Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 01/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

County: Buncombe

(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
C 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual and follow-up survey on January 6, 2015 and January 7, 2015.	C 000		
C 236	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to assure a care plan was developed in conjunction with the resident assessment within 30 days following admission for 1 of 3 residents sampled (#3). The findings are: Review of Resident #3's current FL-2 dated 10/13/14 revealed: -Diagnoses included schizophrenia, cocaine dependence/early remission, borderline intellectual functioning, seizure disorder, hyperlipidemia, and diabetes mellitus type II. -Resident Information had not been filled out apart from nutrition status, where regular diet was indicated. Review of Resident #3's record revealed: -Admission date of 11/8/14. -A completed Resident Register dated 11/8/14. -Resident #3's care plan was missing from the	C 236	Administrator will assure care plan is completed with in 30 days of admission and signed by physician within 15 days of assessment completion.	2/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrater (X6) DATE 2/16/15

Approved 2/23/15 Casey Fitzgerald

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C 236	Continued From page 1 resident record. -Accident reports show Resident #3 has had two falls since admission to the facility, on 11/10/14 and 12/17/14. -The fall on 11/10/14 resulted in a need for EMS transport and sutures at the hospital emergency department. -Resident #3 had a history of inappropriate sexual behaviors toward facility staff, other residents, and medical professionals in the community. Interview with the Administrator on 1/6/15 at 11:00am revealed: -There had been substantial turnover in Supervisor in Charge (SIC) staff position since Resident #3's admission, including a resignation two days ago. -There are no permanent SIC's currently employed at the facility. -She thought the most recent SIC had completed the care plan, but she had not reviewed it herself. -Resident #3 required some supervision with activities of daily living. Interview and observation of Resident #3 on 1/6/15 at 9:30am revealed: -Resident was not able to provide much information of care needs, care provided or medication regimen. -Resident had no complaints about the care he received at the facility and did not verbalize any unmet needs. -Resident had a court-appointed legal guardian. -Resident appeared to be well-groomed and dressed appropriately in clean clothing with no apparent odor and no apparent marks, bruises, or injuries on exposed skin. Interview of Resident #3's legal guardian on 1/6/15 at 3:00pm revealed:	C 236		

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C 236	Continued From page 2 -Guardian had worked with Resident #3 for just one month. -Resident #3 had an EEG scheduled in February 2015 because resident had reported he had been having 5 to 7 seizures per week. Facility staff does not corroborate, therefore it's unknown how much seizure activity he has had. -Resident #3's current neurologist discontinued his Trileptal (used to treat partial seizures in adults) and prescribed Topamax (used to treat seizures in adults) in its place because resident's sodium level was "dangerously low". Interview with the Administrator on 1/6/15 at 3:30pm revealed: -Administrator had looked through facility's storage for the care plan. -Administrator was unable to find a care plan for Resident #3. Interview with the Administrator on 1/7/15 at 10:00am revealed she is responsible for the completion of the care plans. Interview with the Administrator on 1/7/15 at 10:45am revealed she was not aware of Resident #3 having seizures.	C 236		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by:	C 284	Administrator will assure that menus for therapeutic diets are posted within the facility at all times. Administrater will assure all therapeutic diets are followed according to physician orders. Administrater	2/21/15

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C 284	Continued From page 3 Based on observation, interview, and record review, the facility failed to serve one of three sampled residents (#1) a diabetic, no concentrate sugars (NCS) diet as ordered. The findings are: Review of Resident #1's record on 1/6/15 revealed: -Diagnosis of diabetes mellitus. -An order for a diabetic/NCS diet. Observation of the 1/6/15 lunch meal at 12:10pm revealed all residents were served: -Roast Beef sandwich with condiments. -Potato chips. -Sliced tomatoes. -Pickles. -Unsweetened tea (a sugar substitute was available). -Fruit. Observation on 1/6/15 at 1:05pm revealed: -A regular diet/no added salt menu and snack menu were posted on a kitchen cabinet door. -There was no listing of resident diets posted in the kitchen/dining area. -There was no diabetic menu posted in the kitchen/dining area. -There was a stack of menus on the kitchen counter under the posted menus, under a loaf of bread. Interview with Supervisor-in-Charge (SIC) on 1/6/15 at 1:10pm revealed: -She is relief staff and usually worked in one of the other homes. -She had started working at 9:00am this morning. -In the home she usually works in there was a resident diet list posted in the kitchen.	C 284	will monitor weekly for compliance	

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C 284	Continued From page 4 -She did not know reason there wasn't a list for the resident's diets posted in this home. -She had looked in each resident's record this morning to determine their diet orders. -She knew from experience what to fix for diabetics. -She knew there still needed to be a posted menu and it was to be followed. Observation on 1/6/15 at 1:15pm revealed the SIC looked through the stack of menus on the kitchen counter and did not find a diabetic menu. "I guess I will have to go next door and get one." Observation on 1/6/15 at 1:30pm revealed SIC provided surveyor with a copy of a diabetic/NCS menu. Review on 1/6/15 at 1:30pm of the regular and diabetic menus revealed residents were to be served: -Chicken Cacciatore, 3 oz. no added salt. -Candied yams, 1/2 cup. -SF green beans, 1/2 cup. -Sliced tomato salad, 1/2 cup. -Whole grain bread, 1 slice. -Margarine, 1 tsp. -Strawberries, 1/2 cup. -Milk, 2%, 8 oz. Interview on 1/6/15 at 2:25pm with Resident #1 revealed: -She had a "sandwich with chips, a pickle, an orange and tea." -She "ate it all, it was very good." Interview with the Administrator on 1/6/15 at 2:30pm revealed: -She was not aware that a diabetic menu was not posted in the facility.	C 284		

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C 284	Continued From page 5 -"I've been replacing menus all the time." -The "majority of the time the staff will have what is on the menu." -"I've told staff to go by the menu." -She would make sure menus are posted and followed as ordered. Observation on 1/7/15 at 9:30am revealed: -A hand-written list of resident diets posted on the refrigerator door in the kitchen with two of the six residents listed as having NCS therapeutic diet orders. -The regular diet and snack menus were posted on a kitchen cabinet door. -The diabetic/NCS menu was on the kitchen counter directly below the posted menus. -The SIC stated she would post the diabetic/NCS menu next to the other menus.	C 284		
C 294	10A NCAC 13G .0905(f) Activities Program 10A NCAC 13G .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure residents had the opportunity to participate in at least one outing every other month. The findings are: Interview with the Supervisor In Charge (SIC) on 1/6/15 at 9:00am revealed there were six residents residing in the home.	C 294	Administrator will assure activity Calander is posted with 14 hours of activities provided every week. Administrator will assure a outing is provided every other month. Administrator will monitor activities weekly to assure activities are offered to the residents.	2/21/15

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C 294	Continued From page 6 Observation on 1/6/15 at 9:05am during the initial facility tour revealed: -An activity calendar for December 2014 was posted in the hall of the facility. -There was at least 14 hours of activities scheduled weekly. -There was no scheduled outing on the calendar. Confidential interviews with six of six residents during the survey revealed: -Activities listed on calendar were available and offered for participation within the facility. -Five residents stated there were no opportunities offered to participate in at least one outing every other month. -Five residents stated they would like to go out shopping. -When asked if staff offer outings, five residents stated "no". -Five residents stated they would enjoy going on an outing away from the facility if offered to them. -One resident was not available for interview. -One resident stated they choose not to participate in activities within the facility. -There were no opportunities offered by facility to participate in at least one outing every other month. -One resdient indicted they would enjoy going on an outing if offered by the facility. Interview with the Administrator on 1/6/15 at 12:30pm revealed: -She made an effort to take residents individually on outings in her personal vehicle. -There was no facility vehicle to transport residents on outings at least every other month. Interview with the SIC on 1/6/15 at 2:20pm revealed:	C 294		

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C 294	Continued From page 7 -She is relief staff and usually worked in one of the other homes. -She had started working in this home at 9:00am this morning. -She stated the Administrator will take residents to local retail department stores in her personal vehicle. -The facility doesn't have a vehicle to transport residents. Observation on 1/7/15 at 9:00am revealed: -The SIC provided surveyors with the January 2015 activities calendar. -There was no scheduled outing on the calendar. Interview with the Administrator on 1/7/15 at 10:55am revealed: -"I do take them to (local retail, department and convenience) stores." -"We (referencing the owner) just talked about this." -"The big issue is not having a van." -She stated she had taken residents to local retail department stores.	C 294		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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:	C 330	Administrator will assure medications are being administered per physicians orders. Administrator will assure all medication orders are accurate according to all physician orders and all documentation for current medication orders are in the residents record.	2/2/15

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C 330	Continued From page 8 TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure Depakote was administered as prescribed for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's FL-2 dated 10/13/14 revealed: -Diagnoses included schizophrenia, cocaine dependence/early remission, borderline intellectual functioning, seizure disorder, hyperlipidemia, and diabetes mellitus type 2. -Depakote 500 mg, one tablet by mouth twice daily. -Depakote Delayed Release (DR) 250 mg (used to treat seizure disorders), one tablet by mouth every night. Interview with Resident #3 on 1/6/15 at 9:30am revealed: -Resident was not able to provide much information of his medication regimen. -Resident had no complaints about the care he received at the facility and did not report any unmet needs. -Resident had a court-appointed legal guardian. Review of Resident #3's record on 1/6/15 at 10:40am revealed: -The resident was discharged from another facility on 11/07/14. -The resident was admitted to the facility on 11/8/14. -There was no documentation of contact with the resident's physician for verification of medication orders upon admission. -Review of November 2014 Medication	C 330	Administrator will assure all medication changes are reviewed weekly to assure compliance.	

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C 330	Continued From page 9 Administration Record (MAR) from the prior facility revealed a Depakote medication change effective 10/20/14 to 750 mg nightly (500 mg and 250 mg tablets). -There were no other physician's medication orders in the record. Review of Resident #3's November 2014 MAR on 1/6/15 revealed: -A hand-written entry for Depakote ER 500 mg tab take 1 tablet by mouth at bedtime with 250 mg ER tablet for 750 mg ER dose. -750 mg of Depakote ER nightly was documented as administered. Review of Resident #3's December 2014 MAR on 1/6/15 revealed: -There was a hand-written entry to discontinue Depakote ER 500 mg, twice daily on 10/20/14. -There was a handwritten entry for "Depakote ER 500 mg, two tablets by mouth at bedtime with 250 mg pill at a total of 1250 mg at bedtime". -1250 mg of Depakote at bedtime was documented as administered. Review of Resident #3's January 2015 MAR on 1/6/15 revealed: -There was a handwritten "changed order on 10/20/14" entry for Depakote ER 500 mg tab, twice daily. -Depakote DR 250 mg at bedtime was the only amount of Depakote documented as administered. Interview with the Administrator on 1/6/15 at 2:00pm revealed: -At admission the facility received a copy of Resident #3's November 2014 MAR from the prior facility. -The Supervisor on duty at the time of Resident	C 330		

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C 330	Continued From page 10 #3's admission generated the November 2014 MAR to reflect what was printed on the pharmacy-generated MAR from the prior facility. -Administrator did not know why the MARs for November 2014, December 2014, and January 2015 had different instructions for administration of Depakote ER 500 mg. -She had not reviewed the MARs for accuracy. -She was unable to find the doctor's orders. -She would get clarification of the Depakote orders. -She was not aware of Resident #3 having seizures. Telephone interview with the pharmacy on 1/6/15 at 2:33pm revealed: -The pharmacy had Resident #3's FL-2 dated 10/13/14 on file. -The pharmacy packaged Resident #3's medications based on the FL-2 dated 10/13/14. -MARs were printed based on current medication orders on file at the pharmacy. -The pharmacy's records show that Resident #3 was prescribed one tablet of Depakote 500 mg twice daily and one tablet of Depakote 250 mg at bedtime, for a total of 500 mg in the morning and 750 mg at night. -The pharmacy had contacted the facility requesting the facility obtain clarification from Resident #3's physician regarding whether the medication was to be Depakote DR or Depakote ER. -The pharmacy had not heard back from the facility on this issue. Interview of Resident #3's court-appointed legal guardian on 1/6/15 at 3:00pm revealed: -The legal guardian had worked with Resident #3 for approximately one month. -The legal guardian did not know what the current	C 330		

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C 330	Continued From page 11 order was for Resident #3's Depakote. -Resident #3 had reported to his neurologist of having 5 to 7 seizures per week. -The legal guardian indicated facility staff did not report any seizure activity for Resident #3, therefore it's unknown how much seizure activity he has had. -Neurologist had scheduled an EEG in February 2015. Telephone interview on 1/6/15 at 4:38pm with staff at Resident #3's primary care physician's office revealed: -The facility had provided them with a list of Resident #3's medications. -The primary care physician did not prescribe the Depakote. Observation of Resident #3's medication on hand in the medication cart on 1/7/15 at 9:20am revealed: -There were unused pharmacy packaged medications (bubble packs) of Depakote ER 500 mg on hand for Resident #3. -There was a partial bubble pack card of Depakote DR 250 mg on hand. Interview of Administrator on 1/7/15 at 10:45am revealed: -She had obtained a copy of the 10/20/14 change orders from Resident #3's prior facility. -The 10/20/14 change orders indicated the resident was to receive Depakote 1250 mg at bedtime (1-250 mg DR tablet and 2-500 ER mg tablets). -She indicated the change orders were a copy of the electronic prescription on file at the pharmacy. -She wasn't sure the reason the pharmacy's records and the pharmacy-generated MARs show that Resident #3 is to be given 500 mg of	C 330		

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C 330	Continued From page 12 Depakote ER in the morning and 750 mg of Depakote DR at bedtime. -She did not know the pharmacy had requested clarification on Resident #3's Depakote medication order. -She did not know if either of the former Supervisors had requested clarification from the physician. -She will follow up today to obtain clarification with prescribing physician. A plan of protection was provided by the facility on 1/21/15 and included the following: -Administrator will ensure that the residents physician or prescribing practicioner is contacted for verification or clarification of medication orders. -Upon admission to the facility all orders will be clarified with the physician immediately to assure all medication orders are accurate. -Facility will place clarification documentation the ther resident record for review. -The administrator will assure all corrections are made to the MAR. -The administrator will assure that all clarification or medication clarifications are dated within 24 hours of admission or readmission. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 21, 2015.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	C 912	Administrator will assure residents receive care and services which are adequate, appropriate and in compliance with rules and regulations.	2/21/15

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C 912	Continued From page 13 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 are adequate, appropiate and incompliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observation, interview and record review, the facility failed to assure Depakote was administered as prescribed for 1 of 3 sampled residents (#3). [Refer to Tag 330, 10A NCAC 13G .1004(a) (Type B Violation)].	C 912		

Shook, Linda

From: Shook, Linda
Sent: Monday, March 02, 2015 2:03 PM
To: Cathie Beatty (Cathie.Beatty@buncombecounty.org)
Cc: Fitzgerald, Casey E; Penland, Beverly D
Subject: WOODLAND TERRACE FAMILY CARE HOME #3 - BUNCOMBE COUNTY
Attachments: Woodland Terrace #3 2015-02-16 POC-9XFZ11.pdf

Please find attached copy of the approved Plan of Correction (POC) for the above referenced facility.

Thank you.

Linda Y. Shook, Processing Assistant
Adult Care Licensure Section
NC Department of Health and Human Services
Division of Health Service Regulation
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