coordinator on 03/18/15 at 5:25 p.m. and the Wellness Director on 03/19/15 11:45 a.m.

3. Review of Resident #5's current FL-2 dated 10/13/14 revealed diagnoses included epilepsy/recurrent seizures, late cardiovascular disease effect, hypertension, edema, chronic

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D 234	Continued From page 18 pain, gastroparesis, hyperlipidemia, Vitamin D deficiency, low back pain, vision problems, osteoarthritis, and left sided hemiplegia. Review of Resident #5's Resident Register revealed an admission date of 12/14/11. Review of Resident #5's record revealed: -One tuberculosis (TB) skin test placed on 10/21/13 and read as negative on 10/23/13. -No documentation of any other tuberculosis (TB) skin test. Refer to interviews with the Resident Care Coordinator on 03/18/15 at 5:25 p.m. and the Wellness Director on 03/19/15 11:45 a.m. _____ Interview with the Resident Care Coordinator (RCC) on 03/18/15 at 5:25 p.m. revealed: -The Wellness Director (registered nurse) was responsible for doing the TB skin tests. -The second step TB skin tests should be in the residents' records. Interview with the Wellness Director on 03/19/15 at 11:45 a.m. revealed: -She was new to the facility and to this state. -She was from another state and unfamiliar with North Carolina laws. -She was currently working on auditing records to find out which residents needed a second step TB skin test. -She had already identified that Resident #1 needed a second step TB skin test and Resident #1 was on the list to do. -She was still working on auditing all of the residents' records for TB skin tests.	D 234		

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D 270	Continued From page 19	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to provide adequate supervision for 4 of 4 sampled residents (Residents #2, #6, #7, #8) who were diagnosed with dementia or disoriented, including 3 residents (#6, #7, #8) who had exited the facility unsupervised, and 1 resident (#2) who locked her door, was found mixing chemicals in her room, and whose fingerstick blood sugar was not checked due to the locked room door. The findings are: 1. Review of Resident #8's current FL-2 dated 12/26 (no year documented) revealed: -Diagnoses included febrile illness, obesity, urinary incontinence, and Alzheimer's disease. -Resident #8 was ambulatory. -Resident #8 was identified as intermittently disoriented. Review of an FL-2 dated 04/29/2014 for Resident #8 revealed: -Diagnoses included Alzheimers dementia and psychosis with dementia. -The current level of care checked as "other" with	D 270		

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D 270	Continued From page 20 "SCU" [Special Care Unit] handwritten on the line below the area where "other" was checked. -The recommended level of care checked as "domiciliary". Review of a Licensed Health Professional Support (LHPS) review dated 04/30/14 revealed: -Resident #8 was transferred from the Memory Care to the Assisted Living area at the facility. -A recommendation to monitor client for adjustment. -A recommendation to monitor safety and good hygiene. Review of Resident #8's assessment and care plan dated 05/06/14 revealed: -Resident #8 was forgetful and needed reminders. -Resident #8 needed supervision with eating, toileting, dressing, and grooming. Review of Elopement Risk Evaluations for Resident #8 revealed: -On 01/09/15, the evaluation score for Resident #8 was 16 (score of 9 - 18 = moderate risk according to scoring scale printed on the Elopement Risk Evaluation form). -On 01/19/15, the evaluation score for Resident #8 was 31 (score of 18+ = high risk according to scoring scale printed on the Elopement Risk Evaluation form). -Resident #8 was evaluated to be "disoriented daily" on the 01/09/15 and 01/19/15 evaluations. Review of Resident Care Notes revealed Resident #8 moved into the Assisted Living facility on 03/27/2014. Confidential interviews with staff on 03/17/15 revealed:	D 270		

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-Resident #8 eloped from the facility "about 2 months ago, around end of January".
-Resident #8 was found wandering in a shopping center parking lot close to a busy four lane highway.
-It was not known how Resident #8 got outside the facility when the resident eloped.
-Resident #8 got out of the facility during change from first to second shifts.
-Resident #8 was on 30 minute checks when the resident eloped from the facility.
-Resident #8 was placed on every 15 minute checks after the elopement.
-Resident #8 was recently placed back on every 30 minute checks because the resident had not tried to elope again.

Confidential interviews with staff during the survey revealed:
-Resident #8 likes to sit outside on the porch and talk with other residents.
-Staff watch Resident #8 from inside when the resident is sitting outside on the porch.
-Resident #8 was walking up and down a strip mall and out in the street directing traffic when the resident eloped from the facility.
-Resident #8 had only eloped from the facility one time and there had been no problems since the elopement and none prior to the elopement.
-Resident #8 was previously living in the memory care unit and had a tendency to wander but had never wandered off from the locked memory care unit.
-Resident #8 was placed on 30 minute supervision when he came from the memory care unit because staff knew he had potential to wander.
-Resident #8 was placed on every 15 minute checks when the resident eloped from the facility.
-When staff does 15 or 30 minute checks, they

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D 270	Continued From page 22 physically check the resident and document the resident's location and what they are doing. -Another staff went to get Resident #8 when it was known the resident had eloped from the facility. -Resident #8 thinks he is a security guard and police and walks the parameters. -Resident #8 will walk a little far and lose his way. -Staff had concerns Resident #8 could not find his way back to the facility if got too far away. -Staff were told Resident #8 had been walking up and down the 4-lane highway for at least 1 hour 45 minutes when the resident eloped. -Resident #8 was inside a business shop in the shopping center when found and police were with the resident. -Resident #8 told staff he would have returned to the facility but had gotten lost. The owner of the business where Resident #8 was found could not be reached for interview. Interview with the Administrator on 03/17/15 at 5:33 p.m. revealed: -Resident #8 eloped from the facility about 2 months ago. -Resident #8 had gone down to the end of the road beside the facility and turned to the right onto the next highway (4 lane highway). -Resident #8 got past the gas station on the 4-lane highway and was seen by staff who worked at another facility. -The elopement occurred on a Saturday. -The Administrator did an investigation and found out 30 minute supervision checks on Resident #8 had not been done by staff. -The elopement prompted the facility to start 15 minute supervision checks on Resident #8. -Resident #8 was currently back on 30 minute supervision checks.	D 270		

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D 270	Continued From page 23 -There was currently no system to monitor the exit doors and anyone could go in and out. Review of the Investigation Report from Facility revealed: -Incident date of 01/17/2015. -Resident #8 was found to be wandering on main street. -Facility was contacted that Resident #8 had been taken to another nearby facility assuming Resident #8 belonged there and was recognized as being a Courtyards resident. -Staff picked Resident #8 up and brought him back. -Resident was found to have no injuries. -The reisdent's power of attorney was contacted. -The incident was not reported to law enforcement. Review of the New Bern, NC weather posted by accuweather.com revealed the temperature on 01/17/2015 was 53 degrees. Observations of Resident #8 at intervals during the survey revealed: -Resident #8 sat in the day room on the 300 hall with other residents. -Resident #8 walked all the hallways of the facility. -Resident #8 went to the sliding glass door on the 300 hall and looked outside. -Resident #8 stood around the nurses station looking at staff and others. Interview with the Resident Care Coordinator (RCC) on 03/20/15 at 5:45 p.m. revealed: -Resident #8 was seen in activities at 1:30pm on the day the resident eloped. -Resident #8 slipped out of activities. -The RCC did not know how long Resident #8	D 270		

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D 270	Continued From page 24 was gone. -The RCC heard Resident #8 was at another facility when found. -The RCC estimated the resident was about ¼ mile from the facility which was about a 20 minute walk. -Resident #8 was on 30 minute supervision checks because the resident would go outside the front door of facility and would walk around but never leave. -Resident #8 walked outside alone around the building. -Resident #8 moved from the memory care locked unit to the assisted living because it was felt Resident #8 could walk around outside by himself. -The RCC stated "don't think he could" when asked if Resident #8 could have found his way back to the facility if the resident got lost. Interview with the Administrator on 03/20/15 at 6:10 p.m. revealed: -The Administrator did not feel Resident #8 would be able to find way back to facility if lost. -Resident #8 had come from the memory care unit before she became the Administrator. -Staff must have felt the resident was not an elopement risk. -The Administrator heard different stories about how long Resident #8 was gone when Resident #8 eloped from the facility. -Resident #8 had not eloped from the facility since the single incident occurred. 2. Review of Resident #6's current FL-2 dated 08/08/2014 revealed: -Diagnoses included altered mental status, unresponsive at dialysis/syncope, chronic kidney disease - stage V on dialysis, diabetes mellitus, hypertension, and dyspnea.	D 270		

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D 270	Continued From page 25 -Area on the FL-2 for disoriented was left blank. -Resident #6 was semi-ambulatory with a rolling walker. Review of previous FL-2's for Resident #6 dated 04/24/14, 01/28/14, and 12/31/13 revealed the resident was noted to be intermittently disoriented. Review of Resident #6's assessment and care plan dated 01/19/15 revealed: -Resident #6 was sometimes disoriented (mostly after dialysis). -Resident #6 was forgetful and needed reminders. -Resident #6 required extensive assistance with toileting, bathing, and dressing. -Resident #6 required limited assistance with ambulation, grooming, and transferring. Review of Elopement Risk Evaluations for Resident #6 revealed: -On 01/07/15, the evaluation score for Resident #6 was 4 (score of 0 - 9 = minimal risk according to scoring scale printed on the Elopement Risk Evaluation form). -On 01/09/15, the evaluation score for Resident #6 was 4. -There was no scoring in the mental status section of the elopement risk evaluation tool. -There were no further elopement risk evaluations completed for Resident #6. Review of Resident Care Notes for Resident #6 revealed: -On 08/21/14 (no time documented), "Rt [resident] was crying some tonight wanting to leave". -On 08/22/14 (no time documented), "everytime she would go out to sit on porch she would then	D 270		

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roll to parking lot then get mad when you went to get her. She's complaining of not wanting to be here".
-On 09/13/14 (no time documented), "Rt [resident] tried to leave the property today at back entrance of property".
-On 03/03/15 (no time documented), "Rt [resident] called a cab to leave the facility to go to her [family members]. Cab was sent away".
-On 03/07/15 (no time documented), "Rt [resident] tried to leave the facility towards end of shift".
-On 03/08/15 (no time documented), Resident stated "going to leave the facility".
-On 03/09/15 (no time documented), "Rt [resident] stated she would be leaving out of facility today".
-On 03/10/15, (no time documented), "Rt [resident] talked a patient family member at dialysis to push her out of building and take her somewhere. Driver called to say rt [resident] taken off. RCC (Resident Care Coordinator) and ED (Executive Director) went to facility, able to locate rt [resident] and bring back to facility. ED contacted family".
-On 03/12/15, (no time documented), "Rt [resident] was found in parking lot heading towards road. Rt is on 15 min check. Continue to monitor".
-Another entry on 03/12/15, (no time documented), "Rt [resident] was out in (?) on the side of AL building 2 times on tonight. Rt was assisted back into building. Rt cussing very upset because she wants to leave. Rt monitored throughout the shift. Will cont [continue] to monitor".

Observation of Resident #6 on 03/17/15 at 5:15 p.m. revealed:
-Resident #6 was in her wheelchair with her hand

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to the sliding glass door on the 300 hall.
-Resident #6 asked the surveyor to help her get out the sliding glass exit door because the resident could not open the door.
-The medication aide (MA) sitting behind the nurses station was advised Resident #6 needed assistance.
-Resident #6 was assisted away from the exit door by the MA.

Confidential interviews with staff during the survey revealed:
-Resident #6 will try to leave the facility when the resident gets upset.
-Resident #6 was recently found in the middle of the parking lot heading toward the road.
-On 03/17/15, staff thought Resident #6 had "gone to sit on porch to cool off". When staff went to check on Resident #6, the resident had gone off the porch and was halfway down the ramp in her wheelchair. The resident told staff she was going to a doctor appointment. Time of occurrence was about 5:00pm, according to staff.
-Staff were keeping a close eye on Resident #6 because the resident had tried to get out of the facility.
-Resident #6 had been placed on every 15 minute supervision checks in the past two weeks.
-Resident #6 was on every 30 minute supervision checks prior to the last 2 weeks.
-When staff does 15 or 30 minute checks, they physically check the resident and document the resident's location and what they are doing.
-Resident #6 wants to go home and nothing will stop the resident from getting out the door and going home.
-Staff had concerns that Resident #6 could not get back to the facility if the resident got lost.
-Resident #6 does not want to be at the facility.
-A medication aide thought the door alarms would

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D 270	Continued From page 28 sound if the exit door at the end of the halls were opened. Interview with the Administrator on 03/20/15 at 6:15pm revealed: -The Administrator was not aware of Resident #6 ever leaving the facility unsupervised. -The Administrator did not feel Resident #6 would be able to find her way back to the facility if the resident got lost. 3. Review of Resident #7's current FL-2 dated 11/05/2014 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease, hypothyroidism, and osteoporosis. -There was no current level of care or recommended level of care designated. -A check mark was placed in the box beside "constantly" in the area on the FL-2 for disoriented. -A check mark was placed in the box beside "wanderer" in the area on the FL-2 for inappropriate behavior. -A check mark was placed in the box beside "ambulatory" in the area on the FL-2 for ambulatory status. Review of Resident #7's assessment and care plan dated 12/10/14 revealed: -Resident #7 was sometimes disoriented. -Resident #7 was forgetful and needed reminders. -Resident #7 required limited assistance with bathing. Review of Elopement Risk Evaluations for Resident #7 revealed: -On 12/10/14, the evaluation score for Resident #7 was 4 (score of 0 - 9 = minimal risk according	D 270		

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to scoring scale printed on the Elopement Risk Evaluation form).
-On 03/12/15, the evaluation score for Resident #7 totaled 4.
-There were no further elopement risk evaluations completed for Resident #7.

Review of Resident Care Notes for Resident #7 revealed:
-Resident confused.
-Resident does not understand why she cannot go with friend who lives in an apartment outside the facility.

Observations of Resident #7 at different intervals during the survey revealed:
-Resident #7 walked up and down the 100 hall and 200 hall.
-Staff was observed walking with Resident #7 in the halls on occasions.

Confidential interviews with staff during the survey revealed:
-Resident #7 was admitted to the facility from an independent living apartment in close proximity to the facility.
-Resident #7 always wants to be with her friend who lived in the independent living apartments.
-Resident #7 had been "found multiple times" in front of friends apartment.
-Resident #7 would go out the back sliding door, pass the clubhouse, and wait for her friend in front of the friend's apartment.
-If staff looked for Resident #7 and did not see her, staff would find Resident #7 sitting in one of the facility living areas or by the friend's apartment.
-Resident #7 had gone outside the facility unsupervised "maybe 3 or 4 episodes".
-Staff knew Resident #7 was a wanderer when

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the resident first came to the facility because was told to watch Resident #7 because the resident had been trying to get back to her apartment.
-Resident #7 is not allowed to leave the facility alone and always has another resident with her.
-Resident #7 would not be able to get back to the facility if got lost.
-One staff stated she feared Resident #7 would get out, start walking, and not know where she was going.
-Resident #7 was started on every 30 minute supervision checks.
-Staff were unsure when Resident #7's supervision checks were increased to every 15 minutes.

Interview with the Administrator on 03/20/15 at 6:15pm revealed:
-The Administrator was not aware of Resident #7 ever leaving the facility unsupervised.
-The Administrator knew Resident #7 had a friend who lived in the community who would come get the resident for visits.

Based on record review and interview, it was determined Resident #7 was not interviewable.

4. Review of Resident #2's closed record revealed:
-Diagnoses on FL-2 dated 04/22/14 included dementia, insulin dependent diabetes mellitus, pernicious anemia, hypertension, cervical arthritis, hyperlipidemia, coronary artery disease, and chronic gastritis.
-Resident #2 moved into the facility on 05/23/14.
-Resident #2 was discharged and transferred to the sister facility, a memory care unit, on 02/20/15.

Review of blood sugar logs for Resident #2

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revealed:
-The resident's blood sugar was scheduled to be checked twice daily at 6:30 a.m. and 8:00 p.m.
-Staff documented on 8 occasions in August 2014 the resident's blood sugar was not taken because resident's door was locked.
-Staff documented on 2 occasions in September 2014 the resident's blood sugar was not taken because resident's door was locked.
-Staff documented on 6 occasions in October 2014 the resident's blood sugar was not taken because resident's door was locked.
-November 2014 blood sugar log could not be found.
-Staff documented on 4 occasions in December 2014 the resident's blood sugar was not taken because resident's door was locked.

Review of Resident Care Notes for Resident #2 revealed:
-09/28/14 - resident very upset, crying and confused.
-09/29/14 - resident upset and in the bathtub with the dog.
-11/16/14 - resident was found in her room mixing chemicals. Resident had bleach, glass cleaner, nail polish remover, and pine sol. Resident had mixed it all together in the bathroom sink. Fumes were coming out of the room. Resident and dog were pulled out of room and chemicals were removed and locked in med room. Resident was very confused and not making sense with the words. RCC contacted and family. Family will be in on Monday to pick up dog.
-12/03/14 - resident refused all meals and said she could not come because something was running from her.
-12/28/14 - resident was very irate, rude and disrespectful to staff and other residents at lunch. Resident was getting in staff's face threatening

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them.
-12/29/14 - resident at front desk being loud, rude, and disrespectful to other residents. Resident got in staff's face with her fist balled up threatening staff.
-12/30/14 - resident at front desk arguing with staff and residents.
-01/02/15 - resident in dining room arguing with staff. Resident had her hands really close to staff face threatening to slap staff.
-01/03/15 - resident was fine during the night. Medication Aide would like resident to keep door unlocked in case of emergency. Resident keeping door locked is an ongoing problem when it comes to meds and care.
-01/10/15 - resident was very irate and disrespectful when she tried to take another resident's dog.
-01/11/15 - resident blocked off hallway so other residents could not get to dinner. Resident later refused all medications locking herself in her room.
-01/31/15 - resident was very agitated and disruptive during shift. Behavior continued through the day and ended towards the evening.
-02/02/15 - physician contacted regarding resident's increased behaviors. Spoke with family about concern for resident and other staff/residents safety.
-02/04/15 - received new orders for medication. Reassess in two weeks and if not any better in 2 weeks, may transfer to memory care unit.
-02/10/15 - resident was extremely confused and went in dining room, pulled down pants, sat down, and started to relieve herself. Resident wandered into dish room and was barefoot and lost. Family and RCC notified. Resident put on 15 minute checks.

Record review revealed no documentation to

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D 270	Continued From page 33 indicate staff was doing 15 minutes checks on Resident #2. Review of a 30 minute resident check form for Resident #2 revealed: -02/09/15 - staff documented 30 minute checks from 3:00 p.m. - 11:00 p.m. -02/10/15 - staff documented 30 minute checks from 7:00 a.m. - 11:00 p.m. -02/11/15 - staff documented 30 minute checks from 3:00 p.m. - 6:30 a.m. -02/12/15 - staff documented 30 minute checks from 3:00 p.m. - 6:30 a.m. -No checks documented after 02/12/15. Continued review of Resident Care Notes for Resident #2 revealed: -02/11/14 - resident has been urinating in bedroom on floor. Resident had bowel movement on bedroom floor. Contacted physician to send in urine sample. -02/13/15 - resident very confused and wanted to put pills in her pocket and then tried putting them in her pocket after redirecting her on several occasions. -02/13/15 - resident was found on floor and sent out to the hospital. She came back from hospital with new order for urinary tract infection. -02/14/15 resident had first dose of antibiotic. Resident very confused, a lot of wandering and walking around picking up items off the med cart, and talking about things that don't make a lot of sense. Staff having to monitor resident very closely. -02/15/15 - resident still very confused and carried a plant around with her most of evening. Resident having to be constantly redirected. -02/16/15 - resident was sitting on floor in room talking to herself. -02/17/15 - resident has been confused and has	D 270		

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been up and down the halls yelling and going into resident's rooms without permission.
-02/18/15 - resident confused and has been up all night fussing with the television.
-02/19/15 - resident confrontation with staff and residents. Staff unsure as to what to do to get resident calmed down.
-02/19/15 - staff has been redirecting resident for the last hour. Resident crying hysterically one minute and swinging her fists at staff and residents the next. Resident has become more aggressive. One to one supervision provided initially to ensure safety of resident and others. Resident stopped med aide in hallway and would not let med aide pass meds. Resident began yelling at staff and pointer her finger in her face, yelling "no", and attempting to take medications from her. Resident redirected by staff but then resident went in tv room and began yelling and swinging fists at other residents. Called 911 because staff unable to calm resident. Resident transported to emergency room.

Interview with a medication aide (MA) on 03/20/15 at 5:30 p.m. revealed:
-Prior to Resident #2 transferring to the memory care unit facility, she had declined and required assistance with bathing and dressing.
-Resident #2 would lock the door to her room at night and medication aides and personal care aides did not have a key to get in the room.
-MA would keep knocking on the door when it was time to give the resident her morning medications until the resident came to the door.
-Sometimes the resident would not come to the door when the MA knocked.
-This worried the MA so she would have to get housekeeping or security to unlock the door and the resident was usually asleep in the bed.
-The medication aides recently got a master key

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to unlock resident rooms about a month prior to Resident #2 being transferred to the memory care unit.
-Resident #2 was transferred to the memory care unit around the end of February 2015.
-She recalled the incident when Resident #2 had mixed the chemicals in her room.
-Staff reported a cloud of chemicals and very strong odor in the resident's room during the incident.
-Resident #2's behaviors got worse in the "last month or so" before she was transferred to the memory care unit.
-She did not recall doing and documenting 15 or 30 minute checks on Resident #2 but they checked her often (no time specified).

Interview with a personal care aide (PCA) on 03/17/15 at 6:25 p.m. revealed:
-The PCA had worked at the facility for about 6 months.
-Resident #2 was very independent at first and had a dog.
-The resident's mental state declined when the dog was removed from the facility.
-The resident was "out of it" and "talking out of her head".
-The resident would argue with everyone, which was unusual for her.
-The PCA did not recall doing 15 minute or 30 minute checks on Resident #2.
-The PCA reported the resident stayed up front near the receptionist's desk a lot after the dog was removed from the facility.

Interview with a family member of Resident #2 on 03/19/15 at 8:50 a.m. revealed:
-Resident #2 would lock herself in her room all the time.
-Medication aides did not have a key to get in

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Resident #2's room.
-They would have to get a housekeeper or facility campus security to unlock the door.
-A staff member had reported to the family member a concern that Resident #2 was not getting medications because if the door was locked the medication aide would knock but they would just keep on going down the hall if no answer.
-The family member discussed this with the Administrator around February 2015 who said the medication aides used to have a key to the residents' rooms.
-The family came to the facility on one occasion and staff had to get the housekeeper to unlock the door but resident was okay resting in bed.
-Medication aides finally got a key to the room about a week before the resident was transferred to the memory care unit on 02/20/15.
-Resident #2 was very confused just before she was transferred to the memory care unit because she had a urinary tract infection.
-Family member was aware of incident with Resident #2 mixing chemicals in her room.
-Family member stated she did not take any chemicals to the facility.
-Resident #2 had some confusion when she was first admitted in May 2014 but the confusion got worse in the last few months she was at the facility.
-She did not know how often staff was checking on Resident #2.

Interview with the Resident Care Coordinator (RCC) on 03/19/15 at 5:25 p.m. revealed:
-The previous RCC did not allow medication aides to have keys to residents' rooms because if something got missing in the rooms, she did not want the med aides to be blamed.
-She was aware Resident #2 would lock herself in

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D 270	Continued From page 37 her room. -All medication aides now have a master key that will unlock residents' rooms. -They have had the master key for about a month. -She was aware Resident #2 had been found mixing chemicals in her room. -She thought the family had brought in the cleaning supplies. -After incident, staff locked up the chemicals and a family member came and picked them up. -Resident was not on 15 minute or 30 minute checks to her knowledge. -She was unable to locate any documentation that 15 minute checks were done on Resident #2 after it was noted she was put on 15 minute checks in the care note dated 02/10/15. Review of the Plan of Protection submitted by the facility on 03/20/2015 revealed: -Alarms were put on doors to alert when a resident approached door. -Staff were being inserviced on not becoming complacent to door alarming and reacting. -Staff supervision will be provided for residents identified as wanderers in any unsecured areas. -Alarms will remain in place. -Residents who seem to be continuously exit seeking will be reported to physicians for placement in memory care. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 19, 2015.	D 270		
D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

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D 344	Continued From page 38 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure contact with the resident's physician for clarification of medication orders for 1 of 5 residents (#1) sampled with insulin order changes related to the resident's high blood sugars. The findings are: Review of Resident #1's current FL-2 dated 07/31/14 revealed: -Diagnoses included diabetes, dementia, hypertension, microvascular ischemia, gastroesophageal reflux disease, metabolic encephalopathy caused by urinary tract infection, spinal stenosis, anemia, and folic acid deficiency. -Order for Lantus insulin, inject 15 units subcutaneously at bedtime. (Lantus is long-acting insulin used to lower blood sugar.) Review of Resident #1's record revealed: -Facility faxed the physician on 4 occasions from 11/09/14 - 11/17/14 regarding Resident #1 having blood sugar readings that ranged from 427 - 495	D 344		

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on those 4 occasions.
-Facility faxed physician on 11/18/14 to report a blood sugar of 560 at 4:30 p.m.
-Physician order dated 11/18/14 to increase Lantus to 20 units at bedtime.

Review of the November 2014 medication administration record (MAR) revealed:
-Order dated 11/18/14 was printed on the MAR with original date noted to be 11/18/14 at 4:00 p.m.
-Staff documented 15 units of Lantus were administered at 8:00 p.m. on 11/18/14.
-Resident received first dose of Lantus 20 units on 11/20/14 at 8:00 p.m.

Review of Resident #1's record revealed:
-Facility faxed physician on 11/19/14 for a blood sugar of 479 at 4:30 p.m. and on 11/20/14 for a blood sugar of 521 at 4:30 p.m.
-Physician responded on the form on 11/20/14 with a written order to increase Lantus to 25 units at bedtime and add Metformin 500mg by mouth twice daily with food. (Metformin is used to lower blood sugar.)

Review of the November 2014 medication administration record (MAR) revealed:
-Order dated 11/20/14 for the increase in Lantus and the Metformin were not included on the MAR.
-Resident continued to receive Lantus 20 units at 8:00 p.m. from 11/21/14 - 11/30/14.
-Resident did not received any Metformin in 11/2014.

Review of Resident #1's record revealed:
-Facility faxed the physician on 11/24/14 for a blood sugar of 454 at 11:45 a.m. and on 11/26/14 for a blood sugar of 471 at 11:45 a.m.
-Prescription dated 12/01/14 to increase Lantus

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D 344	Continued From page 40	D 344		

to 25 units and Metformin 500mg 1 twice daily with food.
-No documentation the physician was contacted to clarify the order to increase Lantus to 25 units dated 12/01/14 since it would not be an increase based on the order for 25 units dated 11/20/14.

Review of the December 2014 MAR revealed:
-Resident received Lantus 20 units at 8:00 p.m. on 12/01/14.
-Resident started receiving Lantus 25 units at 8:00 p.m. on 12/03/14 - 12/31/14.
-Resident began receiving Metformin 500mg twice daily on 12/03/14.

Review of Resident #1's record revealed:
-Facility faxed the physician on 01/03/15 for a blood sugar of 429 at 11:30 a.m. and on 01/10/15 for a blood sugar of 422 at 8:00 p.m.
-Physician order dated 01/13/15 to increase Lantus to 20 units.
-No documentation the physician was contacted to clarify the order for Lantus dated 01/13/15 since 20 units would be a decrease from the 25 units the resident was receiving.

Review of the January 2015 MAR revealed:
-Lantus 25 units at 8:00 p.m. was documented as administered from 01/02/15 - 01/12/15.
-Lantus 20 units was documented as administered from 01/14/15 - 01/31/15.

Review of Resident #1's record revealed:
-Resident's blood sugar was 453 on 01/28/15 at 12:10 p.m. and she was complaining of abdominal pains.
-Resident was sent to the emergency room.

Review of the February and March 2015 MARs revealed the resident continued to receive Lantus

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D 344	Continued From page 41 20 units at 8:00 p.m. in February and March. Review of Resident #1's blood sugar readings revealed: -Blood sugar ranged from 99 - 450 in February 2015. -Blood sugar ranged from 86 - 434 in March 2015. Interview with the Resident Care Coordinator (RCC) on 03/19/15 at 12:30 p.m. revealed: -Medication aide on duty was responsible for clarification of any unclear or conflicting orders. -She was unaware of the discrepancies with Resident #1's medications. Interview with the Wellness Director on 03/19/15 at 12:30 p.m. revealed: -She was unaware of the problems with Resident #1's medications. -Medication aides are responsible for implementing and clarifying orders. -She will contact the physician's office and notify them the resident has continued to receive 20 units of Lantus. Review of a verbal order from the physician dated 03/19/15 revealed: -Wellness Director notified physician of discrepancy with the increase in Lantus. -Physician noted to continue the resident on the current dose of 20 units. Interview with the nurse at Resident #1's primary physician's office on 03/20/15 at 10:50 a.m. revealed: -They document and scan any contacts from the facility. -There was no documentation in their files the facility had contacted them to clarify the Lantus	D 344		

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D 344	Continued From page 42 order until the previous day on 03/19/15. Based on observation, interview, and record review, Resident #1 was unable to give specific information regarding the administration of insulin due to diagnoses of dementia.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#9) observed during the medication pass which included errors with medications for swelling, pain, and dizziness and 3 of 5 residents (#1, #2, #5) sampled which included errors with medications for diabetes, dementia, pain, inflammation, allergies, swelling, anxiety, depression, blood pressure, infection, acid reflux, leg cramps, cholesterol, calcium, magnesium, and potassium supplements, heart prevention, and vitamins. The findings are:	D 358		

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D 358	Continued From page 43 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 29 opportunities during the 8:00 a.m., 11:30 a.m. / 12:00 noon, and 4:00 p.m. medication passes on 03/18/15. Review of Resident #9's current FL-2 dated 06/16/14 revealed diagnoses included dementia, arthritis, hypertension, chronic obstructive pulmonary disease, hypothyroidism, hyperlipidemia, and depression. A. Review of Resident #9's record revealed: -Order dated 07/08/14 for Furosemide 20mg take 2 tablets daily in the morning. -(Furosemide is a diuretic used to treat swelling.) Observation of the 8:00 a.m. medication pass on 03/18/15 revealed the medication aide administered one Furosemide 20mg tablet to Resident #9 at 8:29 a.m. Review of the March 2015 medication administration record (MAR) revealed: -Entry for Furosemide 20mg 2 tablets every morning. -Furosemide was scheduled to be administered at 8:00 a.m. Review of medications on hand on 03/18/15 revealed directions on the label for Furosemide was to take 2 tablets by mouth daily and it was dispensed on 03/14/15. Interview with the medication aide on 03/18/15 at 10:18 a.m. revealed: -She usually gave Resident #9 two Furosemide tablets every morning but she overlooked it this morning and only gave one tablet.	D 358		

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D 358	Continued From page 44 -Resident #9's ankles are usually swollen every day. -She would complete a medication error report and notify the physician about the Furosemide. Interview with the Resident Care Coordinator (RCC) on 03/18/15 at 11:10 a.m. revealed: -Staff had been trained to read the directions on the MARs prior to administering medications. -They would complete a medication error report and notify the family and physician. Review of a resident care note for Resident #9 dated 03/15/15 revealed: -Resident has swelling in ankles and legs. -Staff removed socks and propped up legs. Observation and interview with Resident #9 on 03/18/15 at 11:25 a.m. revealed: -The resident was unsure what kind of medications she took each day. -The resident was wearing white socks and both ankles were swollen. -Resident #9 stated her legs and ankles were always swollen and they were swollen today about the same as usual. -She usually had to prop up her legs to help with the swelling. B. Review of Resident #9's record revealed: -Order on the FL-2 dated 06/16/14 for Diclofenac/Misoprostol 75/0.2mg 1 tablet twice daily. -(Diclofenac/Misoprostol is a combination product used to treat pain and inflammation caused by arthritis.) Observation of the 8:00 a.m. medication pass on 03/18/15 revealed the medication aide did not administer Diclofenac/Misoprostol when the	D 358		

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D 358	Continued From page 45 resident received her other morning medications. Interview with the medication aide on 03/18/15 at 8:25 a.m. revealed: -She was unable to administer Diclofenac/Misoprostol to Resident #9 because there was none available to administer. -She was unsure when it was reordered because Resident #9 did not use the facility's primary pharmacy. -She stated it may not have been ordered on time because the resident had been out of the medication for a few days. -She would check on it and contact the pharmacy. Review of the March 2015 medication administration record (MAR) revealed: -Entry for Diclofenac/Misoprostol 75/0.2mg 1 tablet twice daily. -Diclofenac/Misoprostol was scheduled to be administered at 8:00 a.m. and 7:00 p.m. -Diclofenac/Misoprostol was not documented as administered on 03/13/15 at 8:00 a.m., 03/16/15 at 8:00 a.m., 03/17/15 at 7:00 p.m., and 03/18/15 at 8:00 a.m. due to "pharmacy notified, awaiting delivery". Interview with the Resident Care Coordinator (RCC) on 03/18/15 at 11:15 a.m. revealed: -Facility's policy was to reorder medications when there was 5 pills left. -The facility just started cycle fills with the primary pharmacy. -Resident #9 used a different pharmacy so staff should have ordered the medication when 5 pills were left. -There was no system to monitor to assure staff was ordering in a timely manner.	D 358		

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D 358	Continued From page 46 Interview with the medication aide on 03/18/15 at 11:18 a.m. revealed: -She had ordered the Diclofenac/Misoprostol on 03/15/15 after it had run out. -She notified the next shift medication aide that it had been ordered that day on 03/15/15. -She could not recall the staff person who came on the next shift. -She was unsure if the medication had been reordered prior to or after she ordered it on 03/15/15. -She just got in a supply of Diclofenac/Misoprostol dispensed today on 03/18/15. -She would not administer the 8:00 a.m. dose now because it was beyond the one hour time frame. Interview with Resident #9 on 03/18/15 at 11:25 a.m. revealed: -The resident was unsure what kind of medications she took each day. -The resident has body aches and pains at times. -She denied any current symptoms of pain. C. Review of Resident #9's record revealed: -Order on the FL-2 dated 06/16/14 for Meclizine 25mg 1 tablet every 4 hours as needed for dizziness. -There was a handwritten note beside the computer printed Meclizine order to "change to schedule a.m. / p.m." with no date, time or initials noted. -Subsequent physician's order dated 07/08/14 for Meclizine 25mg 1 tablet twice daily. -Subsequent physician's order dated 09/08/14 to discontinue Meclizine. -(Meclizine is an antihistamine used to treat dizziness. Drowsiness is a side effect of Meclizine.)	D 358		

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D 358	Continued From page 47 Observation of the 8:00 a.m. medication pass on 03/18/15 revealed the medication aide administered Meclizine 25mg to Resident #9 when she received her other morning medications. Review of the March 2015 medication administration record (MAR) revealed: -Meclizine 25mg was scheduled and administered twice daily at 8:00 a.m. and 8:00 p.m. for March 2015. Interview with the medication aide on 03/18/15 at 10:18 a.m. revealed: -Meclizine was usually administered as a scheduled medication as indicated on the MAR. -She was unaware of an order to discontinue Meclizine. Interview with the Resident Care Coordinator (RCC) on 03/18/15 at 11:10 a.m. revealed: -She contacted Resident #9's physician about the Meclizine order today after it was brought to her attention by surveyor. -She received a fax from the physician today indicating the Meclizine should be "prn" (as needed) and not scheduled. Observation and interview with Resident #9 on 03/18/15 at 11:25 a.m. revealed: -Resident #9 was in the day room sleeping in a chair. -The resident was unsure what kind of medications she took each day. -The resident indicated she was a little sleepy but denied any recent symptoms of dizziness. 2. Review of Resident #1's current FL-2 dated 07/31/14 revealed diagnoses included diabetes,	D 358		

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dementia, hypertension, microvascular ischemia, gastroesophageal reflux disease, metabolic encephalopathy caused by urinary tract infection, spinal stenosis, anemia, and folic acid deficiency.

A. Review of Resident #1's current FL-2 dated 07/31/14 revealed:
-Order for Lantus insulin, inject 15 units subcutaneously at bedtime. (Lantus is long-acting insulin used to lower blood sugar.)

Review of Resident #1's record revealed:
-Facility faxed the physician on 4 occasions from 11/09/14 - 11/17/14 regarding Resident #1 having blood sugar readings that ranged from 427 - 495 on those 4 occasions.
-Facility faxed physician on 11/18/14 to report a blood sugar of 560 at 4:30 p.m.
-Physician order dated 11/18/14 to increase Lantus to 20 units at bedtime.

Review of the November 2014 medication administration record revealed:
-Lantus order dated 11/18/14 was printed on the MAR with original date noted to be 11/18/14 at 4:00 p.m.
-Staff documented 15 units of Lantus were administered at 8:00 p.m. on 11/18/14.
-Documentation for 11/19/14 was blank with no reason for the omission noted.
-Resident received first dose of Lantus 20 units on 11/20/14 at 8:00 p.m.

Review of Resident #1's record revealed:
-Facility faxed physician on 11/19/14 for a blood sugar of 479 at 4:30 p.m. and on 11/20/14 for a blood sugar of 521 at 4:30 p.m.
-Physician responded on the form on 11/20/14 with a written order to increase Lantus to 25 units at bedtime and add Metformin 500mg by mouth

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D 358	Continued From page 49 twice daily with food. (Metformin is used to lower blood sugar.) Review of the November 2014 medication administration record (MAR) revealed: -Order dated 11/20/14 for the increase in Lantus and the Metformin were not included on the MAR. -Resident continued to receive Lantus 20 units at 8:00 p.m. from 11/21/14 - 11/30/14. -Two blanks on 11/23/14 and 11/28/14 with no reasons for the omission documented. -Resident did not received any Metformin in November 2014. Review of Resident #1's record revealed: -Facility faxed the physician on 11/24/14 for a blood sugar of 454 at 11:45 a.m. and on 11/26/14 for a blood sugar of 471 at 11:45 a.m. -Prescription dated 12/01/14 to increase Lantus to 25 units and Metformin 500mg 1 twice daily with food. Review of the December 2014 MAR revealed: -Resident received Lantus 20 units at 8:00 p.m. on 12/01/14. -Dose for 12/02/14 was blank with no reason for the omission documented. -Resident started receiving Lantus 25 units at 8:00 p.m. on 12/03/14 - 12/31/14. -Four blanks on 12/24/14, 12/26/14, 12/29/14, and 12/30/14 with no reasons for the omissions documented. -Resident began receiving Metformin 500mg twice daily on 12/03/14. Review of Resident #1's record revealed: -Facility faxed the physician on 01/03/15 for a blood sugar of 429 at 11:30 a.m. and on 01/10/15 for a blood sugar of 422 at 8:00 p.m. -Physician order dated 01/13/15 to increase	D 358		

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D 358	Continued From page 50 Lantus to 20 units. -No documentation the physician was contacted to clarify the order for Lantus. Review of the January 2015 MAR revealed: -Lantus 25 units at 8:00 p.m. was documented as administered from 01/02/15 - 01/12/15 with refusals on 01/01/15 and 01/13/15. -Lantus 20 units was documented as administered from 01/02/15 - 01/31/15 with 4 refusals on 01/15/15, 01/19/15, 01/28/15, and 01/29/15. Review of Resident #1's record revealed: -Resident's blood sugar was 453 on 01/28/15 at 12:10 p.m. and she was complaining of abdominal pains. -Resident was sent to the emergency room. Review of the February and March 2015 MARs revealed: -The resident continued to receive Lantus 20 units at 8:00 p.m. in February and March 2015. Review of Resident #1's blood sugar readings revealed: -Blood sugar ranged from 99 - 450 in February 2015. -Blood sugar ranged from 86 - 434 in March 2015. Interview with the Resident Care Coordinator (RCC) on 03/19/15 at 12:30 p.m. revealed: -Medication aide on duty was responsible for implementing new orders when received. -She was unaware of the discrepancies with Resident #1's medications. Interview with the Wellness Director on 03/19/15 at 12:30 p.m. revealed:	D 358		

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D 358	Continued From page 51 -She was unaware of the problems with Resident #1's medications. -Medication aides are responsible for implementing and clarifying orders. -She will contact the physician's office and notify them the resident has continued to receive 20 units of Lantus. Review of a verbal order from the physician dated 03/19/15 revealed: -Wellness Director notified physician of discrepancy with the increase in Lantus. -Physician noted to continue the resident on the current dose of 20 units. Based on observation, interview, and record review, Resident #1 was unable to give specific information regarding the administration of insulin due to diagnoses of dementia. B. Review of Resident #1's February and March 2015 medication administration records (MARs) revealed: -Donepezil 5mg by mouth at bedtime was documented as administered at 8:00 p.m. from 02/25/15 - 03/16/15. -Original date of order noted on the MARs was 09/12/13. (Donepezil is for Alzheimer's dementia.) Review of Resident #1's record revealed no order for Resident #1 to receive Donepezil. Interview with the Resident Care Coordinator (RCC) on 03/19/15 at 12:30 p.m. revealed: -She was unaware Resident #1 was receiving Donepezil. -She could not locate an order in the record. -She would contact the pharmacy.	D 358		

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D 358	Continued From page 52 Interview with the Resident Care Coordinator (RCC) on 03/20/15 at 4:55 p.m. revealed -She spoke with the pharmacy staff and they did not know how the order got back on the MAR. -RCC pulled the Donepezil from the medication cart and it had already been sent back to the pharmacy. Interview with the Wellness Director (WD) on 03/19/15 at 5:00 p.m. revealed: -She spoke with the nurse at the physician's office today. -The resident was not supposed to be on Donepezil. -It was an old order that had been discontinued. -WD did not know why or how the order got back on the MAR. Interview with the nurse at the primary physician's office on 03/20/15 at 10:50 a.m. revealed: -She did not see a current order for Donepezil. -The resident was not supposed to be receiving Donepezil. Pharmacy dispensing records were requested but not received by the end of the survey on 03/20/15. 3. Review of Resident #5's current FL-2 dated 10/13/14 revealed diagnoses included edema, left sided hemiplegia, chronic pain, hypertension, osteoarthritis, epilepsy/recurrent seizures, cerebral artery, late cardiovascular disease effect, gastroparesis, hyperlipidemia, low back pain, Vitamin D deficiency, and vision problems. A. Review of Resident #5's record revealed physician's order dated 12/08/14 and 02/17/15 for Hydrocodone/Acetaminophen 5/325mg 1 tablet every 4 hours as needed for pain.	D 358		

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D 358	Continued From page 53 (Hydrocodone/Acetaminophen is a narcotic pain reliever.) Review of the March 2015 medication administration record (MAR) revealed: -Hydrocodone/Acetaminophen was documented as administered on 14 occasions from 03/02/15 through last documented dose on 03/15/15 at 9:13 a.m. Review of Resident #5's controlled substance record revealed: -A supply of 50 Hydrocodone/Acetaminophen tablets were received on 02/18/15. -Thirty tablets were documented as administered from 03/01/15 - 03/17/15. -Last tablet was documented as administered on 03/17/15 at 8:00 a.m. Interview with the medication aide on 03/20/15 at 5:00 p.m. revealed: -There was no Hydrocodone/Acetaminophen on hand for Resident #5. -Resident had been out of the medication for at least 3 days. -She thought they were waiting on a hard script from the physician since it was a controlled substance. -Resident requests the pain medication frequently. Interview with the medication aide on 03/20/15 at 5:40 p.m. revealed: -Medication aides were supposed to reorder medications when there were 5 to 6 pills left. -They usually order controlled substances sooner because of needing a hard script from the physician. -They were working on getting a hard script for the Hydrocodone/Acetaminophen.	D 358		

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D 358	Continued From page 54 Interview with Resident #5 on 03/20/15 at 6:30 p.m. revealed: -Resident has chronic shoulder and hip pain. -Facility has been out of her pain medication for about a week. -She had needed the pain medication since they have been out. -She described her pain as a "9" on a scale of 1 to 10 with 10 being the worst pain when she has needed it. -She denied any current symptoms of pain. -She stated the facility runs out of medication a lot. B. Review of Resident #5's FL-2 dated 10/13/14 and physician's order sheet dated 02/17/15 revealed an order for Lasix 40mg 1 tablet by mouth daily as needed for edema. (Lasix is a diuretic used to decrease swelling and blood pressure.) Interview with the medication aide on 03/20/15 at 5:00 p.m. revealed: -They had a supply of Lasix on hand for the resident for prn (as needed) use. -The prn medications do not automatically pull up on the computer screen in the electronic MARs. -If a resident request a prn, they pull up the screen and can see the orders. -She had not noticed the prn order for Lasix because it did not usually pop up on the screen for the electronic MARs. -She had not checked Resident #5's legs for swelling and she had not administered any Lasix to the resident. -The personal care aides (PCAs) would let the medication aides know if there were problems with residents such as swelling. -No PCAs had notified her that Resident #5 has	D 358		

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D 358	Continued From page 55 any swelling. Review of the January, February, and March 2015 medication administration records (MARs) revealed: -Lasix 40mg daily as needed for edema was included on the MARs. -No Lasix was documented as being administered to the resident in either month. Interview and observation of Resident #5 on 03/20/15 at 6:30 p.m. revealed: -Both of Resident #5's lower legs and ankles were swollen. -The resident's left ankle was swollen large enough the ankle bone could not be distinguished. -The right ankle swollen less than the left ankle. -Resident stated her legs were always swollen and that was about normal size for them. -Her left side was always swollen more than the right because that was her side affected by the paralysis. -She keeps her legs propped up to help with the swelling. -She did not complain of pain but stated her legs "feel tight". -She was unsure what medications she received each day but she thought she was supposed to be getting a diuretic every day. Interview with the Resident Care Coordinator (RCC) on 03/20/15 at 6:45 p.m. revealed: -Resident #5 has chronic swelling in her lower legs. -She was unaware of the prn order for Lasix for Resident #5. -Medication aides should check for swelling daily to see if the Lasix needed to be administered. -The prn orders do not usually pop up on the	D 358		

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screen for the electronic MARs so staff would probably not know to check for swelling unless they noticed or the resident complained.
-She would contact the physician about the prn Lasix order.

4. Review of Resident #2's closed record revealed:
-Diagnoses on FL-2 dated 04/22/14 included dementia, insulin dependent diabetes mellitus, pernicious anemia, hypertension, cervical arthritis, hyperlipidemia, coronary artery disease, and chronic gastritis.
-Resident #2 moved into the facility on 05/23/14.
-Resident #2 was discharged and transferred to the sister facility, a memory care unit, on 02/20/15.

Interview with a family member of Resident #2 on 03/19/15 at 8:50 a.m. revealed:
-Resident #2 had been telling family she was not getting medications like she was supposed to.
-Around January 2015, family received a pharmacy bill that was a lot lower than normal.
-Family checked into it and found that some of the medications had not been refilled since November 2014.
-For example, the resident's memory pill (Aricept) had not been filled since November 2014 when she checked on it in January 2015.
-Resident #2 did not use the facility's primary pharmacy but a local independent pharmacy.
-The facility was responsible for ordering all medications from the pharmacy.
-The pharmacy would deliver the medications to the facility.
-Family member notified the Administrator and RCC.
-Administrator and RCC checked on it and found there was several medications not on hand in the

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med cart that Resident #2 was supposed to be taking.
-Family member was concerned that resident not getting medications contributed to her decline in mental status resulting in her need to be transferred to the memory care unit.
-Family member felt Resident #2 had become more confused and was exhibiting unusual behaviors for her such as urinating in the dining room and defecating on a stool in her room.

A. Review of Resident #2's record revealed:
-Order on the FL-2 dated 04/22/14 for Aricept 10mg at bedtime. (Aricept is for Alzheimer's disease.)

Review of the December 2014 medication administration record (MAR) revealed:
-Aricept was documented as administered daily at 8:00 p.m. except 2 refusals and 2 omissions.

Review of the January 2015 MAR revealed:
-Aricept was documented as administered daily except 6 refusals and 3 omissions.

Review of the February 2015 MAR revealed:
-Aricept was documented as administered daily from 02/01/15 - 02/19/15 except 1 refusal and 1 omission.

Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:
-Aricept 10mg was dispensed on 5 occasions from 05/01/14 - 02/20/15.
-Thirty Aricept 10mg tablets were dispensed on 07/09/14, 08/19/14, 09/29/14, 11/17/14, and 01/12/15.
-Five month supply of Aricept was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period.

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D 358	Continued From page 58 Review of the medication release form dated 02/20/15 revealed: -One Aricept 10mg tablet was transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. B. Review of Resident #2's record revealed an order on the FL-2 dated 04/22/14 for Lexapro 20mg once daily (Lexapro is for depression.) Review of the December 2014 medication administration record (MAR) revealed: -Lexapro was documented as administered at 8:00 a.m. daily from 12/01/14 - 12/31/14 except 1 refusal. Review of the January 2015 MAR revealed: -Lexapro was documented as administered daily from 01/01/15 - 01/30/15 except 1 refusal. Review of the February 2015 MAR revealed: -Lexapro was documented as administered daily from 02/01/15 - 02/20/15 except 2 refusals. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Lexapro 20mg was dispensed on 4 occasions from 05/01/14 - 02/20/15. -Thirty Lexapro 20mg tablets were dispensed on 08/22/14, 10/28/14, 11/24/14, and 01/12/15. -Four month supply of Lexapro was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period.	D 358		

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D 358	Continued From page 59 Review of the medication release form dated 02/20/15 revealed: -Twenty-six Lexapro 20mg tablets were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. C. Review of Resident #2's record revealed: -Order on the FL-2 dated 04/22/14 for Hydralazine 50mg 1 tablet twice daily. (Hydralazine is used to treat high blood pressure.) -Order dated 12/04/14 for Hydralazine 25mg 1 tablet twice daily. Review of the December 2014 medication administration record (MAR) revealed: -Hydralazine 50mg was documented as administered at 8:00 a.m. and 8:00 p.m. from 12/01/14 - 12/04/14. -Hydralazine 25mg was documented as administered at 8:00 a.m. and 8:00 p.m. from 12/05/14 - 12/31/14 except 3 refusals. Review of the January 2015 MAR revealed: -Hydralazine 25mg was documented as administered at 8:00 a.m. and 8:00 p.m. from 01/01/15 - 01/31/15 except 7 refusals and 4 omissions. -It was documented as unavailable on 01/22/15 at 8:00 a.m. Review of the February 2015 MAR revealed: -Hydralazine 25mg was documented as administered at 8:00 a.m. and 8:00 p.m. from	D 358		

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D 358	Continued From page 60 02/01/15 - 02/20/15 except 3 refusals and 1 omission. Review of Resident #2's monthly vitals sign flow sheet revealed her blood pressure ranged from 113/63 - 129/71 from December 2014 - February 2015. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Hydralazine 50mg was dispensed on 6 occasions from 05/01/14 - 02/20/15. -Sixty Hydralazine 50mg tablets were dispensed on 05/12/14, 07/11/14, 09/02/14, and 10/22/14 (one month supply each time). -Thirty Hydralazine 50mg tablets were dispensed on 12/04/14 (one month supply). -Sixty Hydralazine 25mg tablets were dispensed on 01/19/15 (one month supply). -Six month supply of Hydralazine was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated 02/20/15 revealed: -Twenty-two Hydralazine 25mg tablets were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. D. Review of Resident #2's record revealed: -Order on the FL-2 dated 04/22/14 for Metoprolol 25mg twice daily. (Metoprolol is for heart/blood pressure.)	D 358		

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Review of the December 2014 medication administration record (MAR) revealed:
-Metoprolol 25mg was documented as administered at 8:00 a.m. and 8:00 p.m. from 12/01/14 - 12/31/14 except 3 refusals and 2 omissions.

Review of the January 2015 MAR revealed:
-Metoprolol 25mg was documented as administered twice daily from 01/01/15 - 01/31/15 except 6 refusals and 4 omissions.

Review of the February 2015 MAR revealed:
-Metoprolol 25mg was documented as administered twice daily from 02/01/15 - 02/20/15 except 3 refusals and 1 omission.

Review of Resident #2's monthly vitals sign flow sheet revealed her blood pressure ranged from 113/63 - 129/71 from December 2014 - February 2015.

Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:
-Metoprolol 25mg was dispensed on 5 occasions from 05/01/14 - 02/20/15.
-Sixty Metoprolol 25mg tablets were dispensed on 06/26/14, 08/11/14, 10/10/14, 11/28/14, and 01/05/15 (one month supply each).
-Five month supply of Metoprolol was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period.

Review of the medication release form dated 02/20/15 revealed:
-One Metoprolol 25mg tablet was transferred with the resident to the other facility.

Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on

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D 358	Continued From page 62 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. E. Review of Resident #2's record revealed an order the FL-2 dated 04/22/14 for Nexium 40mg once daily. (Nexium reduces acid in the stomach.) Review of the December 2014 medication administration record (MAR) revealed: -Nexium 40mg was documented as administered at 6:30 a.m. from 12/01/14 - 12/30/14 except 5 refusals and 2 omissions. Review of the January 2015 MAR revealed: -Nexium 40mg was documented as administered at 6:30 a.m. from 01/03/15 - 01/31/15 except 4 refusals and 6 omissions. -It was documented as unavailable on 01/13/15 and 01/19/15. Review of the February 2015 MAR revealed: -Nexium 40mg was documented as administered at 6:30 a.m. from 02/01/15 - 02/20/15 except 1 refusal and 2 omissions. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Nexium 40mg was dispensed on 6 occasions from 05/01/14 - 02/20/15. -Thirty Nexium 40mg tablets were dispensed on 05/12/14, 07/14/14, 08/12/14, 09/09/14, 11/04/14, and 01/12/15 (one month supply each). -Six month supply of Nexium was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated	D 358		

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D 358	Continued From page 63 02/20/15 revealed: -Seven Nexium 40mg capsules were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. F. Review of Resident #2's record revealed an order on the FL-2 dated 04/22/14 for Humulin 70/30 insulin 6 units subcutaneously twice a day. (Humulin 70/30 insulin lowers blood sugar.) Review of the December 2014 medication administration record (MAR) revealed: -Humulin 70/30 inject 6 units twice daily was documented as administered on 46 of 62 occasions with 12 refusals and 4 omissions. Review of the January 2015 MAR revealed: -Humulin 70/30 inject 6 units twice daily was documented as administered on 37 of 62 occasions with 12 refusals and 11 omissions. -It was documented as unavailable on 01/19/15 at 6:30 a.m. and 01/29/15 at 5:00 p.m. Review of the February 2015 MAR revealed: -Humulin 70/30 inject 6 units twice daily was documented as administered on 29 of 39 occasions with 7 refusals and 3 omissions. Review of Resident #2's fingerstick blood sugars revealed her blood sugar ranged from 76 - 252 from December 2014 - February 2015. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:	D 358		

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D 358	Continued From page 64 -Humulin 70/30 insulin was dispensed on 5 occasions from 05/01/14 - 02/20/15. -One 10ml vial of Humulin 70/30 insulin was dispensed on 05/23/14, 08/24/14, 10/13/14, 01/13/15 and 02/19/15 (one month supply each due to expiration 30 days after opening). -Five month supply of Humulin 70/30 was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period with one vial being dispensed 1 day prior to resident being transferred. Review of the medication release form dated 02/20/15 revealed: -Humulin 70/30 was documented on the form but no quantity was noted. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. G. Review of Resident #2's record revealed: -Order on the FL-2 dated 04/22/14 for Quinine take 1 by mouth at bedtime. (Quinine Sulfate is used to treat leg cramps.) Review of the December 2014 medication administration record (MAR) revealed: -Quinine Sulfate 324mg was documented as administered at 8:00 p.m. from 12/01/14 - 12/31/14 except 2 refusals and 2 omissions. Review of the January 2015 MAR revealed: -Quinine Sulfate 324mg was documented as administered daily from 01/01/15 - 01/31/15 except 6 refusals and 2 omissions. -It was documented as unavailable on 01/19/15.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025033	A. BUILDING: _____ B. WING _____	R 03/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COURTYARDS AT BERNE VILLAGE	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 358	Continued From page 65 Review of the February 2015 MAR revealed: -Quinine Sulfate 324mg was documented as administered at 5:00 p.m. from 02/01/15 - 02/19/15 except 1 refusal and 1 omission. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Quinine Sulfate was dispensed on 6 occasions from 05/01/14 - 02/20/15. -Thirty Quinine Sulfate capsules were dispensed on 05/12/14, 07/26/14, 09/11/14, 09/15/14, 11/04/14, and 01/12/15 (one month supply each). -Six month supply of Quinine Sulfate was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated 02/20/15 revealed: -Fourteen Quinine Sulfate capsules were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. H. Review of Resident #2's record revealed an order on the FL-2 dated 04/22/14 for Zocor 20mg at bedtime. (Zocor lowers cholesterol.) Review of the December 2014 medication administration record (MAR) revealed: -Zocor 20mg was documented as administered at 8:00 p.m. from 12/01/14 - 12/31/14 except 2 refusals and 2 omissions. Review of the January 2015 MAR revealed: -Zocor 20mg was documented as administered	D 358		

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D 358	Continued From page 66 daily from 01/01/15 - 01/31/15 except 6 refusals and 2 omissions. Review of the February 2015 MAR revealed: -Zocor 20mg was documented as administered daily from 02/01/15 - 02/19/15 except 1 refusal and 1 omission. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Zocor 20mg was dispensed on 6 occasions from 05/01/14 - 02/20/15. -Thirty Zocor 20mg tablets were dispensed on 05/12/14, 07/11/14, 09/10/14, 11/04/14, 12/15/14, and 01/17/15 (one month supply each). -Six month supply of Zocor 20mg was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated 02/20/15 revealed: -Seventeen Zocor 20mg tablets were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. I. Review of Resident #2's record revealed an order on the FL-2 dated 04/22/14 for Allegra 180mg once daily (Allegra is for allergies.) Review of the December 2014 medication administration record (MAR) revealed: -Allegra was documented as administered at 8:00 a.m. daily from 12/01/14 - 12/31/14 except 1 refusal.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 67 -It was documented as unavailable on 12/01/14. Review of the January 2015 MAR revealed: -Allegra was documented as administered at 8:00 a.m. daily from 01/01/15 - 01/31/15 except 1 refusal. -It was documented as unavailable on 01/24/15. Review of the February 2015 MAR revealed: -Allegra was documented as administered at 8:00 a.m. daily from 02/01/15 - 02/20/15 except 2 refusals. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Allegra 180mg was dispensed on 6 occasions from 05/01/14 - 02/20/15. -Thirty Allegra 180mg tablets were dispensed on 05/12/14, 08/07/14, 09/12/14, 11/24/14, 01/05/15, and 01/30/15. -Six month supply of Allegra was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated 02/20/15 revealed: -Three Allegra 180mg tablets were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. J. Review of Resident #2's record revealed: -Order on the FL-2 dated 04/22/14 for Magnesium Oxide 400mg 1 tablet at bedtime. (Magnesium Oxide is an antacid and may also be	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 68 used to treat low magnesium levels.) Review of the December 2014 medication administration record (MAR) revealed: -Magnesium Oxide 400mg was documented as administered at 8:00 p.m. from 12/01/14 - 12/31/14 except 2 refusals and 2 omissions. Review of the January 2015 MAR revealed: -Magnesium Oxide 400mg was documented as administered at 8:00 p.m. from 01/01/15 - 01/31/15 except 6 refusals and 2 omissions. Review of the February 2015 MAR revealed: -Magnesium Oxide 400mg was documented as administered at 8:00 p.m. from 02/01/15 - 02/19/15 except 1 refusal and 1 omission. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Magnesium Oxide 400mg was dispensed on 2 occasions from 05/01/14 - 02/20/15. -One hundred twenty Magnesium Oxide 400mg tablets were dispensed on 05/12/14 (four month supply). -Thirty Magnesium Oxide 400mg tablets were dispensed on 01/19/15 (one month supply). -Five month supply of Magnesium Oxide was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated 02/20/15 revealed: -One hundred four of the 150 tablets of Magnesium Oxide were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 69 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. K. Review of Resident #2's record revealed an order on the FL-2 dated 04/22/14 for Aspirin 81 mg once daily. (Aspirin is used to prevent heart related problems.) Review of the December 2014 medication administration record (MAR) revealed: -Aspirin 81mg was documented as administered at 8:00 a.m. from 12/01/14 - 12/31/14 except 1 refusal. Review of the January 2015 MAR revealed: -Aspirin 81mg was documented as administered at 8:00 a.m. from 01/01/15 - 01/08/15 and 01/11/15 - 01/29/15. -Aspirin was documented as unavailable on 01/09/15, 01/10/15, 01/20/15, and 01/31/15. Review of the February 2015 MAR revealed: -Aspirin 81mg was documented as administered at 8:00 a.m. on 10 days: 02/01/15, 02/02/15, 02/04/15, 02/07/15, 02/09/15, 02/10/15, 02/12/15 - 02/14/15, and 02/19/15. -Aspirin was documented as unavailable on 8 non-consecutive days: 02/03/15, 02/05/15, 02/06/15, 02/11/15, 02/16/15 - 02/18/15, and 02/20/15. -Aspirin was documented as refused on 2 occasions. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -No record of any Aspirin being dispensed for the resident from 05/01/14 - 02/20/15. Review of the medication release form dated	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 70 02/20/15 revealed: -No Aspirin was documented as being transferred to the other facility with the resident. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. L. Review of Resident #2's record revealed order on the FL-2 dated 04/22/14 for Vitamin B12 1000mcg once daily. (Vitamin B12 is a supplement used to treat and prevent B12 deficiency.) Review of the December 2014 medication administration record (MAR) revealed: -Vitamin B12 1000mcg was documented as administered at 8:00 a.m. from 12/02/14 - 12/30/14 except 1 refusal. -It was documented as unavailable on 14 non-consecutive days: 12/01/14, 12/09/14 - 12/11/14, 12/14/14 - 12/16/14, 12/19/14, 12/21/14, 12/23/14, 12/24/14, 12/28/14, 12/29/14, and 12/31/14. -It was documented as administered on 10 occasions during the time period it was noted to be unavailable. Review of the January 2015 MAR revealed: -Vitamin B12 1000mcg was documented as administered at 8:00 a.m. from 01/02/15 - 01/30/15 except 1 refusal. -It was documented as unavailable on 10 non-consecutive days: 01/01/15, 01/05/15, 01/07/15, 01/09/15, 01/10/15, and 01/14/15 - 01/18/15. -It was documented as administered on 8	D 358		

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D 358	Continued From page 71 occasions during the time period it was noted to be unavailable. Review of the February 2015 MAR revealed: -Vitamin B12 1000mcg was documented as administered at 8:00 a.m. from 02/01/15 - 02/20/15 except 2 refusals. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Vitamin B12 1000mcg was dispensed on 2 occasions from 05/01/14 - 02/20/15. -One hundred Vitamin B12 1000mcg tablets were dispensed on 06/24/14 (100 day supply or over a 3 month supply). -Thirty Vitamin B12 1000mcg tablets were dispensed on 01/19/15 (one month supply). -Four month supply of Vitamin B12 was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated 02/20/15 revealed: -Ten Vitamin B12 1000mcg tablets were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. M. Review of Resident #2's record revealed order on the FL-2 dated 04/22/14 for Vitamin D 2000 units once daily. (Vitamin D is a supplement used to treat and prevent Vitamin D deficiency.) Review of the December 2014 medication	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 72 administration record (MAR) revealed: -Vitamin D 2000 units was documented as administered at 8:00 a.m. from 12/05/14 - 12/30/14 except 1 refusal. -It was documented as unavailable on 16 non-consecutive days: 12/01/14 - 12/04/14, 12/09/14 - 12/11/14, 12/14/14, 12/15/14, 12/19/14, 12/21/14, 12/23/14, 12/24/14, 12/28/14, 12/29/14, and 12/31/14. -It was documented as administered on 13 occasions during the time period it was noted to be unavailable. Review of the January 2015 MAR revealed: -Vitamin D 2000 units was documented as administered at 8:00 a.m. from 01/02/15 - 01/19/15. -It was documented as unavailable on 22 non-consecutive days: 01/01/15, 01/05/15, 01/07/15, 01/09/15, 01/10/15, 01/14/15 - 01/18/15, and 01/20/15 - 01/31/15. -It was documented as administered on 9 occasions during the time period it was noted to be unavailable. Review of the February 2015 MAR revealed: -Vitamin D 2000 units was documented as administered at 8:00 a.m. from 02/01/15 - 02/19/15. -It was documented as unavailable on 6 non-consecutive days: 02/06/15, 02/14/15, 02/16/15 - 02/18/15, and 02/20/15 -It was documented as administered on 7 occasions during the time period it was noted to be unavailable. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -No Vitamin D 2000 units was dispensed from 05/01/14 - 02/20/15.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 73 Review of the medication release form dated 02/20/15 revealed: -No Vitamin D 2000 units was transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. N. Review of Resident #2's record revealed order on the FL-2 dated 04/22/14 for Vitamin D 50,000 units once a month in addition to the Vitamin D 2000 units. (Vitamin D is a supplement used to treat and prevent Vitamin D deficiency.) Review of the December 2014 medication administration record (MAR) revealed: -Vitamin D 50,000 units was documented as unavailable on 12/19/14. Review of the January 2015 MAR revealed: -Vitamin D 50,000 units was documented as administered on 01/18/15. Review of the February 2015 MAR revealed: -Vitamin D 50,000 units was documented as unavailable on 02/17/15. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Vitamin D 50,000 units was dispensed on 6 occasions from 05/01/14 - 02/20/15. -One Vitamin D 50,000 capsule was dispensed on 05/23/14, 08/22/14, 09/10/14, 11/24/14, 01/13/15, and 02/19/15 (one month supply each). -Six month supply of Vitamin D 50,000 units was	D 358		

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D 358	Continued From page 74 dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. Review of the medication release form dated 02/20/15 revealed: -One Vitamin D 50,000 units capsule was transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. O. Review of Resident #2's record revealed an order dated 09/15/14 for Calcium 600mg with Vitamin D take 1 table twice daily. (Calcium with Vitamin D is a supplement.) Review of the December 2014 medication administration record (MAR) revealed: -Calcium with Vitamin D was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -It was documented as unavailable on 5 non-consecutive days on 12/21/14, 12/23/14, 12/24/14, 12/29/14, and 12/31/14 (all 8:00 a.m. doses only). -It was documented as administered on 52 of 62 doses for December 2014 with 3 refusals and 2 omissions. Review of the January 2015 MAR revealed: -Calcium with Vitamin D was documented as unavailable on 18 non-consecutive days starting 01/01/15 at 8:00 a.m. with last dose noted unavailable was 01/23/15 (8:00 a.m.). -It was documented as administered on 17 occasions during the time period staff also documented the medication as unavailable.	D 358		

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D 358	Continued From page 75 -Seven refusals were documented with 6 refusals documented during the time staff noted the medication was unavailable. Review of the February 2015 MAR revealed: -Calcium with Vitamin D was as administered on 35 of 40 occasions from 02/01/15 - 02/20/15 except 3 refusals, 1 omission, and 1 "out of the facility". -It was documented as administered at 8:00 a.m. on 10 days: 02/01/15, 02/02/15, 02/04/15, 02/07/15, 02/09/15, 02/10/15, 02/12/15 - 02/14/15, and 02/19/15. -It was documented as unavailable on 8 non-consecutive days: 02/03/15, 02/05/15, 02/06/15, 02/11/15, 02/16/15 - 02/18/15, and 02/20/15. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -One supply of Calcium with Vitamin D was dispensed for the resident from 05/01/14 - 02/20/15. -This one supply was dispensed on 01/23/15 for 30 tablets (a 15 day supply). Review of the medication release form dated 02/20/15 revealed: -Seven Calcium tablets were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. P. Review of Resident #2's record revealed: -A physician's order dated 01/08/15 for Xanax	D 358		

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THE COURTYARDS AT BERNE VILLAGE	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 358	Continued From page 76 0.25mg ½ tablet twice daily. (Xanax is for anxiety.) -Subsequent order dated 02/04/15 to discontinue Xanax. Review of the January 2015 MAR revealed: -Administration of Xanax was blank with no reason for the omissions from 01/08/15 - 01/14/15 (8:00 a.m.) -Xanax was documented as refused on 01/14/15 at 5:00 p.m. -First dose of Xanax was documented as administered on 01/15/15 at 8:00 a.m. -It was documented as unavailable on 01/19/15 at 8:00 p.m. -It was documented as refused on 01/31/15 at 8:00 a.m. -Thirty-two doses were documented as administered in January 2015. Review of the February 2015 MAR revealed: -Stop date for Xanax was noted to be 02/09/15. -Xanax was documented as unavailable on 02/03/15 and 02/06/15 at 8:00 a.m. -Twelve doses were documented as administered in February 2015. Review of the controlled substance logs for Xanax revealed: -First dose of Xanax was administered on 01/09/15 at 8:00 p.m. -Thirty-five doses were documented as administered from 01/09/15 - 01/31/15. -Five doses were documented as administered from 02/01/15 - 02/03/15. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed 30 Xanax 0.25mg was dispensed on 01/08/15.	D 358		

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D 358	Continued From page 77 Review of the controlled substance return records for Xanax revealed: -Nine whole Xanax tablets (18 half doses) were returned to the pharmacy on 02/05/15. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. Q. Review of Resident #2's record revealed an order dated 02/14/15 for Cephalexin 500mg every 12 hours for 5 days (for urinary tract infection). (Cephalexin is an antibiotic for infection.) Review of the February 2015 MAR revealed: -Resident refused Cephalexin at 8:00 a.m. on 02/15/15 and 8:00 p.m. on 0218/15. -First documented dose was administered at 8:00 p.m. on 02/15/15. -It was documented as unavailable on 02/18/15 at 8:00 a.m. and withheld per physician's order on 02/19/15 at 8:00 a.m. -Documentation for 8:00 a.m. on 02/20/15 was blank with no reason for the omission. -Six doses were documented from 02/15/15 - 02/19/15. Review of resident care note dated 02/14/15 revealed staff documented resident received first dose of Cephalexin but no time was documented. Review of pharmacy dispensing information revealed: -Ten Cephalexin 500mg capsules were filled on 12/13/15 at a back up pharmacy. -Cephalexin ws picked up on 02/14/15 at 12:32 a.m.	D 358		

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D 358	Continued From page 78 Review of the medication release form dated 02/20/15 revealed: -Resident #2 was transferred to the sister memory care facility on 02/20/15. -Three Cephalexin 500mg capsules were transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. R. Review of Resident #2's record revealed: -A physician's order on the FL-2 dated 04/22/14 for Lasix 80mg once daily. (Lasix is a diuretic used to treat swelling.) -Physician's order dated 12/04/14 for Lasix 40mg once daily. -Physician's order dated 12/05/14 to discontinue Lasix. Review of the December 2014 medication administration record (MAR) revealed: -Lasix 80mg once daily at 8:00 a.m. was documented as administered from 12/01/14 - 12/04/14. -Lasix 40mg once daily at 8:00 a.m. was documented as administered on 15 occasions after it was discontinued on 12/05/14. -No documentation on the MAR that the order was discontinued on 12/05/14. Review of the January 2015 MAR revealed: -Lasix was documented as administered on 4 days from 01/01/15 - 01/06/15 after it was discontinued. -Stop date listed on the MAR was 01/07/15.	D 358		

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D 358	Continued From page 79 Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Lasix 80mg was dispensed on 4 occasions from 05/01/14 - 02/20/15. -Thirty Lasix 80mg tablets were dispensed on 05/12/14, 08/07/14, and 10/28/14. -Fifteen Lasix 80mg tablets were dispensed on 12/04/14. Review of the medication release form dated 02/20/15 revealed: -No Lasix was documented as transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. S. Review of Resident #2's record revealed: -A physician's order on the FL-2 dated 04/22/14 for Potassium Chloride 10mEq take 3 capsules twice daily. (Potassium Chloride is used for low potassium levels.) -A physician's order dated 12/05/14 to discontinue Potassium Chloride. Review of the December 2014 medication administration record (MAR) revealed: -Potassium Chloride was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -No documentation to indicate the order was discontinued on 12/05/14 and staff continued to document administration after 12/05/14 for a total of 43 doses.. Review of the January 2015 MAR revealed:	D 358		

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-Potassium Chloride was documented as administered on 9 occasions from 01/01/15 - 01/06/15 after the order was discontinued.
-Stop date listed on the MAR was 01/07/15.

Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:
-Potassium Chloride 10mEq was dispensed on 5 occasions from 05/01/14 - 02/20/15.
-One hundred eighty Potassium Chloride 10mEq capsules were dispensed on 05/12/14, 07/11/14, 09/02/14, 10/16/14, and 11/29/14 (one month supply each).
-Five month supply of Potassium Chloride was dispensed from 05/01/14 - 12/05/14, for over a 6 month time period that the medication was ordered to be administered.

Review of the medication release form dated 02/20/15 revealed:
-No Potassium Chloride was documented as transferred with the resident to the other facility.

Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m.

T. Review of Resident #2's record revealed:
-A physician's order on the FL-2 dated 04/22/14 for Celebrex 100mg twice daily. (Celebrex is used to treat pain and inflammation.)
-A physician's order dated 12/05/14 to discontinue Celebrex.

Review of the December 2014 medication administration record (MAR) revealed:
-Celebrex was scheduled to be administered at

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D 358	Continued From page 81 8:00 a.m. and 8:00 p.m. -No documentation to indicate the order was discontinued on 12/05/14 and staff continued to document administration after 12/05/14 for a total of 30 doses. Review of the January 2015 MAR revealed: -Celebrex was as administered on 8 occasions from 01/01/15 - 01/06/15 after the order had been discontinued. -Stop date listed on the MAR was 01/07/15. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Celebrex 100mg was dispensed on 4 occasions from 05/01/14 - 02/20/15. -Sixty Celebrex 100mg capsules were dispensed on 06/26/14, 08/11/14, 09/29/14, and 11/17/14. -Four month supply of Celebrex was dispensed from 05/01/14 - 12/05/14, for over a 6 month time period that the medication was ordered to be administered. Review of the medication release form dated 02/20/15 revealed: -No Celebrex was documented as transferred with the resident to the other facility. Refer to interviews with the Administrator on 03/19/15 at 5:07 p.m., the Wellness Director on 03/19/15 at 5:10 p.m., the RCC on 03/19/15 at 10:40 a.m. and 5:25 p.m., a medication aide on 03/19/15 at 10:40 a.m., and the nurse at physician's office on 03/19/15 at 3:35 p.m. _____ Interview with the Administrator on 03/19/15 at 5:07 p.m. revealed: -Facility staff printed a MAR for a family member to take Resident #2 to a physician's appointment	D 358		

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in either December 2014 or January 2015.
-Resident #2's family member brought to their attention there were problems with the resident's medications being available and administered.
-She thought Resident #2 refused medications a lot.
-There was no system prior to this for the facility staff to monitor medications.
-Afterwards, RCC and Wellness Director pulled reports and asked staff and residents about medication refusals.
-RCC printed physician's order sheets for medication aides who are supposed to be checking the orders and medications 3 times a week.
-RCC is not currently checking behind the medication aides to see if they are checking the medications with the physician's orders.

Interview with the Wellness Director (registered nurse) on 03/19/15 at 5:10 p.m. revealed:
-She thought medication aides are having a hard time trying to determine what to choose on the drop down menu on the electronic MARs when a medication is not administered for any reason.
-She does not think residents are refusing medications because the medications were not available to refuse.
-She thinks staff are choosing the wrong reasons on the menu for omissions.
-She stated staff needed to be in-serviced on how to properly document on the MARs and what the choices mean.
-There have not been any physician's orders to hold medications to her knowledge.

Interviews with the Resident Care Coordinator (RCC) on 03/19/15 at 10:40 a.m. and 5:25 p.m. revealed:
-A family brought to their attention about the

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D 358	Continued From page 83 medication being unavailable for Resident #2. -She gets her medications from an outside pharmacy so staff was responsible for ordering Resident #2's medications when there was 5 pills left. -She did not know why Resident #2's medications were not ordered in a timely manner. -Resident #2 would refuse medications at times. -She did not think staff was documenting correct information on the MARs when a medication was missed. -They had looked into the problems with Resident #2's medications and checked with the medication aides. -She did not know what medications were received, if any, when Resident #2 was admitted. -They did not document when families brought in medications. -The facility was responsible for ordering all of Resident #2's medications. -She did not know if the family had brought in any over-the-counter medications at any time for the resident. -There was no written policy for medications refusals to her knowledge. -If a resident refused, staff attempts 3 times to offer and then documents as refused. -If constantly reoccurring they will call the physician. -She was unsure why Lasix, Potassium, and Celebrex were not discontinued when ordered in December 2014. Interview with a medication aide on 03/19/15 at 10:40 a.m. revealed: -There was no written policy for medications refusals to her knowledge. -If a resident refused for 3 consecutive days, they were supposed to fax the physician.	D 358		

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D 358	Continued From page 84 Interview with the nurse at Resident #2's physician's office on 03/19/15 at 3:35 p.m. revealed: -They were notified around 01/08/15 that Resident #2 was refusing medications at times. -They changed the time of administration of her 8:00 p.m. medications to 5:00 p.m. to help with the refusals. -The facility had contacted them in January 2015 to get renewal orders on some of the resident's medications but they did not need to get renewals. -There was already current refills on the resident's medications at the pharmacy. -She did not understand why the facility called them when all they had to do was contact the pharmacy and reorder the medications. -Physician discontinued Lasix, Potassium Chloride, and Celebrex in December 2014 because the resident's renal function had gotten worse based on lab work. _____ Review of the facility's plan of protection dated 03/20/15 revealed: -Audits will be done on all medication carts by the close of business on Friday, 03/20/15, to assure all medications are in house for all residents. -Binders will be put into place for new orders to be followed up on by Resident Care Coordinator (RCC) to make sure medications are received in a timely manner. -Wellness Director (WD) will pull reports to monitor and follow up on things such as documentation of medications being unavailable and resident refusals. -A lead medication aide trainer will be put in place to make sure training is consistent. -RCC will do sample audits of medications on hand, medication orders, and medication	D 358		

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D 358	Continued From page 85 administration records. -RCC will monitor to assure medication aides are doing weekly audits to make sure all medications are in house. -RCC and WD will conduct a medication pass weekly on different shifts. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 19, 2015.	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 observation, interview, and record	D 367		

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review, the facility failed to assure the medication administration records (MARs) were accurate for 3 of 5 residents (#1, #2, #5) sampled including 2 residents (#2, #5) with documentation on MARs that did not match controlled substance logs, 1 resident (#1) with documentation on the MARs that did not match blood sugar logs, and 1 resident (#2) with inaccurate documentation on the MARs for medications being unavailable, refused, or omitted.

The findings are:

1. Review of Resident #1's current FL-2 dated 07/31/14 revealed diagnoses included diabetes, dementia, hypertension, microvascular ischemia, gastroesophageal reflux disease, metabolic encephalopathy caused by urinary tract infection, spinal stenosis, anemia, and folic acid deficiency.

Review of Resident #1's record revealed:
-Physician's orders dated 07/31/14 and 03/18/15 for Apidra to be given before meals based on fingerstick blood sugars (FSBS) according to the following sliding scale: 70 - 150 = none; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units and call MD; go to emergency room if >400.
-(Apidra is rapid-acting insulin that lowers blood sugar.)

Review of the February and March 2015 medication administration records (MARs) and the FSBS logs revealed the order for Apidra sliding scale insulin was transcribed and printed with the correct scale as ordered on both forms.

Review of the February 2015 MAR and the FSBS logs revealed the MAR did not match the log on the following occasions:

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D 367	Continued From page 87 -02/19/15 at 6:30 a.m. - FSBS 192 with 2 units documented on the MAR but 4 units on the FSBS log. -02/26/15 at 6:30 a.m. - FSBS 189 with 2 units documented on the MAR but 4 units on the FSBS log. Review of the March 2015 MAR and the FSBS logs revealed the MAR did not match the log on the following occasions: -03/01/15 at 4:30 p.m. - FSBS 208 with 2 units documented on the MAR but 4 units on the FSBS log. -03/03/15 at 4:30 p.m. - FSBS 205 with 2 units documented on the MAR but 4 units on the FSBS log. -03/05/15 at 4:30 p.m. - FSBS 325 with 6 units on MAR but FSBS 365 with 10 units on the FSBS log. -03/06/15 at 11:30 a.m. - FSBS 343 with 10 units on MAR but FSBS 434 with 10 units on the FSBS log. -03/07/15 at 11:30 a.m. - FSBS 257 with 6 units on the MAR but FSBS 247 with 4 units on the FSBS log. -03/07/15 at 4:30 p.m. - FSBS 216 with 4 units on the MAR but FSBS 220 with no units on the FSBS log. -03/08/15 at 4:30 p.m. - FSBS 217 with 4 units on the MAR but FSBS 212 with 4 units on the FSBS log. -03/09/15 at 4:30 p.m. - FSBS 246 with 6 units on the MAR but 4 units on the FSBS log. -03/10/15 at 4:30 p.m. - FSBS 242 with 6 units on the MAR but FSBS 261 with 6 units on the FSBS log. -03/12/15 at 6:30 a.m. - FSBS 123 with 2 units on the MAR but no units on the FSBS log. Review of Resident #1's blood sugar readings	D 367		

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revealed:
-Blood sugar ranged from 99 - 450 in February 2015.
-Blood sugar ranged from 86 - 434 in March 2015.

Interview with the Resident Care Coordinator (RCC) and the Wellness Director on 03/19/15 at 12:30 p.m. revealed:
-Medication aides documented FSBS and sliding scale on the electronic MARs and the FSBS logs.
-They were unaware the MARs and the FSBS logs did not match.
-Documentation on the MARs and FSBS logs should match.
-There was not currently a system to check the MARs and FSBS logs.

2. Based on observation, interview, and record review, Resident #5 and Resident #2's medication administration records that did not match their controlled substance logs.

A. Review of Resident #5's current FL-2 dated 10/13/14 revealed diagnoses included edema, left sided hemiplegia, chronic pain, hypertension, osteoarthritis, epilepsy/recurrent seizures, cerebral artery, late cardiovascular disease effect, gastroparesis, hyperlipidemia, low back pain, Vitamin D deficiency, and vision problems.

Review of Resident #5's record revealed physician's order dated 12/08/14 and 02/17/15 for Hydrocodone/Acetaminophen 5/325mg 1 tablet every 4 hours as needed for pain. (Hydrocodone/Acetaminophen is a narcotic pain reliever.)

Review of the January 2015 medication administration records (MARs) and controlled

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D 367	Continued From page 89 substance (CS) logs revealed: -Administration of Hydrocodone/Acetaminophen was documented on the CS logs but not on the MARs on 23 occasions. -Examples documented included the following: 01/01/15 at 7:30 a.m., 01/08/15 at 5:00 a.m., 01/11/15 at 7:29 a.m., 01/16/15 at 7:22 a.m., 01/18/15 at 8:00 a.m., 01/20/15 at 1:00 p.m., 01/22/15 at 2:00 a.m., 01/24/15 at 4:30 p.m., 01/25/15 and 01/26/15 at 2:00 a.m. Review of the February 2015 MARs and CS logs revealed: -Administration of Hydrocodone/Acetaminophen was documented on the CS logs but not on the MARs on 12 occasions. -Examples documented included the following: 02/19/15 at 4:00 a.m. and 8:00 p.m., 02/20/15 at 7:45 p.m., 02/21/15 at 9:30 a.m. and 7:30 p.m., 02/23/15 at 12:30 p.m., 02/24/15 at 8:30 a.m., 02/26/15 at 8:00 a.m. and 8:00 p.m., and 02/28/15 at 9:15 a.m. Review of the March 2015 MARs and CS logs revealed: -Administration of Hydrocodone/Acetaminophen was documented on the CS logs but not on the MARs on 14 occasions. -Examples documented included the following: 03/01/15 at 8:00 a.m., 03/02/15 at 11:35 p.m., 03/08/15 at 8:30 a.m., 03/09/15 at 4:00 a.m., 03/10/15 at 8:00 p.m., 03/12/15 at 8:00 a.m. and 2:25 p.m., 03/15/15 at 8:00 p.m., 03/16/15 at 5:15 a.m., and 03/17/15 at 8:00 a.m. Interview with a medication aide on 03/20/15 at 5:00 p.m. revealed: -Medication aides were supposed to document on the MARs and the CS logs for administration of any controlled substances.	D 367		

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D 367	Continued From page 90 -She usually documented on both forms. Interview with the Resident Care Coordinator and Wellness Director on 03/20/15 at 6:45 p.m. revealed: -They were unaware of the discrepancies with the MARs and the CS logs. -Staff have been trained to document on both forms. B. Review of Resident #2's closed record revealed: -Diagnoses on FL-2 dated 04/22/14 included dementia, insulin dependent diabetes mellitus, pernicious anemia, hypertension, cervical arthritis, hyperlipidemia, coronary artery disease, and chronic gastritis. Review of Resident #2's record revealed: -A physician's order dated 01/08/15 for Xanax 0.25mg ½ tablet twice daily. (Xanax is for anxiety.) -Subsequent order dated 02/04/15 to discontinue Xanax. Review of the January 2015 medication administration records (MARs) and controlled substance (CS) logs revealed: -Administration of Xanax was documented on the CS logs but not on the MARs on 01/09/15, 01/12/15, and 01/13/15 at 8:00 a.m. -Xanax was documented as administered on the MAR on 01/22/15 at 8:00 a.m. but not on the CS log. -Xanax was documented as refused on the MAR on 01/31/15 at 8:00 a.m. but it was documented as administered on the CS log. Review of the February 2015 MARs and CS logs revealed:	D 367		

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D 367	Continued From page 91 -Administration of Xanax was stopped on 02/03/15 at 5:00 p.m. due to the Xanax being discontinued on 02/04/15. -The remaining 18 tablets were documented as returned to the pharmacy on 02/05/15 (with pharmacy confirmation). -Staff documented 7 doses on the MAR as being administered after the Xanax was discontinued. -These 7 doses were not documented on the CS log and would have been unavailable due to being sent back to the pharmacy. -The 7 doses included: 02/04/15 at 8:00 a.m. and 5:00 p.m., 02/05/15 and 02/06/15 at 5:00 p.m., 02/07/15 at 8:00 a.m. and 5:00 p.m., and 02/09/15 at 8:00 a.m. Interview with a medication aide on 03/20/15 at 5:00 p.m. revealed: -Medication aides were supposed to document on the MARs and the CS logs for administration of any controlled substances. -She usually documented on both forms. Interview with the Resident Care Coordinator and Wellness Director on 03/20/15 at 6:45 p.m. revealed: -They were unaware of the discrepancies with the MARs and the CS logs. -Staff have been trained to document on both forms. 3. Review of Resident #2's closed record revealed: -Diagnoses on FL-2 dated 04/22/14 included dementia, insulin dependent diabetes mellitus, pernicious anemia, hypertension, cervical arthritis, hyperlipidemia, coronary artery disease, and chronic gastritis. -Resident #2 moved into the facility on 05/23/14 and was discharged and transferred to the sister	D 367		

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D 367	Continued From page 92 facility, a memory care unit, on 02/20/15. A. Review of Resident #2's record revealed an order on the FL-2 dated 04/22/14 for Aspirin 81 mg once daily. (Aspirin is used to prevent heart related problems.) Review of the February 2015 MAR revealed: -Aspirin was documented as unavailable on 8 non-consecutive days: 02/03/15, 02/05/15, 02/06/15, 02/11/15, 02/16/15 - 02/18/15, and 02/20/15. -Aspirin was documented as administered on 8 occasions during the time period it was noted to be unavailable. -Aspirin was documented as refused on 02/08/15 and 02/15/15 during the time it was noted to be unavailable. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -No record of any Aspirin being dispensed for the resident from 05/01/14 - 02/20/15. Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care Coordinator on 03/19/15 at 5:25 p.m. B. Review of Resident #2's record revealed an order dated 09/15/14 for Calcium 600mg with Vitamin D take 1 table twice daily. (Calcium with Vitamin D is a supplement.) Review of the December 2014 medication administration record (MAR) revealed: -Calcium with Vitamin D was documented as unavailable on 5 non-consecutive days on 12/21/14, 12/23/14, 12/24/14, 12/29/14, and 12/31/14 (all 8:00 a.m. doses only). -It was documented as administered on 13	D 367		

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occasions during the time period it was documented as unavailable.
-It was documented as refused on 3 occasions during the time it was noted to be unavailable.
-Documentation was blank with no reasons for the omissions on 12/24/14 and 12/30/14 at 8:00 p.m.

Review of the January 2015 MAR revealed:
-Calcium with Vitamin D was documented as unavailable on 18 non-consecutive days starting 01/01/15 at 8:00 a.m. with last dose noted unavailable was 01/23/15 (8:00 a.m.).
-It was documented as administered on 17 occasions during the time period it was documented as unavailable.
-There was 4 blank doses with no reasons for the omissions documented: 01/10/15 and 01/16/15 at 8:00 p.m. and both doses on 01/17/15.
-Seven refusals were documented with 6 refusals documented during the time staff noted the medication was unavailable.

Review of the February 2015 MAR revealed:
-Calcium with Vitamin D was documented as unavailable on 8 non-consecutive days: 02/03/15, 02/05/15, 02/06/15, 02/11/15, 02/16/15 - 02/18/15, and 02/20/15.
-It was documented as administered on 8 occasions during the time period staff also documented the medication as unavailable.
-It was documented as refused on 3 occasions during the time it was noted to be unavailable.
-One blank on 02/13/15 at 5:00 p.m. with no reason for the omission documented.

Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:
-One 15 day supply of Calcium with Vitamin D was dispensed from 05/01/14 - 02/20/15.

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D 367	Continued From page 94 Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care Coordinator on 03/19/15 at 5:25 p.m. C. Review of Resident #2's record revealed: -A physician's order on the FL-2 dated 04/22/14 for Celebrex 100mg twice daily. (Celebrex is used to treat pain and inflammation.) -A physician's order dated 12/05/14 to discontinue Celebrex. Review of the December 2014 medication administration record (MAR) revealed: -No documentation the order was discontinued on 12/05/14 and staff continued to document administration after 12/05/14 for a total of 30 doses. -It was documented as unavailable on 5 non-consecutive days on 12/09/14 and 12/10/14 at 8:00 a.m., and 12/14/14 - 12/16/14 at 8:00 a.m. -It was documented as "withheld per physician's orders" on 11 non-consecutive days: 12/07/14 and 12/08/14 at 8:00 p.m., both doses on 12/17/14, 12/19/14 and 12/21/14 at 8:00 a.m., 12/23/14 and 12/24/14 at 8:00 a.m., and 12/28/14, 12/29/14 and 12/31/14 at 8:00 a.m. -It was documented as "physically unable to take" on 12/18/14 at 8:00 a.m. -It was documented as refused on 3 occasions. -Two blanks with no reasons for the omissions on 12/24/14 and 12/30/14 at 8:00 p.m. Review of the January 2015 MAR revealed: -Celebrex was documented as withheld per physician's order on 01/01/15 and 01/05/15 at 8:00 a.m. -It was documented as refused on 01/02/15 and 01/05/15 at 8:00 p.m. -It was documented as administered on 8	D 367		

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occasions from 01/01/15 - 01/06/15.
-Stop date listed on the MAR was 01/07/15.

Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:
-Four month supply of Celebrex was dispensed from 05/01/14 - 12/05/14, for over a 6 month time period it was ordered.

Interview with a medication aide on 03/20/15 at 5:00 p.m. revealed when she chose "physically unable to take" on the MARs, it meant the medication was unavailable so she was physically unable to give it.

Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care Coordinator on 03/19/15 at 5:25 p.m.

D. Review of Resident #2's record revealed:
-A physician's order on the FL-2 dated 04/22/14 for Lasix 80mg once daily. (Lasix is a diuretic used to treat swelling.)
-Physician's order dated 12/04/14 for Lasix 40mg once daily.
-Physician's order dated 12/05/14 to discontinue Lasix.

Review of the December 2014 medication administration record (MAR) revealed:
-Lasix 40mg once daily at 8:00 a.m. was documented as administered on 15 occasions after it was discontinued on 12/05/14.
-No documentation on the MAR that the order was discontinued on 12/05/14.
-It was documented as unavailable on 12/09/14 and 12/10/14.
-It was documented as "physically unable to give" on 12/16/14 and 12/18/14.
-It was documented as "withheld per physician's

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orders" on 7 occasions: 12/16/14, 12/19/14, 12/21/14, 12/23/14, 12/24/14, 12/28/14, and 12/29/14.

Review of the January 2015 MAR revealed:
-It was documented as withheld per physician's order on 01/01/15 and 01/05/15.
-It was documented as administered on 4 days from 01/01/15 - 01/06/15 after it was discontinued.
-Stop date listed on the MAR was 01/07/15.

Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:
-Lasix 80mg was dispensed on 4 occasions from 05/01/14 - 12/05/14 including 15 tablets on 12/04/14.

Interview with a medication aide on 03/20/15 at 5:00 p.m. revealed when she chose "physically unable to take" on the MARs, it meant the medication was unavailable so she was physically unable to give it.

Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care Coordinator on 03/19/15 at 5:25 p.m.

E. Review of Resident #2's record revealed:
-A physician's order on the FL-2 dated 04/22/14 for Potassium Chloride 10mEq take 3 capsules twice daily. (Potassium Chloride is used for low potassium levels.)
-A physician's order dated 12/05/14 to discontinue Potassium Chloride.

Review of the December 2014 medication administration record (MAR) revealed:
-Potassium Chloride was scheduled to be administered at 8:00 a.m. and 8:00 p.m.

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D 367	Continued From page 97 -No documentation to indicate the order was discontinued on 12/05/14 and staff continued to document administration after 12/05/14 for a total of 43 doses. -Two doses were documented as unavailable on 12/09/14 and 12/10/14 and 2 doses were withheld per physician's orders on 12/07/14 and 12/17/14. -It was documented as refused on 3 occasions after the order was discontinued on 12/05/14. Review of the January 2015 MAR revealed: -Potassium Chloride was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -It was documented as administered on 9 occasions from 01/01/15 - 01/06/15 after it was discontinued. -It was documented as refused on 01/02/15 and 01/05/15 at 8:00 p.m. after it was discontinued. -Stop date listed on the MAR was 01/07/15. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Potassium Chloride 10mEq was dispensed on 5 occasions from 05/01/14 - 02/20/15. -One hundred eighty Potassium Chloride 10mEq capsules were dispensed on 05/12/14, 07/11/14, 09/02/14, 10/16/14, and 11/29/14 (one month supply each). -Five month supply of Potassium Chloride was dispensed from 05/01/14 - 12/05/15, for over a 6 month time period the medication was ordered to be administered. Review of the medication release form dated 02/20/15 revealed: -No Potassium Chloride was documented as transferred with the resident to the other facility. Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care	D 367		

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D 367	Continued From page 98 Coordinator on 03/19/15 at 5:25 p.m. F. Review of Resident #2's record revealed an order the FL-2 dated 04/22/14 for Humulin 70/30 insulin 6 units subcutaneously twice a day. (Humulin 70/30 insulin lowers blood sugar.) Review of the December 2014 medication administration record (MAR) revealed: -Four blanks with no reasons for the omissions on 12/16/14 and 12/31/14 at 6:30 a.m. and 12/24/14 and 12/30/14 at 8:00 p.m. Review of the January 2015 MAR revealed: -Humulin 70/30 was documented as unavailable on 01/19/15 at 6:30 a.m. and 01/29/15 at 5:00 p.m. -Eleven blanks with no reasons for the omissions were documented. Review of the February 2015 MAR revealed: -Three blanks with no reasons for the omissions were documented on 02/04/15 and 02/09/15 at 6:30 a.m. and 02/13/15 at 5:00 p.m. Review of Resident #2's fingerstick blood sugars revealed her blood sugar ranged from 76 - 252 from December 2014 - February 2015. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -Five month supply of Humulin 70/30 was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period with one vial being dispensed 1 day prior to resident being transferred. Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care Coordinator on 03/19/15 at 5:25 p.m.	D 367		

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G. Review of Resident #2's record revealed order on the FL-2 dated 04/22/14 for Vitamin B12 1000mcg once daily. (Vitamin B12 is a supplement used to treat and prevent B12 deficiency.)

Review of the December 2014 medication administration record (MAR) revealed:
-It was documented as unavailable on 14 non-consecutive days: 12/01/14, 12/09/14 - 12/11/14, 12/14/14 - 12/16/14, 12/19/14, 12/21/14, 12/23/14, 12/24/14, 12/28/14, 12/29/14, and 12/31/14.
-It was documented as administered on 10 occasions during the time period it was noted to be unavailable.
-One refusal was documented on 12/27/14 during the time it was noted to be unavailable.

Review of the January 2015 MAR revealed:
-It was documented as unavailable on 10 non-consecutive days: 01/01/15, 01/05/15, 01/07/15, 01/09/15, 01/10/15, and 01/14/15 - 01/18/15.
-It was documented as administered on 8 occasions during the time period it was noted to be unavailable.

Review of the pharmacy dispensing records from Resident #2's pharmacy revealed:
-Four month supply of Vitamin B12 was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period.

Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care Coordinator on 03/19/15 at 5:25 p.m.

H. Review of Resident #2's record revealed order on the FL-2 dated 04/22/14 for Vitamin D 2000

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D 367	Continued From page 100 units once daily. (Vitamin D is a supplement used to treat and prevent Vitamin D deficiency.) Review of the December 2014 medication administration record (MAR) revealed: -It was documented as unavailable on 16 non-consecutive days: 12/01/14 - 12/04/14, 12/09/14 - 12/11/14, 12/14/14, 12/15/14, 12/19/14, 12/21/14, 12/23/14, 12/24/14, 12/28/14, 12/29/14, and 12/31/14. -It was documented as administered on 13 occasions during the time period it was noted to be unavailable. -One refusal was documented on 12/27/14 during the time it was noted to be unavailable. Review of the January 2015 MAR revealed: -It was documented as unavailable on 22 non-consecutive days: 01/01/15, 01/05/15, 01/07/15, 01/09/15, 01/10/15, 01/14/15 - 01/18/15, and 01/20/15 - 01/31/15. -It was documented as administered on 9 occasions during the time period it was noted to be unavailable. Review of the February 2015 MAR revealed: -It was documented as unavailable on 6 non-consecutive days: 02/06/15, 02/14/15, 02/16/15 - 02/18/15, and 02/20/15 -It was documented as administered on 7 occasions during the time period it was noted to be unavailable. Review of the pharmacy dispensing records from Resident #2's pharmacy revealed: -No Vitamin D 2000 units was dispensed from 05/01/14 - 02/20/15. Refer to interview with the Wellness Director on 03/19/15 at 5:10 p.m. and the Resident Care	D 367		

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	HAL025033	A. BUILDING: _____ B. WING _____	R 03/20/2015

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D 367	Continued From page 101 Coordinator on 03/19/15 at 5:25 p.m. _____ Interview with the Wellness Director (registered nurse) on 03/19/15 at 5:10 p.m. revealed: -She thought medication aides were having a hard time trying to determine what to choose on the drop down menu on the electronic MARs when a medication was not administered for any reason. -She does not think residents are refusing medications because the medications were not always available to refuse. -She thinks staff are choosing the wrong reasons on the electronic drop down menu for omissions. -She stated staff needed to be in-serviced on how to properly document on the MARs and what the choices mean. -There have not been any physician's orders to hold medications to her knowledge. Interview with the Resident Care Coordinator (RCC) on 03/19/15 at 5:25 p.m. revealed: -She did not think staff was documenting correct information on the MARs when a medication was missed. -She was not aware of a system to check MARs for accuracy.	D 367		
D 410	10A NCAC 13F .1010(c) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.	D 410		

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D 410	Continued From page 102 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the provision of pharmaceutical services to meet the needs of residents including procedures that assure the accurate ordering, receiving, and administering of all prescribed medications to 3 of 6 residents (#2, #5, #9) sampled whose medications were not administered as ordered due to the medications being unavailable at the facility. The findings are: 1. Review of Resident #2's closed record revealed: -Diagnoses on FL-2 dated 04/22/14 included dementia, insulin dependent diabetes mellitus, pernicious anemia, hypertension, cervical arthritis, hyperlipidemia, coronary artery disease, and chronic gastritis. -Resident #2 moved into the facility on 05/23/14. -Resident #2 was discharged and transferred to the sister facility, a memory care unit, on 02/20/15. Interview with a family member of Resident #2 on 03/19/15 at 8:50 a.m. revealed: -Resident #2 had been telling family she was not getting medications like she was supposed to. -Around January 2015, family received a pharmacy bill that was a lot lower than normal. -When family checked, some of the medications had not been refilled since November 2014. -For example, the resident's memory pill (Aricept) had not been filled since November 2014 when the family member checked in January 2015. -Resident #2 did not use the facility's primary	D 410		

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D 410	Continued From page 103	D 410		

pharmacy but a local independent pharmacy.
-The facility was responsible for ordering all medications from the pharmacy.
-The pharmacy would deliver the medications to the facility.
-The family member notified the Administrator and RCC.
-The Administrator and RCC checked on it and found there was several medications not on hand in the med cart that Resident #2 was supposed to be taking.
-The family member was concerned that resident not getting medications contributed to her decline in mental status resulting in her need to be transferred to the memory care unit.

Based on interviews and review of medication administration records and pharmacy dispensing records, at least 18 medications for Resident #2 were not administered as ordered due to medications not being reordered in a timely manner.

Review of Resident #2's record revealed orders for the following medications:
-04/22/14 - Aricept 10mg at bedtime. (Aricept is for Alzheimer's disease.)
-04/22/14 - Lexapro 20mg once daily (Lexapro is for depression.)
-04/22/14 - Hydralazine 50mg 1 tablet twice daily. (Hydralazine is for high blood pressure.)
-12/04/14 - Hydralazine 25mg 1 tablet twice daily.
-04/22/14 - Metoprolol 25mg twice daily. (Metoprolol is for heart/blood pressure.)
-04/22/14 - Nexium 40mg once daily. (Nexium reduces acid in the stomach.)
-04/22/14 - Humulin 70/30 insulin 6 units subcutaneously twice a day. (Humulin 70/30 insulin lowers blood sugar.)
-04/22/14 - Quinine take 1 by mouth at bedtime.

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D 410	Continued From page 104 (Quinine Sulfate is used to treat leg cramps.) -04/22/14 - Zocor 20mg at bedtime. (Zocor lowers cholesterol.) -04/22/14 - Allegra 180mg once daily (Allegra is for allergies.) -04/22/14 - Magnesium Oxide 400mg 1 tablet at bedtime. (Magnesium Oxide is an antacid and may also be used to treat low magnesium levels.) -04/22/14 - Aspirin 81 mg once daily. (Aspirin is used to prevent heart related problems.) -04/22/14 - Vitamin B12 1000mcg once daily. (Vitamin B12 is a supplement used to treat and prevent B12 deficiency.) -04/22/14 - Vitamin D 2000 units once daily. (Vitamin D is a supplement used to treat and prevent Vitamin D deficiency.) -04/22/14 - Vitamin D 50,000 units once a month in addition to the Vitamin D 2000 units. -09/15/14 - Calcium 600mg with Vitamin D take 1 table twice daily. (Calcium with Vitamin D is a supplement.) -04/22/14 - Lasix 80mg once daily. (Lasix is a diuretic used to treat swelling.) -04/22/14 - Potassium Chloride 10mEq take 3 capsules twice daily. (Potassium Chloride is used for low potassium levels.) -04/22/14 - Celebrex 100mg twice daily. (Celebrex is used to treat pain and inflammation.) Review of pharmacy dispensing records from Resident #2's pharmacy revealed: -Five month supply of Aricept was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -Four month supply of Lexapro was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -Six month supply of Hydralazine was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period.	D 410		

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D 410	Continued From page 105 -Five month supply of Metoprolol was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -Six month supply of Nexium was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -Five month supply of Humulin 70/30 was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period with one vial being dispensed 1 day prior to resident being transferred. -Six month supply of Quinine Sulfate was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -Six month supply of Zocor 20mg was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -Six month supply of Allegra was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -Five month supply of Magnesium Oxide was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -No record of any Aspirin being dispensed for the resident from 05/01/14 - 02/20/15. -Four month supply of Vitamin B12 was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -No Vitamin D 2000 units was dispensed from 05/01/14 - 02/20/15. -Six month supply of Vitamin D 50,000 units was dispensed from 05/01/14 - 02/20/15, for over a 9 month time period. -One 15 day supply of Calcium with Vitamin D was dispensed for the resident from 05/01/14 - 02/20/15. -Three month supply of Lasix was dispensed from 05/01/14 - 12/05/14, for over a 6 month time period that the medication was ordered to be administered. -Five month supply of Potassium Chloride was	D 410		

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D 410	Continued From page 106	D 410		

dispensed from 05/01/14 - 12/05/14, for over a 6 month time period that the medication was ordered to be administered.
-Four month supply of Celebrex was dispensed from 05/01/14 - 12/05/14, for over a 6 month time period that the medication was ordered to be administered.

Interview with the pharmacist at Resident #2's pharmacy on 03/19/15 at 1:15 p.m. revealed:
-The facility was responsible for contacting the pharmacy to reorder medications when needed.
-The pharmacy usually fills orders and delivers to the facility within 24 hours of the request but it was usually delivered the same day.
-The facility had not contacted the pharmacy about any problems with reordering medications.

Interview with the nurse at Resident #2's physician's office on 03/19/15 at 3:35 p.m. revealed:
-The facility had contacted them in January 2015 to get renewal orders on some of the resident's medications but they did not need to get renewals.
-There was already current refills on the resident's medications at the pharmacy.
-She did not understand why the facility called them when all they had to do was contact the pharmacy and reorder the medications.

Interview with the Administrator on 03/19/15 at 5:07 p.m. revealed:
-Resident #2's family member brought to their attention there were problems with the resident's medications being available and administered in December 2014 or January 2015.
-There was no system prior to this for the facility staff to monitor medications.

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D 410	Continued From page 107 Interview with the Resident Care Coordinator (RCC) on 03/19/15 at 5:25 p.m. revealed: -A family brought to their attention about the medication being unavailable for Resident #2. -She gets her medications from an outside pharmacy so staff was responsible for ordering Resident #2's medications when there was 5 pills left. -She did not know why Resident #2's medications were not ordered in a timely manner. -They had looked into the problems with Resident #2's medications. -She did not know what medications were received, if any, when Resident #2 was admitted. -They did not document when families brought in medications. -The facility was responsible for ordering all of Resident #2's medications. -She did not know if the family had brought in any over-the-counter medications at any time for the resident. -There was no system for the facility to account for medications that did not come from the primary pharmacy. 2. Review of Resident #5's current FL-2 dated 10/13/14 revealed diagnoses included edema, left sided hemiplegia, chronic pain, hypertension, osteoarthritis, epilepsy/recurrent seizures, late cardiovascular disease effect, gastroparesis, hyperlipidemia, low back pain, Vitamin D deficiency, and vision problems. Review of Resident #5's record revealed physician's orders dated 12/08/14 and 02/17/15 for Hydrocodone/Acetaminophen 5/325mg 1 tablet every 4 hours as needed for pain. (Hydrocodone/Acetaminophen is a narcotic pain reliever.)	D 410		

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D 410	Continued From page 108 Review of the March 2015 medication administration record (MAR) revealed: -Hydrocodone/Acetaminophen was documented as administered on 14 occasions from 03/02/15 through last documented dose on 03/15/15 at 9:13 a.m. Review of Resident #5's controlled substance record revealed: -A supply of 50 Hydrocodone/Acetaminophen tablets were received on 02/18/15. -Last tablet was documented as administered on 03/17/15 at 8:00 a.m. Interview with a medication aide on 03/20/15 at 5:00 p.m. revealed: -There was no Hydrocodone/Acetaminophen on hand for Resident #5. -Resident had been out of the medication for at least 3 days. -She thought they were waiting on a hard script from the physician since it was a controlled substance. -Resident requested the pain medication frequently. Interview with a medication aide on 03/20/15 at 5:40 p.m. revealed: -Medication Aides were supposed to reorder medications when there were 5 to 6 pills left. -They usually order controlled substances sooner because of needing a hard script from the physician. -They were working on getting a hard script for the Hydrocodone/Acetaminophen. Interview with Resident #5 on 03/20/15 at 6:30 p.m. revealed: -Resident has chronic shoulder and hip pain. -Facility has currently been out of her pain	D 410		

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D 410	Continued From page 109	D 410		

medication for about a week.
-She had needed the pain medication since they have been out.
-She described her pain as a "9" on a scale of 1 to 10 with 10 being the worst pain when she has needed it.
-She denied any current symptoms of pain.
-She stated the facility runs out of medication a lot.

Interview with the Resident Care Coordinator (RCC) on 03/20/15 at 6:45 a.m. revealed:
-She was unaware they were out of Resident #5's pain medication.
-Facility's policy was to reorder medications when there was 5 pills left.
-Staff should be ordering controlled substances sooner because they usually had to get a hard script.
-She was unaware of a specific policy of how far in advance staff should order the controlled substances to make sure hard scripts are obtained prior to the resident running out of medication.

3. Review of Resident #9's current FL-2 dated 06/16/14 revealed:
-Diagnoses included dementia, arthritis, hypertension, chronic obstructive pulmonary disease, hypothyroidism, hyperlipidemia, and depression.

Review of Resident #9's record revealed:
-Order on the FL-2 dated 06/16/14 for Diclofenac/Misoprostol 75/0.2mg 1 tablet twice daily.
-(Diclofenac/Misoprostol is a combination product used to treat pain and inflammation caused by arthritis.)

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D 410	Continued From page 110 Observation of the 8:00 a.m. medication pass on 03/18/15 revealed the medication aide did not administer Diclofenac/Misoprostol when the resident received her other morning medications. Interview with the medication aide on 03/18/15 at 8:25 a.m. revealed: -She was unable to administer Diclofenac/Misoprostol to Resident #9 because there was none available to administer. -She was unsure when it was reordered because Resident #9 did not use the facility's primary pharmacy. -She stated it may not have been ordered on time because the resident had been out of the medication for a few days. Review of the March 2015 medication administration record (MAR) revealed: -Entry for Diclofenac/Misoprostol 75/0.2mg 1 tablet twice daily. -Diclofenac/Misoprostol was scheduled to be administered at 8:00 a.m. and 7:00 p.m. -Diclofenac/Misoprostol was not documented as administered on 03/13/15 at 8:00 a.m., 03/16/15 at 8:00 a.m., 03/17/15 at 7:00 p.m., and 03/18/15 at 8:00 a.m. due to "pharmacy notified, awaiting delivery". Interview with the Resident Care Coordinator (RCC) on 03/18/15 at 11:15 a.m. revealed: -Facility's policy was to reorder medications when there was 5 pills left. -The facility just started cycle fills with the primary pharmacy. -Resident #9 used a different pharmacy so staff should have ordered the medication when 5 pills were left. Interview with a medication aide on 03/18/15 at	D 410		

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D 410	Continued From page 111 11:18 a.m. revealed: -She had ordered the Diclofenac/Misoprostol on 03/15/15 after it had run out. -She notified the next shift medication aide that it had been ordered that day on 03/15/15. -She could not recall the staff person who came on the next shift. -She was unsure if the medication had been reordered prior to or after she ordered it on 03/15/15. _____ Review of the facility's plan of protection dated 03/20/15 revealed: -Audits will be done on all medication carts by the close of business on Friday, 03/20/15, to assure all medications are in house for all residents. -Binders will be put into place for new orders to be followed up on by Resident Care Coordinator (RCC) to make sure medications are received in a timely manner. -Wellness Director (WD) will pull reports to monitor and follow up on things such as documentation of medications being unavailable and resident refusals. -A lead medication aide trainer will be put in place to make sure training is consistent. -RCC will do sample audits of medications on hand, medication orders, and medication administration records. -RCC will monitor to assure medication aides are doing weekly audits to make sure all medications are in house. -RCC and WD will conduct a medication pass weekly on different shifts. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 4, 2015.	D 410		

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D912	Continued From page 112	D912		
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 review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with releveant federal and state laws and rules and regulations related to physical environment, personal care and supervision, medication administration, and pharmaceutical services. The findings are: 1. Based on observation, interview, and record review, the facility failed to have door alarm sounding devices on 2 of 2 exit doors and failed to ensure door alarm sounding devices were activated upon doors opening for 3 of 4 sampled exit doors to prevent 3 of 3 sampled residents (Residents #6, #7, #8) from exiting the building who were known to be wanderers and noted to be disoriented, and had exited the facility without staff knowledge. [Refer to Tag D 067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type A2 Violation)]. 2. Based on observation, interview, and record review, the facility failed to provide adequate supervision for 4 of 4 sampled residents (Residents #2, #6, #7, #8) who were diagnosed with dementia or disoriented, including 3	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025033	A. BUILDING: _____ B. WING _____	R 03/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COURTYARDS AT BERNE VILLAGE	2701 AMHURST BOULEVARD NEW BERN, NC 28562

(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
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residents (#6, #7, #8) who had exited the facility unsupervised, and 1 resident (#2) who locked her door, was found mixing chemicals in her room, and whose fingerstick blood sugar was not checked due to the locked room door. [Refer to Tag D 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].

3. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#9) observed during the medication pass which included errors with medications for swelling, pain, and dizziness and 3 of 5 residents (#1, #2, #5) sampled which included errors with medications for diabetes, dementia, pain, inflammation, allergies, swelling, anxiety, depression, blood pressure, infection, acid reflux, leg cramps, cholesterol, calcium, magnesium, and potassium supplements, heart prevention, and vitamins. [Refer to Tag D 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

4. Based on observations, interviews and record reviews, the facility failed to assure the provision of pharmaceutical services to meet the needs of residents including procedures that assure the accurate ordering, receiving, and administering of all prescribed medications to 3 of 6 residents (#2, #5, #9) sampled whose medications were not administered as ordered due to the medications being unavailable at the facility. [Refer to Tag D 410, 10A NCAC 13F .1010(c) Pharmaceutical Services (Type B Violation)].