| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL060136 | A. BUILDING: _____ B. WING _____ | R 09/06/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINT HILL SENIOR LIVING | 10830 LAWYERS ROAD CHARLOTTE, NC 28227 |

| (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<br><br>The Adult Care Licensure Section and the Mecklenburg Department of Social Services conducted a follow-up survey on September 6, 2017. | {D 000} | | |
| {D 358} | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Non-Compliance Continues<br><br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents (Resident #3) observed during the medication pass including Amlodipine (used to treat high blood pressure) and Januvia (used to treat diabetes).<br><br>The findings are:<br><br>The medication error rate was 6% as evidenced by the observation of 2 errors out of 30 opportunities during the 8:00 a.m. medication pass on 09/06/17.<br><br>Review of Resident #3's current FL2 dated | {D 358} | | |

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| {D 358} | Continued From page 1<br><br>08/31/17 revealed:<br>-Diagnoses included vascular dementia, ischemic stroke in 2013, diabetes mellitus, hyperlipidemia, right sided weakness, aphasia, anemia, and hypertension.<br>-A physician's order for Amlodipine 5 mg daily and Januvia 100 mg daily.<br><br>Observation on 09/06/17 from 8:00 am to 8:05 am of medication administration for Resident #3 revealed:<br>-Resident #3 was sitting in her room; on the side of her bed.<br>-The Medication Aide (MA) reviewed Resident #3's electronic medication administration record (eMAR) for medications due for administration.<br>-The MA prepared 4 oral medications (including Amlodipine 2.5 mg and Januvia 50 mg) for Resident #3 and administered them with a 4 ounce cup of water.<br>-The MA documented administration of the 8:00 am medications on the September 2017 eMAR.<br><br>Review of Resident #3's September 2017 eMAR revealed:<br>-An entry for Amlodipine 5 mg daily at 8:00 am.<br>-An entry for Januvia 100 mg daily at 8:00 am.<br><br>Interview on 09/06/17 at 11:45 am with Resident #3 revealed:<br>-She was unaware of the medications and dosages she was receiving.<br>-The staff administer all her medications.<br><br>Telephone interview on 09/06/17 at 2:45 pm with the contracted pharmacy revealed:<br>-The pharmacy representative confirmed the pharmacy only had orders for Amlodipine 5 mg daily and Januvia 100 mg daily.<br>-The order was originally received on 09/01/2017. | {D 358} | | |

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| {D 358} | Continued From page 2<br>-The medications were sent to the facility on 09/06/17.<br>-The facility had notified the pharmacy after the morning medication pass on 09/06/17 they had not received Amlodipine 5 mg and Januvia 100 mg medications.<br>-The bubble packs were delivered on 09/06/17 for Amlodipine 5 mg and Januvia 100 mg for Resident #3.<br><br>Observation on 09/06/17 at 3:45 pm of Resident #3's medication on hand for administration revealed:<br>-There were 2 bottles of Januvia 50 mg and 100 mg that the resident brought from home.<br>-There was a bottle of Amlodipine 2.5 mg that the resident brought from home.<br><br>Interview on 09/06/17 at 4:00 pm with the Medication Aide revealed:<br>-She had worked at the facility for a year.<br>-She was not aware she had administered the incorrect dosage.<br>-She was not aware there were two different Januvia bottles with different dosages.<br><br>Interview on 09/06/17 at 4:20 pm with the Administrator-in-Charge revealed:<br>-She had been the Administrator for about 5 months.<br>-She was not aware Resident #3 had received the incorrect dose of Amlodipine and Januvia during the 09/06/17 morning med pass.<br>-She had notified Resident #3's Prescribing Physician and the contracted pharmacy.<br><br>Attempted telephone interview on 09/06/17 at 12:51 pm with Resident #3's Primary Care Physician was unsuccessful. | {D 358} | | |