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
	HAL034035	A. BUILDING: ______ B. WING ______	C 04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE REYNOLDA ROAD	2980 REYNOLDA ROAD WINSTON SALEM, NC 27106

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D 000	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services conducted a complaint investigation on 04/08/15 through 04/14/15. The complaint investigation was initiated by the Forsyth County Department of Social Services on 03/25/15.	D 000		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide clean and appropriate bedding for 3 of 33 residents' rooms (Rooms #35, #37, and #25). The findings are:	D 087		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Observation of Room #35 on 04/14/15 at 10:30 am revealed:
-Two beds in the room.
-A resident lying on bed #2 on top of the bedspread.

Interview on 04/14/15 at 10:30 am with a resident in Room #35 revealed:
-Sheets were supposed to be changed on the days that they received showers.
-He had not been receiving assistance with showers twice a week.
-He had to put cream on his feet at night for arthritis and they soiled his sheets.
-His sheets had stains on the top sheet and bottom sheet from the cream.
-His sheets had not been changed by staff in three weeks.
-He had requested to staff (Resident Care Assistants (RCA) and Medication Aides(MAs)) on numerous occasions that his sheets needed to be changed, but they had not been changed.
-He changed the sheets on his bed himself last week.
-The facility had a lot of staff turnover recently that impacted the residents sheets not being changed by staff.

Observation on 04/14/15 at 10:35 am in Resident Room #35 revealed:
-Bed #2 had a fitted sheet with a brown-colored stain on the mid-right side of the fitted sheet approximately two inches in diameter and a smeared brown stain on the lower right side of the fitted sheet approximately three inches in length and two inches in diameter.
-The top sheet on his bed had two round brown-colored stains on the lower right side of the top sheet approximately one inch in diameter each.

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-No permeable odor was noted.

Observation on 04/14/15 at 4:55 pm in Resident Room #35 revealed:
-Bed #2's sheets had not been changed.
-The resident had a clean top sheet folded over a chair near his bed.
-The resident picked up one of the two pillows from his bed and smelled the pillowcase.
-The pillowcase appeared "dingy white", but no noticeable stains were visible.

Second interview with the resident in room #35 on 04/14/15 at 4:55 pm revealed:
-The resident's sheets, both top and bottom, as well as the pillowcase, on bed #2 had not been changed since the observation and resident interview at 10:35 am.
-His pillowcase "smelled" and he thought it needed to be changed as well as his sheets.
-He had informed the Medication Aide (MA) this afternoon that he had asked several staff to change his sheets and they had not changed them yet.
-The MA told him that she would ask staff to change his sheets tonight .

Review of the resident's Personal Care Service (PCS) Record for April 2015 revealed no documentation that bed linens had been changed.

Observation of a resident in Resident Room #37 on 04/14/15 at 11:06 am revealed:
-A resident sitting in the bedroom in a wheelchair with tears in her eyes appearing distressed.
-The resident was leaning from her wheelchair and pulling on the sheets of her bed.
-The resident resided in a private room with only one bed.

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Observation of the linens on the bed in Resident Room #37 on 04/14/15 at 11:05 am revealed:
-There were two brown stains, approximately two inches in diameter, in the middle of the fitted sheet.
-There was a top sheet (no stains noted) and a bedspread on the bed.

Interview with the resident in Room #37 revealed:
- "I need my bed changed. It is dirty and I don't know who to tell."
-"They have only changed it one time since I have been here. "
- Resident was not certain of when she was admitted to the facility, but she thought it had been several months.
- Resident had "sores" on her feet and had to have an ointment put on her feet each night and the ointment soiled the bed.
-Resident had not asked any staff to change the sheets on her bed.
-Resident requested the surveyor to ask staff to change her linens.

Review of the resident's PCS Record for April 2015 revealed bed linens were changed once in April on 04/14/15 on first shift by an RCA with no time noted.

Surveyor notified the a staff person the resident requested bed linens to be changed because no PCA was located on the hall.

Observations at later times attempted to follow-up if the bed linens were changed were unsuccessful.

Interview with a family member revealed:
-She visited relatives at the facility daily.

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-The facility did not have enough staff to assist residents who needed bed linens changed.
-For the past month there had been a problem with facility staff changing her relative's bed linen.
-The family member was aware staff should change bed linen weekly, but said most times bed linen did not get changed, unless the family member changed the bed linen.
-The family member said when in the facility, it was hard to find a staff person to ask to change the bed.
-The family member had even started writing the dates on the corner of the sheets to see if staff were changing the bed linen.
-Staff were not changing the bed linen.
Interview with a resident on 04/14/15 at 9:15 am revealed:
-The facility did not have enough staff to change linens as often as they needed to be changed.
-For that reason, she changed her own sheets.
-The resident had changed the sheets on her bed the day before.

Observation on 04/14/15 at 9:20 am revealed the resident's bed was covered with a bedspread and was neatly made.

Confidential interviews with six staff persons revealed:
- One staff person stated that linens were to be changed on both bath days.
- One staff person stated that linens were to be changed on the first shower day of the week and as needed at this facility.
-Staff was aware that residents were not getting their baths as scheduled.
-There were times when a resident would go as long as a week without a bath.
-Some days there would only be one RCA on duty.

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-The RCA's were responsible for documenting tasks that they completed each day for each resident they assisted, including changing linens.
-The documentation of tasks was kept in a Personal Care Service (PCS) binder.
-There was a "Shower Assignment Sheet" that let staff know who was scheduled for baths on which days.
-The Executive Director was responsible for monitoring PCS documentation.

Interview with the Executive Director on 04/14/15 at 5:35 pm revealed:
-The policy of the facility was that residents' sheets are to be changed on their shower days.
-She was not sure how the facility determined which days the resident's sheets were to be changed if they did not require assistance with bathing.
-The facility had a weekly bath schedule that designated the days that residents were to receive baths or showers.
-She was not aware there were residents whose sheets had not been changed as scheduled or requested.
-Residents whose sheets became soiled due to ointments would need their sheets changed more often.

D 167 — D 167

10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation

10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation
Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver,

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D 167	Continued From page 6 provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record reviews, there were 31 of 69 shifts from 03/15/15 to 04/07/15 when there was no staff scheduled who had completed cardiopulmonary resuscitation training within the past 24 months. The findings are: Review of staffing schedule from 03/15/15 to 04/07/15 revealed there were 31 of 69 shifts when there was no staff scheduled who had completed cardiopulmonary resuscitation training within the past 24 months. Interview on 04/08/2015 at 2:45 pm with Executive Director (ED) revealed: -She and the lead Supervisor (LS) were responsible for the staffing schedule. -She was aware there was supposed to be a CPR certified staff person on duty at all times. -The county Adult Home Specialist informed her in March 2015 that there was not a CPR certified staff on duty at all times as required, so she had "been trying to get staff certified". -She scheduled a CPR training class for 04/02/2015 and several staff got trained at that time. -If a resident required CPR or Heimlich and there	D 167		

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was not a CPR-certified staff person on the premises, she would expect staff to call 911.

Interview on 04/08/2015 at 2:25 pm with the Lead Supervisor (LS) revealed:
-She had been assisting the ED with scheduling since February 2015.
-She did not know whose responsibility it was to ensure there was CPR-certified staff on duty at all times.
-No residents had required CPR or the Heimlich since she began working at the facility a year ago.

A. Review of Staff A's personnel file revealed:
-Hire date of 08/12/15 as a Medication Aide.
-No documentation of CPR training within the past 24 months.

Interview on 04/08/15 at 2:25 pm with Staff A revealed:
-She had CPR training in the past but it was currently expired.
-She could not remember when her certification had expired.
-She had been assisting the ED with scheduling since February 2015.
-She did not know whose responsibility it was to ensure there was a CPR-certified staff on duty at all times.
-No residents had required CPR or the Heimlich since she began working at the facility almost a year ago.

B. Review of Staff B's personnel file revealed:
-Hire date of 06/12/12 as a Medication Aide.
- No documentation of CPR training.

Interview on 04/08/15 at 8:15 am with Staff B revealed:
-She was not CPR certified.

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-There had been times in the past when a CPR class was scheduled but she did not attend.
- No one ever questioned her about whether she was CPR certified.
- No one ever told her what the protocol was if someone required CPR and there was not any staff onsite to assist.
- If CPR was needed while she was on duty she would call 911.
- She did not take the CPR certification class that was recently scheduled on 04/02/2015.

C. Review of Staff C's personnel file revealed:
-Hire date 03/04/13 as Resident Care Aide (RCA).
-Staff C later became a Medication Aide (MA), but there was no documentation in the personnel file to indicate when the change was made.
- No documentation of CPR training.

Interview on 04/10/15 at 2:25 pm with Staff C revealed:
-She was not CPR certified.
-No one questioned her about getting her certification.
-While she was duty she never had an instance where CPR was needed and if the need arose she would call 911.
-She took the CPR training class that was offered on 04/02/2015.

D. Review of Staff D's personnel file revealed:
- Hire date of 02/01/2015 as a Resident Care Aide.
- No documentation of CPR training.

Interview on 04/13/15 at 3:20 pm with Staff D revealed:
-She was not CPR certified.
-She took the CPR training class that was offered

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on 04/02/2015.
-She has never worked when a resident required CPR or Heimlich.
-There was not a protocol as to what to do if someone was in crisis and needed CPR but she knew to call 911.

E. Review of Staff E's personnel file revealed:
-Hire date of 05/05/2014 as a Medication Aide.
-No documentation of CPR training.

Interview on 04/09/15 at 3:20 pm with Staff E revealed:
-He had not had CPR training within the past 24 months.
-He was told a class was going to be scheduled, but he did not attend.
-He had been working a lot of double shifts alone and was too tired.
-He had never worked when there was a situation where CPR would have been needed.
-He would call 911 if someone needed CPR.

F. Review of Staff F's personnel file revealed:
-Hire date of 10/02/14 as a Medication Aide.
-No documentation of CPR training.

Telephone interview on 04/15/15 at 1:08 pm with Staff F revealed:
-She terminated her employment with the facility in the first week of April 2015.
-She had not had CPR training within the past 24 months.
-She was told a class was going to be scheduled soon, but it was not mandatory for them to attend.
-While in employment, there was never a time when CPR was needed.
-She knew to call 911 if CPR was needed.

G. Review of Staff G's personnel file revealed:

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D 167	Continued From page 10 -Hire date of 06/13/2013 as a Medication Aide. -No documentation of CPR training. Interview on 04/08/15 at 8:35 am with Staff G revealed: -She had not had CPR training within the past 24 months. -She did not take the class that was scheduled on 04/02/2015. -She never had a situation when CPR needed to be performed. -There was no protocol for what to do if someone required CPR assistance but she knew to call 911. H. Review of Staff H's personnel file revealed: -Hire date of 06/02/2013 as a Medication Aide. -Documentation of CPR training 03/13/2013. Telephone interview on 04/14/15 at 3:30 pm with Staff H revealed: -Her last day of employment was 04/02/2015. -She was aware a CPR certified staff had to be on every shift. -She was never asked by the LS or the ED that made the schedule if she was CPR certified. -While employed here, there was never a situation where she had to use CPR.	D 167		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter.	D 176		

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The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure the Administrator was responsible for the total operation of the facility to maintain compliance in the rule areas of health care, medication administration, staff qualifications, staffing, training in cardiopulmonary resuscitation, personal care and supervision, infection prevention, resident rights, housekeeping, accuracy of medication administration records, and self-administration of medications.

The findings are:

Interviews on 04/08/15 at 2:45 pm and 04/14/15 at 11:15 am with the Executive Director (ED) revealed:
-She began working at the facility on 02/09/15.
-She had been a licensed adult care home Administrator previously but her license had expired.
-The Regional Nurse was the Administrator of record while the ED was getting her Administrator's license reinstated.
-The ED was responsible for the day to day operations of the facility.

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-The Resident Care Coordinator (RCC) handled all the clinical aspects of the facility, such as medications, providing care, and physician appointments and visits.
-The RCC quit on 03/07/15 and the position had not yet been filled.
-The medication aides (MAs) and a nurse from a sister facility were working together to ensure the duties of the RCC were done.

A. Based on observation, record review and interviews, the facility failed to schedule appointments for referrals as ordered by the physician for 5 out of 10 sampled residents with mental health and new physician referral (Resident #2), dermatologist and mental health referral (Resident #16), ENT and GI referral (Resident #4), dermatologist referral and response to chest pain (Resident #9), and order for hospital bed (Resident #17). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]

B. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 of 7 residents (#9, and #10) observed during medication administration which included errors with medications for vitamin supplementation, elevated lipids, allergies, skin disorders, and convulsion, and 5 of 10 residents (#9, #12, #18, #22, #16) sampled which included errors with medications for chest pain, pain, insomnia, allergies, skin disorders, and convulsions. [Refer to Tag D 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]

C. Based on interview, observation and record review, the facility failed to assure supervision for

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3 of 3 sampled residents (Resident #19, #17, and #8) who were at risk for frequent falls resulting in injury to Residents #19, #17, and #8.[Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]

D. Based on interview and record reviews, there were 31 of 72 shifts from 03/15/15 to 04/07/15 when there was no staff scheduled who had completed cardiopulmonary resuscitation training within the past 24 months. [Refer to Tag 167, 10A NCAC 13F .0507 Training in Cardiopulmonary Resuscitation.]

E. Based on observations, interviews, and record reviews, the facility failed to ensure minimal staffing requirements were being met for all shifts from 02/01/15 through 04/08/15. [Refer to Tag 201, 10A NCAC 13F .0604 Personal Care and Other Staffing (Type B Violation).]

F. Based on observation, record review, and interview the facility failed to provide bathing assistance for 4 of 9 sampled residents who were unable to attend to personal care needs independently (Residents #7, #18, #22, and #23). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation).]

G. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 8 sampled staff who administered medications had completed the clinical skills validation portion of the competency evaluation prior to the administration of medications (Staff C and Staff I). [Refer to Tag 935, G.S.&131D-4.5B(b) Adult Care Homes Medication Aides: Training and Competency (Type B Violation).]

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D 176	Continued From page 14 H. Based on interviews and record reviews, the facility failed to ensure every resident was free from neglect, related to the mistreatment of residents by 1 staff member (Staff A). [Refer to Tag 338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation).] I. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the use of "house" glucometers for multiple residents and sharing labeled glucometers for 2 of 2 sampled residents (Residents #3 and #4). [Refer to Tag 932, G.S. 131D-4.4A(b) Adult Care Homes Infection Prevention Requirements (Type B Violation).] J. Based on observations, record reviews, and interviews, the facility failed to provide clean and appropriate bedding for 3 of 4 residents' rooms (Rooms #35, #37, and #25). [Refer to Tag 087, 10A NCAC 13F .0306(b)(1) Housekeeping and Furnishings.] K. Based on observation, interview, and record review, the facility failed to assure medications were administered to residents within one hour before or one hour after scheduled medications for 6 of 7 residents (Residents #10, #9, #11, #12, #13, and #14) observed during medication administration on 4/08/15. [Refer to Tag 364, 10A NCAC 13F .1004(g) Medication Administration (Type B Violation).] L. Based on observations, interviews and record reviews, the facility failed to assure accuracy of the Medication Administration Record (MAR) including documentation of any omission of medications or treatments and the reason for the	D 176		

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omission, including refusals, for 3 of 3 sampled residents (Residents #4, #7 and #16). [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration.]

M. Based on interview and record review, the facility failed to assure physician contact regarding 1 of 1 resident (Resident #5) sampled who was non-compliant with self-administered medications. [Refer to Tag 376, 10A NCAC 13F .1005(b) Self-Administration of Medications.]

____

On 04/14/15, the Administrator submitted a Plan of Protection as follows:
-The facility management team would be re-educated regarding the role of the Executive Director/Administrator including expectations, follow through, and documentation.
-The Director of Operations or Director of Clinical Services would review manager meeting minutes to ensure follow up of all concerns.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.

D 201 10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing D 201

10A NCAC 13F .0604 Personal Care And Other Staffing
(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.
(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide

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duty hours on each 8-hour shift shall at all times be at least:
(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure minimal staffing requirements were met for all shifts from 02/01/15 through 04/08/15.

The findings are:

Interviews with the Business Office Manager, Executive Director, and Lead Supervisor at various times from 04/08/15 through 04/10/15

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revealed:
-There had been many revisions to the schedule since it was originally posted.
-The revisions were not documented on the schedule, so the currently posted schedule was not accurate.
-There was no documentation to show what revisions had been made.
-The electronic system used to clock in and out was currently out of order.
-It was unable to be determined what staff or how many staff had been on duty in the facility at any given time from 02/01/15 through 04/08/15.

Review of county monitoring visits on 02/10/15, 03/25/15, 03/31/15, and 04/08/15 revealed the facility census ranged from 47 to 52 residents.

Interview on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
-She knew "exactly" how many staff were supposed to be scheduled for each shift.
-Day shift was supposed to have 2 MAs and 2.5 Resident Care Aides (RA).
-Evening shift was supposed to have 2 MAs and 2 RAs.
-Night shift was supposed to have 1 MA and 1 RA.
-For about the past four months, there had usually been 1 MA and 2 RAs on day shift, 1 MA and 1 RA on evening shift, and 1 MA and 1 RA on night shift.
-The current census was 48.

Interviews on 04/10/2015 at 3:34 pm and 04/14/15 at 5:35 pm with the Executive Director (ED) revealed:
-She was aware the facility was not meeting staffing requirements.
-There had been several staff leave recently and

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there was not enough staff to meet the requirements.
-They were trying to get new staff hired and trained as quickly as possible.
-She had sent out a request by email to sister facilities asking for help but received no response because "the other buildings are short too".
-The policy of the facility was that all residents were supposed to be scheduled for showers and linen changes twice weekly.
-The facility had a bathing schedule that designated which days each resident was to receive their bath.
-She was not aware that there were residents were not being bathed and linens changed according to the schedule.

Confidential interviews with 35 of 48 residents at various times from 04/08/15 through 04/14/15 revealed:
-There were numerous complaints of staff shortage.
-Meals and medications were late due to shortage of staff.
-One resident stated that in the past few weeks there had been only one staff person scheduled to administer the medications on the evening shift.
-"They need help. It is not fair to the staff or the residents."
-"They have been short of help for about two or three weeks".
-One resident stated (at 11:50 pm) that he had not yet received his 8:00 am medications today. He thought the facility may not have enough staff.
-The staff that works here is helpful and kind, but is overworked because there is not enough staff.
-Sometimes there was only one or two staff people for the whole building.
-One resident stated she was thankful she did not

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have to ask for help very often because there was not enough help.
-Usually they don't have enough staff, especially on the weekends.
-She used her call bell to request assistance from staff, but there was not enough staff to answer call lights timely. "Sometimes they come and sometimes they don't. If you were dying, you would be dead before they get to you."
-The facility did not have enough staff (Resident Care Assistants) to help serve meals to the residents.
-Residents had to sit in the dining room and wait to be served because there was not enough staff to serve.
-The staff "never knows what job they are going to be doing" because the facility did not have enough staff.
-One resident stated she fell while in the shower and broke her wrist. Staff was supposed to be helping her with her showers twice a week but were not because of shortage of staff.
-They had been short of help for about two or three weeks.
-One resident stated since there was not enough staff to assist with showers, she thought she "might start doing my own showers but I'm afraid I might fall."
-One resident stated she was supposed to receive showers twice a week, but "my name is not on the shower list because they have so many people to shower."
-One resident stated when she had plans for an activity, she had to request her showers the day prior so she can remind them of her needing help with her shower and she had missed bible study because she did not get her shower when the facility was short on staff.
-There was not enough staff to make sure everyone get their showers.

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-There needed to be more staff to do all the work that needs to be done.
-One resident stated, "I don't get two showers a week because they don't have enough staff working here." He had received a shower once a week for the past two weeks.

Confidential interviews with four family members revealed:
-The facility was always short of staff.
-Some days there was only one staff person in the dining room to serve meals.
-One family member said her relative told her that one day the resident got one piece of toast for breakfast because there was no one to serve the meal.
-Two days the family member recalled the facility ordering out for fast food (chicken and pizza) because there was no staff to cook the meals.
-The family member said there was no staff (Resident Care Assistants) to serve or help the residents in the dining room. There was usually only one Resident Care Assistant to serve all the residents.
-One family member said her relative was ordered compression stockings and when she came to the facility, the stockings were not on the resident, but she did not tell anyone, because it was usually hard to find staff to tell.
-One family member stated their resident went 12 days before getting a shower because of the shortage of staff.

Confidential interview with a visiting staff member revealed:
-She was in the facility several days each week.
-Most days during her visit there was one Medication Aide on duty and one Resident Care Assistant.
-The morning medication pass was never

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completed before lunch.
-The residents at the facility complained to her daily about not enough staff being present in the building to assist with their activities of daily living care.
-Resident complaints were also about medications not being administered, medications being out of stock or medications being administered up to two hours late.

Confidential interviews with 10 staff at various times from 04/08/15 through 04/14/15 revealed:
-Sometimes there was only one Medication Aide for the morning medication pass and she was told she had to pass all the meds.
-Not enough staff to take care of the residents needs.
-There were 52 residents with only 2 staff people (Resident Care Aides) to serve breakfast and that staff also had to do baths, give out medications, and clean the dining room.
-Staff had been leaving because of being over worked.
-The medication aides do not have enough time to pass the medications for the residents.
-Sometimes when you come to work you end up staying to work double shifts because no one was scheduled to come in on the next shift.
- Many times there was not a staff name on the schedule for third shift because there was only one third shift medication aide and she had to have some time off.
-The management never helped to fill in the holes on the schedule.
-The nurse from a sister facility, who was sent to help get the facility "turned around", told staff when she first came that she did not do direct care for residents.
-One staff stated the only time she saw management working the medication cart or

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doing personal care was when the regulatory personnel were in the building and even then the medications were still given late.
-Staff stated residents were complaining but it could not be helped when there was only one person trying to get everything done.
-Sometimes there would be two medication aides but only one would do all the work. The new Lead Supervisor (LS) wouldn't help unless you went directly to her and sometimes it was just easier to do it yourself.
-There had been problems with not being able to do all baths due to a shortage of staff.
-One staff person stated she felt bad knowing there was not a lot that one person could do alone.
-Residents often complain about not receiving baths due to the shortage of staff.

____

On 04/10/2015, the Administrator submitted a plan of correction as follows:
-Current staffing schedule will be reviewed immediately to ensure appropriate staffing requirements are met on all shifts.
-ED or designee will review and assure appropriate staffing needs are met at all times.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2015.

D 269 10A NCAC 13F .0901(a) Personal Care and Supervision D 269

10A NCAC 13F .0901 Personal Care and Supervision
(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care

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needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observation, record review, and interview the facility failed to provide bathing assistance for 4 of 9 sampled residents who were unable to attend to personal care needs independently (Residents #7, #18, #22, and #23).

The findings are:

A. Review of Resident #7's current FL-2 dated 5/19/14 revealed:
- Diagnoses included coronary artery disease, s/p (status post) coronary artery bypass graft, hypertension, chronic obstructive pulmonary disease, and hyperlipidemia.
Observation of Resident #7 on 04/14/15 at 10:35 revealed:
-Resident lying on top of bedspread on bed #2.
-Resident was dressed in street clothes.
-Resident was able to get off the bed to ambulate without assistance.
-Resident was upset that there was "not enough staff" to assist residents with showers.

Review of Resident #7's Personal Service Plan (PSP) dated 05/20/14 revealed:
-Staff was to provide set-up, selection or laying out of showering supplies and safety devices as needed.
-Resident used a shower chair.
-Resident was able to perform the showering task of washing his upper body with staff attention and/or verbal prompts as needed.
-Preferred shower or bath days were Wednesday

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between 8:00 am and 9:00 am and Saturday between 8:00 am and 9:00 am.
-Resident was on the Falls Management Program.
-Resident ambulated with a walker.
-Resident required supervision with bathing and dressing on Wednesdays and Saturdays.

Review of Resident #7's Personal Care Service Record for April 2015 revealed:
- Resident #7 had received assistance with bathing on 04/14/15.
-There was no additional documentation that Resident #7 had received assistance with bathing.

Interview with Resident #7 on 04/14/15 at 10:35 am revealed:
-He was to receive assistance with showers twice a week and he had not been receiving showers.
-He had a stroke several weeks ago and he was supposed to have someone with him for showers.
-He had requested assistance with a bath from several staff persons during the past several weeks.
-He took a shower this week by himself because there was not a staff person to help him.
-The physical therapist helped him take a shower today.
-The facility had a lot of staff turnover recently that had impacted the residents not receiving assistance with bathing and changing sheets.

Review of the Weekly Bath Schedule dated 04/14/15 revealed that Resident #7 was not listed on the bath schedule.

Interview on 04/14/15 at 6:00 pm with the nurse from a sister facility revealed that Resident #7 was not on the weekly bath schedule because he

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was independent with his bathing.

Refer to interview with a Resident Care Aide.

Refer to interviews with two Medication Aides.

Refer to interview on 04/10/15 at 3:17 pm with the Lead Supervisor.

Refer to interview on 04/14/15 at 3:05 pm with a nurse from a sister facility.

Refer to interview on 04/14/15 at 5:05 pm with the Executive Director.

B. Review of Resident #18's current FL-2 dated 08/14/14 revealed:
-Diagnoses included spastic hemiplegia nondominate side (movement on one side of the body is affected), joint contractures, and paraplegia (paralysis of the lower half of the body with involvement of both legs).
-Resident #18 required assistance with bathing, dressing, and was total care.
-Resident #18 was incontinent at times of bowel and bladder.
-Resident #18 was non-ambulatory.

Interview with Resident #18 on 04/13/15 at 12:30 pm revealed:
-Resident had gone for as long as a week without getting her shower without an explanation as to why.
-Resident stated no one checked her every two hours and she was unable to provide her own personal care.
-Resident stated that least once a week she did not receive personal care that was needed.
-On one occasion on third shift, a staff person came into her room and stated she smelled wet

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and left.
-The staff person did not return for about two hours to change her.

Review of the Personal Service Plan dated 03/13/15 revealed:
-Resident required total assist with dressing, grooming, personal hygiene and toileting needs daily.
-Resident required a bed bath with total assistance.
-Resident required use of incontinent products and refused to use the toilet for bathroom needs due to the need of using a Hoyer Lift for all transfers.
-Assist resident using the bathroom schedule: approximately every two to four hours during the day and as needed during the night.

Review of the Weekly Bath Schedule dated 04/14/15 revealed that Resident #18 was scheduled for showers on Tuesdays and Fridays on first shift.

Review of Resident #18's Personal Care Service Record for April 2015 revealed:
-Resident received assistance with personal hygiene on first shift on 04/06/15 and 04/09/15.
-Resident received assistance with bathing on first shift on 04/02/15, 04/09/15, and 04/13/15, and on second shift on 04/06/15.
-Resident received assistance with toileting:
-04/01/15 once on first shift, twice on second shift, and twice on third shift.
-04/02/15 twice on first shift and twice on third shift.
-04/03/15 twice on third shift.
-04/04/15 twice on first shift and twice on third shift.
-04/05/15 twice on first shift and twice on third

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shift.
-04/06/15 no documentation of assistance with toileting.
-04/07/15 twice on first shift and twice on third shift.
-04/08/15 twice on first shift and twice on third shift.
-04/09/15 twice on first shift and twice on third shift.
-04/10/15 twice on first shift, twice on second shift, and twice on third shift.
-04/11/15 once on second shift.
-04/12/15 once on second shift.
-04/13/15 twice on first shift, twice on second shift, and twice on third shift.

Refer to interview with a Resident Care Aide.

Refer to interviews with two Medication Aides.

Refer to interview on 04/10/15 at 3:17 pm with the Lead Supervisor.

Refer to interview on 04/14/15 at 3:05 pm with a nurse from a sister facility.

Refer to interview on 04/14/15 at 5:05 pm with the Executive Director.

C. Review of Resident #22's current FL-2 dated 4/14/14 revealed:
-Diagnoses of pneumonia, atrial fibrillation, and congestive heart failure.
-Resident did not require assistance with bathing.

Interview with Resident #22 on 04/14/15 at 9:15 am revealed:
-She was supposed to receive showers twice a week, but "my name is not on the shower list because they have so many people to shower."

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D 269	Continued From page 28 -Staff did not assist the resident with showers. -"I pray that this place gets turned around because there are people here that need the care." Review of the resident's Personal Service Plan dated 03/13/15 revealed: -Staff were to provide set-up, selection and laying out of showering supplies and safety devices as needed. -Resident used a shower chair. -Resident was able to perform showering tasks with staff attention and/or verbal prompts as needed for shampooing hair, washing upper body, washing lower body. -Resident was able to perform showering tasks with physical assistance as needed for shampooing hair and washing lower body. -The resident was to receive assistance with bathing twice a week with days specified. Review of the Weekly Bath Schedule dated 04/14/15 revealed that the resident was listed on the bath schedule for Tuesdays and Fridays on second shift. Review of the Personal Care Service Records revealed: -The resident had not been assisted with bathing in April 2015. -The March 2015 Personal Care Service Record was not available. -The resident had received assistance with a bath or shower on February 24, 2015. -The resident had not received assistance with a bath or shower in January 2015. Refer to interview with a Resident Care Aide. Refer to interviews with two Medication Aides.	D 269		

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D 269	Continued From page 29 Refer to interview on 04/10/15 at 3:17 pm with the Lead Supervisor. Refer to interview on 04/14/15 at 3:05 pm with a nurse from a sister facility. Refer to interview on 04/14/15 at 5:05 pm with the Executive Director. D. Review of Resident #23's FL-2 dated 4/9/15 revealed: -Diagnoses included syncope and hypertension. -Resident required assistance with bathing. Interview with Resident #23 on 04/13/2012 at 11:20 am revealed resident required assistance with bathing. A confidential interview with a family member revealed the resident had gone for as long as a couple of weeks without getting a bath. Review of the resident's Care Plan dated 03/19/15 revealed: -Staff were to provide set-up, selection and laying out of showering supplies and safety devices as needed. -The resident used a shower chair. -The resident needed assistance getting in and out of the shower. The resident required assistance bathing herself and drying off. -Resident was able to perform showering tasks with physical assistance as needed for shampooing hair and washing upper and lower body. -The resident was to be assisted with a shower or bath two days a week. -The goal was for showering needs to be met.	D 269		

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Review of the Weekly Bath Schedule dated 04/14/15 revealed that the resident was listed on the bath schedule for the days specified on the care plan.

Review of the Personal Care Service Records for the resident for April 2015 revealed the resident was assisted with a bath on 04/06/15 and 04/13/15.

Refer to confidential interview with a Resident Care Assistant (RCA).

Refer to confidential interviews with two Medication Aides.

Refer to interview on 04/10/15 at 3:17 pm with the Lead Supervisor.

Refer to interview on 04/14/15 at 3:05 pm with a nurse from a sister facility.

Refer to interview on 04/14/15 at 5:05 pm with the Executive Director.

____

Interview with a Resident Care Assistant (RCA) revealed:
-A bath assignment sheet was displayed in the medication room to notify which residents were to have a shower/bath on a particular day.
-The residents on the "pink hall" were scheduled for bath days on Mondays and Thursdays.
-The residents on the "green hall" were scheduled for bath days on Tuesdays and Fridays.
-The residents on the "blue hall" were scheduled for bath days on Wednesdays and Saturdays.
-No baths were given on Sundays.

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Interviews with two Medication Aides (MA) revealed:
-Baths were to be done two times a week.
-When a bath was completed, staff were to initial in the Personal Care Services binder located on the medication room.
-The Executive Director was responsible for monitoring Personal Care Service binders.
-"There is a bath book but I have not been oriented to the process."
-There had not been enough staff for at least the past month to give assistance to residents with baths twice a week.

Interview on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
-For the past four months, the facility had been 1.5 positions short on day shift and 2 aides short on evening shifts.

Interview on 04/14/15 at 3:05 pm with a Health and Wellness Director from a sister facility revealed:
-A shower assignment sheet should have been displayed to notify staff which residents were scheduled for baths on a particular day.
-The Executive Director (ED) or Lead Supervisor (LS) discussed assigned baths during morning stand up meetings at 10:30 am and 4:00 pm.

Interview on 04/14/15 at 5:05 pm with the Executive Director revealed:
-She began working at the facility in February 2015.
-It was the facility's policy to provide personal care according to the resident's Care Plan.
-The RCD was to schedule residents' baths according to their Care Plan.
-The RCD had resigned the month prior.
-She was not aware that residents were not

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receiving personal care according to their care plan and requests for assistance.
-She would discuss with the nurse who was responsible at this time for the bathing schedule.

____

The facility provided the following Plan of Protection on 04/17/15:
-Residents will be assessed for appropriate care and needs.
-Staff will provide assistance according to resident care plans and needs.
-Review of care needs will be done on an ongoing basis and adjustments made in care plan accordingly.

THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2015.

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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 interview, observation and record review, the facility failed to assure supervision for 3 of 3 sampled residents (Resident #19, #17, and #8) who were at risk for frequent falls resulting in injury to Residents #19, #17, and #8.

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The findings are:

A. Review of Resident #19's current FL-2 dated 01/23/15 revealed:
-Diagnoses included cerebrovascular accident (CVA), ataxia, dysphagia, hypertension, and malignant neoplasm of bone and bone marrow.
-Physical Therapy and Speech therapy were ordered to evaluate.
-She was semi-ambulatory with a rolling walker and wheelchair.

Review of the Resident Register revealed that Resident #19 was admitted to the facility on 01/26/15.

Observation of Resident #19 on 04/13/15 at 11:05 am revealed:
-Resident sitting in a chair in her room.
-Resident was dressed in street clothing.
-Resident had a brace on right wrist.

Interview with Resident #19 on 04/13/15 at 11:05 am revealed:
-Resident #19 had been residing at the facility for 8 weeks.
-She fell and broke her wrist when she was in the shower "shortly after I came here, but I can't remember exactly when."
-She had a recent stroke prior to her admission to the facility.
-The staff was supposed to be helping her with shower, but no one was helping her because they were short staffed.
-"I am slower doing my personal care since I had my stroke."
-"When I had a stroke it affected my eyes."
-The facility contacted her doctor and she had an x-ray of her wrist.
-She had not fallen at any other time since her

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admission to the facility.
-She was currently receiving physical therapy services.
-She was able to transfer from her bed to chair.
-She was able to dress herself.

Review of Incident Report dated 02/13/15 revealed:
-Resident #19 fell in the shower on 02/12/15 at approximately 6:50 pm.
-The fall was witnessed.
-The resident sustained injury to the right wrist.
-A Resident Care Assistant observed or came upon the incident and reported it to the nurse, a family member, and the resident's physician on 2/12/15.

Review of physician orders revealed an order on 02/12/15 at 8:13 pm to "send resident to Emergency Department with fracture of right wrist."

Review of a radiology report dated 02/12/15 at 10:36 pm revealed:
-"There is a fracture involving distal radial metaphysis with impaction. There is associated soft tissue swelling. Carpal bones are intact."
-Conclusion: Acute distal radial fracture.

Review of Home Health Plan of Care dated 04/01/15 revealed:
-Resident #19 to receive Physical Therapy once a week for 1 week starting 04/01/15, 3 times a week starting 04/05/15, and twice a week for 2 weeks starting 04/26/15.
-Resident #19's functional limitations included pain, balance, transfers, and ambulation.
-Safety measures were required in the bathroom.
-Education interventions included Fall Prevention Measures

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Review of Occupational Therapy (OT) notes dated 04/14/15 revealed:
-Resident #19 to receive OT once a week for 1 week starting 04/05/2015, 2 times a week for 4 weeks starting 04/12/15, and 1 time a week for 1 week starting 05/10/15.
-OT contacted patient's orthopedic MD to clarify patient's right wrist activity level.
-OT received a verbal order for Occupational Therapy to perform passive range of motion to right wrist.
-Resident required supervision and assistance due to ataxia and related fall risk with recent fall with attempted transfer without assistance.
-"Patient to wear right wrist brace at all times except for bathing and during passive range of motion to right wrist."
-Resident #19 had late effects cerebrovascular accident with right side weakness.

Review of Resident #19's Personal Care Services (PCS) plan dated 02/03/15 revealed:
-Be alert to placing resident's personal items within reach.
-The resident was independant going to and from the dining room or community activities.
-The resident used a walker as a mobility aid.
-The resident required stand by assistance due to weakness on her left side and for transfers in and out of the shower.
-Staff was to be alert to weakness on the left side as well as decreased eyesight on the left.
-Be alert to possible changes.
-Allow adequate time and do not rush.
-Resident used a manual wheelchair for mobility.
-The resident needed no assistance with transfers or ambulation/locomotion.

Refer to confidential interviews with two Resident

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D 270	Continued From page 36 Care Assistants (RCA). Refer to Interview on 04/14/15 at 3:45 pm with the Lead Supervisor. Refer to Interview on 4/13/15 at 10:55 am with the second nurse from sister facility. Refer to Review of the facility's Fall Policy. B. Review of Resident #17's current FL2 dated 10/28/14 revealed: -Diagnoses included atherosclerosis native art extremities with gangrene, lower limb amputation -below knee (right leg), depressive disorder, gout, and mononeuritis. -The resident was semi-ambulatory. -No disorientation documented. Review of Resident #17's current Personal Service Plan dated 03/13/15 revealed: -The resident was admitted to the facility on 01/31/15. -The resident falls management program (assessment) was as follows: -The resident needs assistance with transfer in and out of shower. -Safety awareness may be a concern. -Monitor ongoing ability. -Resident uses a walker as a mobility aide. -Educate resident on the use of emergency call system. -Minimize environmental clutter. -Encourage resident to lock wheelchair if applicable. -Encourage resident for the appropriate use of assistive device(s). -The falls management strategy was to encourage the resident to ask for assistance as needed, slow down, do not reach unsafely.	D 270		

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The Personal Service Plan noted: recent fall 3/19/15 no injury, receiving PT/OT (Physical Therapy/Occupational Therapy) until reaches maximum potential.
-There was no documentation for any increased supervision for Resident #17.

Review of the Licensed Health Professional Support (LHPS) review completed on 02/03/15 revealed:
-The Registered Nurse completing the review checked the box for transferring and semi-ambulatory or non-ambulatory residents.
-No documentation of transfer needs.
-No documentation of application and removal of prosthetic devices.
-No documentation Resident #17 needed supervision.

Review of the Resident Logs in Resident #17's record revealed:
-On 02/08/15 8:00 am Resident #17 was found sitting on the floor.
-On 03/19/15 Resident #17 was found on the floor beside her bed.
-On 03/29/15 at 7:00 am Resident #17 was found on the floor.
-On 04/02/15 at 11:00 pm staff was assisting Resident #17 to the bathroom. The staff was unable to hold onto the resident and the resident slid down, hitting her left knee, and fell onto the floor on her bottom. Note faxed (4/3/15) to Nurse Practitioner (NP), replied monitor for complaint of pain and signs and symptom of injury.
-On 04/08/15 at 8:30 (no am or pm) Resident #17 observed on the floor beside her bed. Note faxed (4/8/15) to NP replied monitor for safety.
-On 04/13/15 at 6:30 am Resident #17 rolled out of bed onto the floor and hit her head on the night

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stand.

Interview on 04/08/15 at 8:10 am with Resident #17 revealed:
-She fell out of bed this morning.
-Staff helped her up, but the resident did not feel good.
-The resident said she had not gotten her medications or ate breakfast.

Observation 04/08/15 at 8:10 am revealed:
-Resident #17's right leg was amputated below the knee.
-The resident had a prosthetic leg.

Interview on 04/14/15 with staff revealed the resident was in the hospital a result of a fall on 04/13/15.

Interview on 04/14/15 at 10:59 am with Resident #17's family member:
-The resident lived at the facility since January 31, 2015.
-The resident shared a room with her spouse.
-One 04/13/15 the resident rolled out of bed and hit her head.
-The resident received stitches from the injury.
-A month ago, the family member had talked with the home health nurse about getting a "noodle" mattress to prevent the resident from rolling out of bed.
-He had not talked with anyone at the facility about fall prevention techniques.
-He and other family members were trying to figure out ways to keep the resident from falling.
-The facility called and reported to him 4 falls.
-The family member was unable to recall specific dates and times because he documented the events at home, and he was not at home.
-Two falls were when the resident was trying to

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get out of bed into her wheelchair.
-Two falls happened because the resident rolled out bed. He was unsure why the resident was rolling out of the bed.
-He was unaware of other falls.
-The resident had a right leg amputation and when rising from a sitting position it took a minute to get her balance.
-The family member felt the resident getting up without assistance might be causing some of the falls.
-He was unaware the facility had the resident on a fall management plan. He was unaware what the plan consisted of.
-He was unaware how often facility staff checked on his relative.

Interview with a staff member revealed:
-Resident #17 was in the hospital.
-The resident was always falling.
-The resident had at least four falls within the past month.
-She was sure management was aware of the resident's falls, because they were discussed in morning "stand-up" meetings. The Executive Director (ED) was at the meetings.
-There had been no discussion about implementing measures to address the resident's falls.
-There had been no discussion about supervision or checking on the resident more than the routine every two hours.
-No one had informed the staff member to monitor the resident more often then the routine every 2 hour checks.

Interview on 04/14/15 at 3:30 pm with the Executive Director revealed:
-Resident #17 was discussed at the morning "stand-up" meeting, but she was only made

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aware of two falls.
-There was no system for increased supervision.

Interview on 04/14/15 at 3:45 pm with the Lead Supervisor revealed:
-She was aware that Resident #17 had falls.
-She was unaware how many falls the resident had.
-Staff had been told to observe residents at least every two hours.
-Staff had not been instructed by her or any management to check on Resident #17 more often.

Interview on 04/14/15 at 3:51 pm with the evening medication aide revealed:
-He was aware of Resident #17's fall on Monday, April 13, 2015.
-The Resident Care Assistant (RCA) was doing rounds on 4/13/15 and found the resident on the floor.
-The resident told staff she rolled out of the bed and hit the floor.
-The resident's head was bleeding, so he sent the resident to the hospital.
-To his knowledge the resident had 2 to 3 falls in past month.
-There could be more falls, that he was unaware of.
-Most falls happened over night or in the evening.
-It was the facility's policy to check on residents every two hours for continence needs.
-No one had discussed checking on Resident #17 more frequently for falls.
-He knew the resident had falls, but no one had informed him the resident was on fall risk management program.
-He was unaware of any measures put in place to address the resident's falls.
-He felt the resident needed to be monitored

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more frequently when in bed, especially in the morning to ensure the resident did not get out of bed without staff assistance.
-He thought Resident #17 required 2 people assist with transfers.

Interview on 04/14/15 at 1:03 pm with Resident #17's Nurse Practitioner (NP) revealed:
-She was notified twice about Resident #17's falls, once on 04/13/15 the recent fall, and on 04/02/15.
-She was unaware of other incidents related to falls.
-She replied to monitor the resident for safety, meaning she expected staff to monitor at the least according to their schedule, every 2 hours.
-She intended for staff to answer call bells within a reasonable amount of time so the resident did not attempt to get up without staff assistance.
-She also expected staff to continually remind the resident to ask for staff assistance before getting out of bed.
-She ordered physical and occupational therapy, but the resident was unable to complete physical therapy due to the inability to wear her prosthetic leg.
-Prior to coming to the facility the resident lost weight and the prosthetic leg did not fit comfortably.

Interviews with two Resident Care Assistants (RCA) revealed:
-Both RCAs said when they started working at the facility no staff trained them or explained to them the needs of Resident #17.
-One RCA said she asked the resident and the resident told her what she needed help with.
-One RCA said the resident only needed help with showers because she had one leg. The RCA usually did not have any problem assisting the

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resident with showers with one person assist.
-One RCA said the resident would try to get herself out of bed which caused the resident to fall.
-The second RCA was not familiar with the resident because she was unable to see the resident face-to-face (the resident was in hospital).

Refer to interviews with two Resident Care Assistants (RCA).

Refer to Interview on 04/14/15 at 3:45 pm with the Lead Supervisor.

Refer to Interview on 4/13/15 at 10:55 am with the second nurse from sister facility.

Refer to Review of the facility's Fall Policy.

C. Review of Resident #8's current FL-2 dated 6/2/14 revealed:
-Diagnoses of Parkinson's disease, dementia, osteoarthritis, coronary artery disease, hypertension, depressive disorder, transient ischemic attack, insomnia, bipolar disorder, peripheral neuropathy, diabetes mellitus Type 2, and memory loss.

Review of Resident #8's Resident Register revealed an admission date of 5/29/14.

Review of Resident #8's current Care Plan signed by the physician was dated 6/3/14 revealed:
-Resident was on the Falls Management Program.
-Resident needed supervision with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.

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-Resident was prescribed narcotic medications.
-Resident was taking 7 or more medications.
-Resident takes antipsychotic and benzodiazepine medications.
-Resident was on chronic condition management related to Parkinson's disease, diabetes, and depression.

Review of Resident #8's record revealed a completed Risk Identification Evaluation dated 6/2/14 revealed:
-The resident had vision deficits (glasses).
-The resident used an assistive device (walker).
-The resident was prescribed medications such as anti-pyschotics, anti-anxiety medications, anti-depressants, anti-hypertensives, benzodiazepine, cardiovascular medications, hypoglycemic medications, and narcotics.
-The resident was diagnosed with the following health conditions: Parkinson's disease and diabetes.

Review of incident reports and Post-Fall investigation forms revealed staff documented the resident had 3 falls from 1/18/15 through 4/7/15.

-Review of incident report dated 1/18/15 at 3:30 am revealed:
-Resident #8 had an unwitnessed fall. No apparent injuries noted.
-Resident #8's family was notified of the fall on 1/18/15 at 7:00 am via voice mail message.
-Resident #8's physician was notified of fall on 1/18/15 at 2:00 pm via fax.
-Post-Fall Investigation form dated 1/18/15 revealed Resident #8 informed staff, "Resident said she slipped out of her bed."

-Review of incident report dated 4/3/15 at 4:00

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am revealed:
-Resident #8 had an unwitnessed fall. Skin tear to left forearm noted.
-Resident #8 denied hitting head and denied pain or discomfort at present time.
-Resident #8's family was notified of the fall on 4/3/15 at 4:30 am. Medication Aide (MA) spoke directly to family.
-Resident #8's physician was notified of fall on 4/3/15 at 4:35 am via fax.
-Post-Fall Investigation form dated 4/3/15 revealed Resident #8 informed staff, "She was sleeping in her bed then rolled over and hit her left forearm on walker and fell to the floor."

-Review of incident report dated 4/7/15 at 10:00 am revealed:
-Resident #8 had an unwitnessed fall. Scrape/Abrasion and skin tear noted to right forearm, and lower back.
-MA documented, "Resident observed on floor in apartment. Abrasion observed to mid right back and right posterior upper arm, and skin tear to right elbow. Stated she was coming out of bathroom, lost balance and fell. First aid applied per staff."
-Resident #8's family was notified of the fall at 7:45 am. MA spoke directly to family.
-Resident #8's physician was notified of the fall at 8:00 am. MA left voice mail message.
-Post-Fall Investigation form for 4/7/15 was not provided by facility.

Observation on 4/8/15 at 7:45 am of Resident #8 revealed:
-The resident was lying in bed with eyes closed.
-The resident complained of pain due to recent fall as evidenced by moaning and grimacing while attempting to set on side of the bed.
-Dressings noted to right elbow, left forearm, right

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forearm, and mid-lower back.
-Dressings clean, dry and intact.
-A wooden chair was located on the right side of the bed and a rolling walker was located on the left side of the bed.

Interview on 4/18/15 at 7:50 am with medication aide (MA) revealed:
-The MA was aware of Resident #8's recent falls on 4/3/15 and 4/7/15.
-The resident had multiple dressings in place due to recent falls.
-MA believed the resident's physician had been notified of the falls.
-The resident's family was aware of the falls.

Interview on 4/18/15 at 7:55 am with Resident #8 revealed:
-Resident stated, "I just fell backwards and hit the corner of the cabinet when I was coming out of the bathroom."
-"I hit my lower back on the corner of the cabinet and scraped my arm during the fall."
-The resident denied hitting her head during the fall.
-The resident did fall a lot. She used call bell when she needs assistance.
-Resident stated she falls out of bed due to bed "being too little."
-Staff assisted her quickly after falls.
-When asked about the wooden chair and walker at bedside, the resident stated, "They are there to keep me from falling out of bed."

Interview on 4/9/15 at 9:40 am with Resident #8's family member revealed:
-The family member had been notified frequently regarding falls when the resident was initially admitted to the facility.
-The family member was unable to recall the

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exact dates of the past resident falls.
-The family member was very concerned about the safety of the resident because the resident experienced nightmares during the night which caused the resident to fall out of bed.
-The family member was told by the previous Health and Wellness Director (HWD) that she could not purchase bedrails for Resident's #8 because bed rails are not allowed in the facility.
-The family member discussed an occurrence that happened on 2/22/15, family member received "a very disturbing voice mail" from Resident #8. She stated Resident #8 was "extremely distressed and said there was not one there that she could turn to at the facility." The family member described Resident #8 as sounding "terrified."
-The resident went into the hallway and asked the MA for something for a panic attack.
-Per the family member, the MA told the resident, "She had to wait until he got to her. He was the only person on duty and he had a lot of other people to give medications to before he could get to her."
-The family member was concerned regarding the facility not having enough staff on duty and staff not being properly trained.
-The family member discussed another occurrence however, she could not recall the exact date of the event. She stated the resident fell during the night while trying to get to the bathroom. Resident crawled into the hallway after a fall because the call bell cord was not working properly.
-The family member submitted a written letter to the Business Office Manager on 4/3/15 regarding her concerns as it related to the resident's personal care and supervision. The Business Office Manager was to deliver letter to the ED. Family member had not received a response

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D 270	Continued From page 47 from the letter at this time. Interview on 4/9/15 at 9:55 am with the nurse from a sister facility revealed: -The nurse spoke to family member regarding rearranging Resident #8's room. -The nurse nformed family member of faxed request for order to physician for home health nurse to monitor orthostatic blood pressure and medication and physical therapy (PT) referral. -The nurse stated another fall assessment should have been completed after each resident fall. -The nurse completed an updated Risk Identification Evaluation on 4/9/2015. -The nurse notified the resident's physician regarding recent fall on 4/7/15 via fax sent on 4/9/15. Observation of Resident's room on 4/13/15 at 10:40 am revealed: -The resident's family member had moved the resident's bed up against the wall. -Furniture bumper pads were applied to all sharp corners including night stand beside bed. -Environmental clutter was reduced and organized. -Scatter rugs remain in resident's bathroom. Interview on 4/13/15 at 10:55 am with the Health and Wellness Director (HWD) from sister facility revealed: -The HWD provided a copy of the current facility fall policy. -A Risk Identification Evaluation should have been completed by the facility nurse on Resident #8 upon change of condition and every 6 months thereafter. -All falls were reviewed at the Collaborative Care Review meeting twice a month to assure follow up after each fall.	D 270		

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-The facility was unable to provide current Collaborative Care Review notes for Resident #8.

Interview on 4/13/15 at 3:20 with MA revealed:
-The MA stated, "I understand resident has been scheduled for physical therapy and the home health nurse discussed it with the resident."
-The MA unaware of any issues with call bell in resident's bathroom not working in the past.
-All staff were responsible for answering call bells.

Interview on 4/13/15 at 4:35 pm with Resident # 8's physician revealed:
-The resident was last seen in her office on 3/18/15 due to complaints of hip pain.
-The physician had ordered a Computed Tomography (CT) scan and X-ray of hip during office visit.
-Imaging was completed on 4/8/15 and revealed "an old healing rib fracture."
-The physician confirmed a receipt of request for the home health nurse to monitor orthostatic blood pressure, medication and PT referral faxed on 4/9/15.
-The physician stated, "Resident has lots of co-morbidities contributing to falls in combination of narcotics that she takes on a daily basis."

Interview on 4/14/15 at 9:15 am with Executive Director revealed:
-"I have been in this facility since 2/9/15. The resident has fallen without injury several times. I have not spoken to the family directly."
-The ED confirmed nurse from sister facility had been communicating with resident's family regarding rearranging resident's room to decrease falls.
-During this particular interview,the ED requested the nurse from sister facility to discuss with family

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about getting a hospital bed, bedside floor mat and a med alert pendant.

Interview on 4/14/15 at 9:45 am with Resident #8 revealed she was pleased with the new room arrangement. She stated, "Things are going well."

Interview on 4/14/15 at 4:00 pm with Lead Supervisor (LS) revealed:
-LS stated, "I was not here when the resident fell."
-All residents should be checked on every 2 hours minimum.
-The LS was unaware of any interventions in place regarding Resident #8's history of frequent falls.

Refer to confidential interviews with two Resident Care Assistants (RCA).

Refer to Interview on 04/14/15 at 3:45 pm with the Lead Supervisor.

Refer to Interview on 4/13/15 at 10:55 am with the second nurse from sister facility.

Refer to Review of the facility's Fall Policy.

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Confidential interviews with two Resident Care Assistants (RCA) revealed:
-One RCA had worked at the facility for almost three weeks.
-The other RCA had worked at the facility for two weeks.
-Both RCA's said no one had instructed them to check on, observe or supervise any residents in the facility.
-When they were hired another RCA told them it was the facility's policy to check residents every two hours.
Interview on 04/14/15 at 3:45 pm with the Lead

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Supervisor revealed staff had been told to observe residents at least every two hours.

Interview on 4/13/15 at 10:55 am with the second nurse from sister facility revealed:
-The nurse discussed current facility fall policy.
-All falls are reviewed at the Collaborative Care Review twice a month to assure follow up after each fall.

Review of the facility's fall policy revealed:
-The fall management consisted of post fall investigation.
-A risk identification evaluation is completed for each resident upon move-in, upon change of condition and every six month thereafter.
-Interventions for residents who have fall risks identified will have individualized interventions in their personal service plan.
-Following a fall a post fall investigation will be completed by staff to determine if the resident's fall risks have changed and/or if interventions need to be updated. Falls are reviewed at collaborative care review to ensure follow-up was done.

____
The facility provided the following Plan of Protection on 04/14/15:
-A review will be done of all residents that had falls in the past 60 days.
-A falls risk assessment will be done on all residents that had a fall and interventions put in place.
-All staff will review falls management training with appropriate follow through to include reactivation of collaborative care.
-A review of falls will be done monthly either by the Executive Director or Health and Wellness Director.

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D 270	Continued From page 51 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, record review and interviews, the facility failed to schedule appointments for referrals as ordered by the physician for 5 out of 10 sampled residents with mental health and new physician referral (Resident #2), dermatologist and mental health referral (Resident #16), ENT and GI referral (Resident #4), dermatologist referral and response to chest pain (Resident #9), and order for hospital bed (Resident #17). The findings are: A. Review of Resident #2's current FL-2 dated 6/23/14 revealed diagnoses included: diabetes mellitus, stroke, chronic obstructive pulmonary disease (COPD), coronary artery bypass graft, subarachnoid hemorrhage, coronary artery disease (CAD), and chest pain. Review of Resident #2's Resident Register revealed date of admission was 3/25/11.	D 273		

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Review of facility care notes revealed:
-On 12/30/14 at 2:20pm, Resident #2 was "a little agitated today."
-On 1/19/15 at 9:00pm, "Several times throughout the day that he is not happy with his new roommate at all. The man smells bad and makes too much noise. Whenever I am in my room I cannot breathe because he smells so bad."
-On 1/21/15 at 11:00am, "Resident seems to be in a bad mood today. Stated his room was too small and he was feeling under the weather."
-On 1/30/15 at 6:00am, "Resident was found lying in his vomit and bed wet through and through. Tried to get resident to change his clothes but he was uncooperative. Cursing and throwing things. Had to leave him to calm down. He seems agitated and weak."
-On 3/14/15 at 2:45pm, "Resident is refusing medication for multiple days now. Resident states he is fed up and angry but does not elaborate why."

Review of documentation dated 2/2/15 by the Business Office Staff related to Resident #2 revealed:
-Resident made a statement that someone was going to get hurt if someone did not do something about his roommate going to the bathroom all night, making noises and keeping the resident awake.
-December 2014, Resident #2 had a pair of scissors concealed in his wheelchair that the Executive Director (ED) took from him.
-Dated 1/20/15, Resident #2 showed the Business Office staff a straight pin and suggested "You could kill someone by sticking it through their neck."
-Business Office staff asked to see the pin and he did not mention it again.

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-(No date or time); Various reports of Resident #2 saying "someone gonna get hurt"slamming his fist into his hand and making reference to how powerful he was.
-(No date or time); A verbal altercation with another resident while waiting for breakfast.
-Resident sitting in a wheelchair and another resident moved a chair next to where he was sitting. The other resident accidentally hit his wheelchair.
-All above incidents were reported in Stand Up meeting, to Resident Care Coordinator (RCC) and ED.

Review of Resident #2's February 2015 and March 2015 Medication Administration Records (MARs) revealed:
-On 2/20/15, the resident refused 7 of 17 medications, including Novolin (insulin) 18 units at 8:00 am.
-On 3/2/15, the resident refused 8 of 17 medications, including Novolin 18 units at 8:00 am.
-On 3/4/15, the resident refused Novolin 18 units at 8:00 am.
-On 3/6/15, the resident refused Novolin 18 units at 8:00 am.
-On 3/13/15, the resident refused 11 of 17 medications, including Novolin 18 units at 8:00 am.
-On 3/14/15, the resident refused 8 of 17 medications, including Novolin 18 units at 8:00 am.
-On 3/19/15, the resident refused 8 of 17 medications, including Novolin 18 units at 8:00 am.
-On 3/22/15, the resident refused 7 of 17 medications, including Novolin 18 units at 8:00 am.
-On 3/23/15, the resident refused 4 of 17

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medications, including Novolin 18 units at 8:00 am.

Review of Resident #2's Blood Glucose Monitoring Form for February 2015 and March 2015 revealed:
-Resident refused Fasting Blood Sugar Monitoring (FSBS) on the following days during the morning fasting check at 7:30 am (before breakfast):
2/20/15
3/8/15
3/13/15
3/18/15
3/22/15
3/23/15
3/27/15

Review of Resident #2's Personal Service Assessment (PSA) related to behavior management dated 2/19/14 revealed resident demonstrates anxious, disruptive or obsessive behaviors requiring additional attention.

Review of Resident #2's Personal Service Plan (PSP) related to behavior management dated 3/13/15 revealed:
-PSP was not signed by a prescribing licensed practitioner.
-At times refused PM insulin. Becomes upset some days and resistive to taking medications as ordered.
-Non-compliant with carbohydrate controlled diet.
-Becomes easily agitated by other residents. Will become argumentative to the point of yelling at other residents.
-Difficult to direct at times.
-Early intervention by staff before it escalates to a point of concern is best.

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Review of Resident #2's Home Health care notes revealed:
-Home Health Nurse (HHN) visited 5 times between 4/3/14 and 6/26/14 with documentation of non-compliance with diet.
-On 9/8/14, HHN visit and assessment documented, "Patient [resident] alternates between paranoia and aggression. He believes the staff wants him gone. He states his neighbor needs to be gone and he is gonna beat the crap out of him because he keeps him awake all night." He later stated he could stick a hammer in his head and fix the whole problem.
-On 9/8/14, HHN visit and assessment documented, "Patient's [resident's] dementia is advancing and he is unable to name a common household item. Refuses to bathe. SN [HHN] will request mental health evaluation and intervention ASAP."
-On 9/12/14, Physical Therapy (PT) visit and treatment documented, "Patient [resident] verbalized aggression towards neighboring resident. States he would like to hit another resident on the head with a hammer."
-On 9/16/14, PT visit and treatment documented, "Patient [resident] continues to verbalize threats towards another resident. Patient [resident] also visibly agitated and voicing complaints issues with facility."
-On 9/17/14 HHN visit and assessment documented, "Patient [resident] very negative in his verbalization. Still loses words and has difficulty expressing himself. This leads to increased agitation. Patient [resident] is difficult to appease or console."
-On 9/30/14 HHN visit and assessment documented, "Still awaiting psychiatric services from Executive Director. Patient [resident] would benefit greatly from this."
-On 10/15/14 HHN visit and assessment

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documented: "Patient [resident] discharged from Home Health services due to failure to receive FTF (face to face) from any provider. Patient [resident] refused care from staff and SN [HHN]. Patient [resident] disoriented to place, time and situation."

Review of Resident #2's Pharmacy Review dated 11/24/14 revealed:
-A recommendation for mental health evaluation.
-No documentation the facility followed up on the pharmacy recommendation.

Interview on 4/9/15 at 4:45pm with Resident #2's family member revealed:
-Family member was unaware of any issues regarding resident's medications.
-Family member stated, "My dad always complains."
-Family member believed the facility monitored the resident's fasting blood sugar without issue.
-Family member did not verbalize any specific concerns related to facility and resident care.

Interview on 4/10/15 at 12:25pm with the nurse from a sister facility revealed:
-The nurse was unable to provide documentation for a mental health consult for Resident #2.
-The nurse stated, "Mental health consult had not been done."
-The Resident Care Coordinator (RCC) and Health and Wellness Director (HWD) were responsible for following up with pharmacy recommendations.
-The nurse unsure why mental health consult was not scheduled because she worked at a sister facility and was not here at the time of the recommendation.
-The physician refused to sign the Care Plan for Resident #2.

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-The nurse stated, "The physician who signed the resident ' s FL-2 on 6/23/14 refused to sign updated Care Plan and refused to continue to provide health care to resident due to non-compliance and behavior issues.
-Per the nurse, Resident #2 went to a local urgent care on 12/5/14 to be seen by a physician due to not having an assigned primary care physician at this time.
-The resident had a scheduled physician appointment on 12/29/14 however; documentation revealed resident refused to go to appointment.

Attempted telephone interview with previous Primary Care Physician on 4/13/15 at 10:32am was unsuccessful.

Interview on 4/13/15 at 3:20pm a Medication Aide (MA) revealed:
-The MA stated, "I never had any issues with Resident #2. It is all in how you approach him."
-The MA was unaware of refusal of medications from certain staff members.
-The MA observed and overheard Resident #2 "going off " when he was agitated.
-The MA was aware resident had been admitted to a skilled nursing facility (SNF) after his hospitalization 4/4/15 for complaints of chest pain.

Interview on 4/14/15 at 9:05pm with Executive Director (ED) revealed:
-Resident #2 was belligerent and agitated during bath times.
-The ED stated, "I have not seen it; but has been reported to me."
-Resident #2 visited a physician at an Urgent Care Center on 12/5/14 due to previous physician refusing to continue to care for resident because

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of non-compliance.
-The ED stated, Resident #2 would refuse medications and "cuss staff."

Interview on 4/14/15 at 9:10am with the nurse from a sister facility revealed:
-The facility informed previous physician he had to provide a 30-day notice in order for facility to locate a new physician for Resident #2.
-The nurse offered Resident #2 to be seen by the facility physician ongoing.
-The nurse stated, "The resident would consider it but probably would not do it."
-The paperwork to transfer services to another physician was not completed prior to Resident #2's admission to the hospital on 4/4/15.
-Resident #2 would become agitated and upset when personal care was provided. Recommended 2 staff members assist resident during these times.
-Resident #2 would refuse medications, fasting blood sugar monitoring and insulin injections.

Interview on 4/14/15 at 9:35 am with a MA revealed:
-"I personally did not have any issues with resident."
-"[Resident #2] never refused medications from me."
-MA stated, "Resident would cuss however; he was that way with everyone."

B. Review of Resident #4's current FL2 dated 01/25/15 revealed:
-Diagnoses of diabetes mellitus, chronic renal insufficiency, gout, hypertension, hypothyroid, osteoarthritis, and bradycardia.

Review of the Resident Register in Resident #4's record revealed an admission date of 02/05/10.

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1. Review of Resident #4's record revealed:
-An order dated 03/05/15 from the Nurse Practitioner (NP) to "please schedule ENT (Ear, Nose, and Throat) F/u ASAP due to continued problems with Sinusitis."

Continued review of Resident #4's record revealed no documentation of a scheduled appointment for the resident's ENT consult.

Interview on 04/09/15 at 12:40 pm with Resident #4 revealed:
-She had bad sinus problems that caused her face and head to hurt continually.
-She had a lot of sinus infections.
-She recalled telling the NP about the pain (3/5/15), but was unaware the NP had ordered a consult with the ENT specialist.
-The facility staff were supposed to schedule all her appointments and provide transportation.
-As of today, 04/09/15 no one at the facility had informed her that she had an appointment with the ENT specialist.

Interview on 04/09/15 at 3:10 pm with the NP revealed:
-She saw Resident #4 in March 2015 and the resident complained about swollen glands behind her ear.
-The resident had sinus problems and tenderness.
-She ordered the ENT consult ASAP because the resident was afraid of the gland being cancerous.
-She was unaware the facility had not scheduled the ENT consult.
-After she sees residents she gives the orders to the staff, usually the RCC or medication aide on duty.
-She had no idea what happened to orders after

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that.

Interview on 04/08/15 at 4:10 pm with the Lead Supervisor (LS) revealed:
-Initially, orders for referral were given to the Resident Care Coordinator (RCC) to sort through and make appointments with the appropriate health care professional.
-The facility did not have an RCC, so the interim Health and Wellness Director (HWD) recently changed that process and decided it would be better for medication aides to give referral orders to the transportation driver to schedule appointments.
-There was no system in place to ensure medication aides made referral appointments.

Interview on 04/09/15 at 11:40 am with the interim HWD revealed:
-Two weeks ago she made changes to scheduling referral appointments.
-The medication aide on duty when the NP or physician left orders for referral appointments were to sort through orders and give orders to appropriate individual making appointments.
-She decided that it would be beneficial for the transportation driver to make referral appointments because he was responsible for transporting residents to their appointments.
-She was not sure if the system worked because it was recently implemented.
-There was no system in place to ensure appointments were made.
-She was unaware of Resident #4's referral orders for an ENT consult and did not know why the appointment were not scheduled.

Interview on 04/10/15 at 10:30 am with the transportation driver/maintenance worker revealed:

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-He worked as the transportation driver and maintenance worker.
-Two weeks ago he was informed that he was responsible for making appointments for residents.
-The medication aides were supposed to give him the orders for referral and he made the appointments.
-After he made the appointments he documented the appointment on this calendar to remind him to transport the resident to the appointment.
-He was unaware that Resident #4 had orders for an ENT consult because no one gave him the orders.

Interview on 04/10/15 at 11:15 am with a medication aide revealed:
-When she was hired the RCC was responsibility to ensure appointments for referral orders were made.
-No orders for referral appointments had been given to her, so she thought the LS was responsible for making referral appointments.
-She assumed the LS had control over many things at the facility.
-Today she was told by LS that medication aides were to sort through orders for referral and make appropriate appointments.
-Medication aides were to give referral orders to the transportation driver.
-Since she worked at the facility there was no system to ensure orders for referral appointments had been made.

Interview on 04/13/14 at 3:50 pm with the Executive Director revealed:
-What was supposed to happen was the medication aide on duty was to sort through orders and make referral appointments as ordered.

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-There was no system to ensure referral appointments were made.

2. Continued review of Resident #4's record revealed an order from the NP dated 03/30/15 to "Please schedule follow appointment with GI (Gastroenterology) specialist to determine worsening of hernia pain."
-No documentation of an appointment with a GI specialist.

Interview in 04/09/15 at 12:25 pm with Resident #4 revealed:
-She had two hernias in her stomach and they were getting worse.
-The resident asked the NP to see a specialist because she was continually in pain and feared the hernias had gotten worse.
-The resident said if the pain got too bad and she felt that she could not take it she would ask for a Tramadol for pain.
-The resident said she did not like taking Tramadol, because it made her really sleepy and she slept all day.
-Resident #4 said as of today 04/09/15 no one at the facility had informed her the physician had ordered a follow-up appointment with a GI specialist, or that the facility had scheduled an appointment for her with a GI specialist.

Interview on 04/09/15 at 3:00 pm with the NP revealed:
-She was aware that Resident #4 had more than one hernia in her stomach.
-The resident complained they were painful.
-She wanted a follow-up appointment with the GI specialist to determine the progression of the hernias.
-She was unaware the follow-up appointment with the GI specialist had not been scheduled.

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-She visited the facility at least weekly, and every resident on her case load was seen at least monthly.

Interview on 04/08/15 at 4:10 pm with the Lead Supervisor (LS) revealed:
-Initially, orders for referral were given to the Resident Care Coordinator (RCC) to sort through and make appointments with the appropriate health care professional.
-The facility did not have an RCC, so the interim Health and Wellness Director (HWD) recently changed that process and decided it would be better for medication aides to give referral orders to the transportation driver to schedule appointments.
-There was no system in place to ensure medication aides made referral appointments.

Interview on 04/09/15 at 11:40 am with the interim HWD revealed:
-Two weeks ago she made changes to scheduling referral appointments.
-The medication aide on duty when the NP or physician left orders for referral appointments were to sort through orders and give orders to appropriate individual making appointments.
-She decided that it would be beneficial for the transportation driver to make referral appointments because he was responsible for transporting residents to their appointments.
-She was not sure if the system worked because it was recently implemented.
-There was no system in place to ensure appointments were made.
-She was unaware of Resident #4's referral orders for a GI consult and did not know why the appointment were not scheduled.

Interview on 04/10/15 at 10:30 am with the

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transportation driver/maintenance worker revealed:
-He worked as the transportation driver and maintenance worker.
-Two weeks ago he was informed that he was responsible for making appointments for residents.
-The medication aides were supposed to give him the orders for referral and he made the appointments.
-After he made the appointments he documented the appointment on this calendar to remind him to transport the resident to the appointment.
-He was unaware that Resident #4 had orders for a GI consult because no one gave him the orders.

Interview on 04/10/15 at 11:15 am with a medication aide revealed:
-When she was hired the RCC was responsibility to ensure appointments for referral orders were made.
-No orders for referral appointments had been given to her, so she thought the LS was responsible for making referral appointments.
-She assumed the LS had control over many things at the facility.
-Today she was told by LS that medication aides were to sort through orders for referral and make appropriate appointments.
-Medication aides were to give referral orders to the transportation driver.
-Since she worked at the facility there was no system to ensure orders for referral appointments had been made.

Interview on 04/13/14 at 3:50 pm with the Executive Director revealed:
-What was supposed to happen was the medication aide on duty was to sort through

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orders and make referral appointments as ordered.
-There was no system to ensure referral appointments were made.

C. Review of Resident #17's current FL2 dated 10/28/14 revealed:
-Diagnoses included atherosclerosis native art extremities with gangrene, lower limb amputation -below knee (right leg), depressive disorder, gout, and mononeuritis.
-The resident was semi-ambulatory.
-No disorientation documented.

Review of Resident #17's record revealed:
-An order dated 02/19/15 for a hospital bed with pressure reducing mattress due to right leg amputation, left leg pain, and gangrene of left great toe the resident was unable to position herself in a regular bed.
-The mattress on a regular bed was not appropriate for the resident.

Observation on 04/14/14 at 9:40 am of Resident #17's bed revealed:
-The resident had a regular twin sized bed with a head board and foot board.
-The bed was 13 inches high off the floor.
-The mattress was a regular twin straight mattress that was 5 inch high and was flat.
-The bed did not elevate up or down.

Interview with a staff member revealed Resident #17 was in the hospital as a result of a fall on 04/13/15.

Interview on 04/14/15 at 10:59 am with Resident #17's family member:
-The resident lived at the facility since January 31, 2015.

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-The resident shared a room with her spouse.
-One 04/13/15 the resident rolled out of bed and hit her head.
-The resident received stitches for the injury.
-A month ago he talked with the home health nurse about getting a "noodle" mattress to prevent the resident from rolling out of bed.
-He was unaware the Nurse Practitioner (NP) ordered the resident a hospital bed.
-The family member felt the hospital bed would be the answer he wanted to help prevent the resident from falling.
-The family member said a hospital bed would allow Resident #17 to lift her head and/or feet up and down.
-Being able to reposition in the bed before getting up out of the bed may help the resident keep her balance and prevent the resident from falling.

Interview with a staff member revealed:
-She was unaware there was an order in Resident #17's record for a hospital bed.
-When the NP wrote orders they were left in the medication room.
-The Resident Care Director (RCC) previously was responsible to ensure follow-up of orders.
-The RCC left on 3/7/15.
-Prior to last Friday, April 10, 2015 she thought the Lead Supervisor assumed the same responsibility as the RCC.

Interview with a second staff member on 4/14/15 revealed:
-Resident #17 had fallen yesterday (4/13/15) and was found on the floor when doing rounds.
-The resident needed reminders to use the call bell for staff assistance.
-The staff member thought Resident #17 required 2 people assistance with transfers.

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Interview on 04/14/15 at 1:03 pm with Resident #17's NP revealed:
-She wrote the order for the hospital bed on 02/19/15.
-Due to the resident's condition (amputee and gangrenous left toe) she thought the hospital bed would be beneficial to help the resident move around in bed, help with circulation, and may prevent rolling out of bed.
-The PA said the resident had to put great effort to move in a regular bed, the rolling out of bed may have been the resident's efforts to move around in the bed.
-She was unaware the facility had not followed-up on getting the resident a hospital bed.

D. Review of Resident #9's current FL2 dated 11/07/14 revealed:
- Diagnoses included chest pain, coronary atherosclerosis, diabetes, retinopathy, glaucoma, and hypertension.
- An order for Nitroglycerin 0.4 mg sublingual tablet one under the tongue every 5 minutes as needed for chest pain. (Nitroglycerin tablets are used to treat episodes of chest pain.)

Review of Resident #9's record revealed physician's orders dated 12/19/14 prescribing Nitroglycerin 0.4 mg sublingual tablet one under the tongue every 5 minutes as needed for chest pain.

1. Observation on 04/13/15 at 11:15 am revealed:
-Resident #9 was coming out of her bathroom and said she was feeling dizzy.
-Resident sat on her bed and stated that sitting down seemed to help.
-Resident's eyes were reddened.

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D 273	Continued From page 68 Interview with Resident #9 on 04/13/15 at 11:20 am revealed: -She was admitted to the facility in November 2014 following a heart attack. -On the morning of 04/13/15, a family member had asked her to make sure that two tables in the activities room were clean for a luncheon the resident was having for friends and family. -At approximately 9:25 am on 04/13/15, Resident #9 wiped off both tables and began to have chest and arm pain. -She had not requested that facility staff clean the tables for her. -Resident #9 went into the hallway outside of the activity room at approximately 9:30 am on 04/13/15 and told the nurse from a sister facility, who was passing medications, that she was having chest pain and arm pain from wiping tables. -Resident #9 requested a Nitroglycerin tablet from the nurse at the time of informing her that she was having chest pain and arm pain. -The nurse from a sister facility asked her room number, and then informed Resident #9 that the medication aide for her hall was supposed to give Resident #9 her medications. -The nurse from a sister facility had Resident #9 to sit down on her walker seat and to inhale and exhale for a few minutes. -"When I felt a little better, I went back to my room." (Measured by the surveyor as approximately 400 feet from activity room to resident's room.) -She returned to her room without assistance after sitting for a few minutes. -Resident #9 stated she rested in her bed and the chest pain eased off. -She did not understand why the facility nurse did not give her the nitroglycerin, because she had had a previous heart attack and knew that	D 273		

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Nitroglycerin was ordered by her doctor to help if she had chest pain.

One of the morning Medication Aides (MA) was notified on 4/13/15 at 11:40 am that Resident #9 had complained of being dizzy and previous chest pain.

Observation on 4/13/15 at 12:15 pm revealed 2 MAs were standing next to the medication cart outside Resident #9's room.

Interview on 4/13/15 at 12:15 pm with one of the MAs revealed:
- She was assigned to administer morning medications to residents on the hall.
- She had checked on Resident #9 after being told the resident felt dizzy.

Interview on 4/13/15 at 12:15 pm with the second MA revealed:
- She was working as a Resident Care Assistant (RCA) today, but had joined first MA to assist with medications and checking on Resident #9.
- She had taken Resident #9's blood pressure at 11:49 am (175/102) and administered a nitroglycerin 0.4 mg SL tablet per the resident's request, took a blood pressure reading at 11:54 am (220/127) and administered a second nitroglycerin 0.4 mg SL tablet per the resident's request.
- The second MA stated the resident told her chest pain was much better after these doses, but requested a third nitroglycerin 0.4 mg SL tablet.
- The resident's blood pressure was down to 175/80 and the resident was feeling better.
- The resident told the MA she wanted to get ready for her guest that were coming for lunch at 1:00 pm.

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Interview on 4/13/15 at 12:30 pm with Resident #9 revealed:
- She was feeling much better.
- She had a slight headache from the nitroglycerin, but she really wanted to have time with her friends.

Interview on 4/13/15 at 12:35 pm with the first MA revealed:
- The facility did not currently have a Health and Wellness nurse or Resident Care Coordinator due to staff turnover
- She had informed the nurse from a sister facility that was helping out at the facility of the administration of nitroglycerin to Resident #9.
- The nurse had instructed the first MA to take the resident's blood pressure in both arms and provided no further instruction.
- She had not contacted Resident #9's physician.

Interview on 4/13/15 at 12:40 pm with the nurse from a sister facility revealed:
- She was passing medications on a hall earlier in the day when Resident #9 came out of the activity room.
- The resident told her that resident's right shoulder was hurting from wiping down the table.
- She stated she did not hear the resident say she was having chest pain as well as shoulder pain.
- She did not take the resident's blood pressure but took her pulse (72) and suggested she sit on her rolling walker/seat for a couple of minutes and do deep breathing.
- The nurse stated she was not aware the resident was taking nitroglycerin as needed, because she did not have her medications on the cart she was working.

Observation on 4/13/15 at 12:48 pm revealed the

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nurse from a sister facility came to the hall for Resident #9, went in the room with a manual blood pressure cuff and came back out of the room. (She stated Resident #9's blood pressure was 160/72 and the resident was not complaining of any chest pain.)

Interview on 4/13/15 at 12:48 pm with the Administrator revealed:
- The MA told her (a few minutes ago) that she gave a resident nitroglycerin. (She was in the dining room at the time assisting with lunch.)
- The Administrator told the MA she did not know the resident and she needed to talk to the nurse from the sister facility.
- She was not aware Resident #9 stated she had requested nitroglycerin tablets at 9:40 am.

Observation on 4/13/15 at 2:55 pm revealed Resident #9 was in the activity room with 3 people playing cards at a table.

Interview on 4/13/15 at 3:00 pm with the nurse from a sister facility revealed:
- The MA had come to her earlier to tell her Resident #9's blood pressure was up.
- The MA was using an automatic blood pressure cuff.
- She instructed the MA to take the blood pressure manually, in both arms.
- The nurse stated the MA never came back to let her know the blood pressure.
- The nurse stated the MA did not tell her she had given nitroglycerin to the resident.
- She had not contacted Resident #9's physician for notification Resident #9 had chest pains earlier in the day and received nitroglycerin 0.4 mg sublingual tablets starting at 11:49 am on 4/13/15.

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Interview on 4/13/15 at 4:30 pm with the Administrator revealed:
- She was not aware Resident #9 had complained of chest pains at 9:30 am and did not receive nitroglycerin tablet at that time.
- She had contacted Resident #9's physician on 4/13/15 prior to 1:00 pm.
- She had faxed information about the administration of nitroglycerin to Resident #9's Nurse Practitioner (NP) around 1:00 pm.
- The NP had instructed her to give the resident an anxiety medication, monitor the resident, and take her blood pressure 3 times a week in the afternoon.
- The NP did not request the resident be sent out to hospital.

2. Review of Resident #9's record revealed a physician's order dated 3/05/19 ordering "Dermatology consult due to brown spots on her torso."

Continued record review revealed a subsequent physician's order dated 3/19/15 ordering "Dermatology consult due to widespread skin condition that causes dark scars after flare-ups. Please set up for as soon as possible."

Review of the facility transportation schedule log on 4/14/15 revealed no documentation for a Dermatology consult scheduled for Resident #9.

Interview on 4/08/15 at 7:43 am with Resident #9, during the initial tour, revealed:
- The facility Nurse Practitioner had referred her to a dermatologist however, she had not seen the dermatologist yet.
- She asked the nurse from a sister facility a few weeks ago about her dermatology appointment.
- She was told by the nurse that the transportation

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driver made the appointments.
- She stated the current transportation driver was the janitor until a few weeks ago.
- She asked the transportation driver several times about the dermatology appointment and he said "I'm doing it- I'm gonna do it".

Interviews on 04/10/15 at 11:15 am with a medication aide (MA) revealed:
- The MA stated it was the Resident Care Coordinator's (RCC) responsibility to schedule all appointments and she did not know who was performing those tasks since the RCC left.

Interview on 04/10/15 with a second MA revealed:
- Scheduling appointments was the responsibility of the MA on duty when the order was received.
- The MA was supposed to schedule the appointment and put it in the transportation aide's book so he could transport the resident to the appointment.

Telephone interview on 4/14/14 at 4:10 pm with the transportation driver revealed:
- He had not been at the facility for 4 days.
- Previously, the RCC was responsible to schedule appointments and the transportation driver used the appointment book to transport resident's to the appointments.
- The nurse from a sister facility had changed the procedure and the transportation driver was to make the appointments, but that was last week.
- He was not aware if Resident #9's dermatology appointment was scheduled. (Review of the transportation log revealed no dermatology appointment scheduled.)
- Resident #9 told him the former RCC had set up the appointment.
- He had told Resident #9 he would "ask around about it".

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- He checked the appointment book last Friday (4/10/15), but he did not see the appointment scheduled or an order for the appointment.
- He had not seen a request for a Dermatology consult for Resident #9.

Interview with Resident #9 on 04/13/15 at 11:20 am revealed:
- "The doctorthat comes here saw me recently and told them that I need to see a dermatologist."
- The doctor told the staff to make the appointment and that has not been done yet.
- "I have told the nurse, but I don't know why it hasn't been done yet."

Telephone interview on 4/13/15 at 11:15 am with the facility Nurse Practitioner revealed:
- Resident #9's Endocrinologist had been treating the rash on Resident #9's torso and she was continuing the treatment.
- She ordered a Dermatology consult for Resident #9 on 2/09/15, and 3/5/15 because the resident had a skin lesion not responding to the treatment she prescribed.
- She ordered the Dermatology consult again on 3/19/15 with instruction for the referral as soon as possible because she found no documentation for the visit and she wanted to "rule out any kind of melanoma rash."

Interview on 04/14/15 at 4:10 pm with the Lead Supervisor (LS) revealed:
-Initially, orders for referral were given to the Resident Care Coordinator (RCC) to sort through and make appointments with the appropriate health care professional.
-The facility did not have an RCC, so the nurse from a sister facility recently changed that process and decided it would be better for medication aides to give referral orders to the

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transportation driver to schedule appointments.
-There was no system in place to ensure medication aides made referral appointments.

Interview on 4/14/15 at 4:45 pm with the nurse from a sister facility revealed:
- The facility had an appointment book for scheduling residents' appointments.
- The former RCC was scheduling appointment, but she left a couple of months ago.
- The medication aides were scheduling the appointments most recently.
- That system did not work well because the transportation driver had appointments scheduled at the same time or too close together (if the appointments were across town from each other.)
- Recently, the nurse from a sister facility changed the procedure to the medication aides received the order or request for appointments, filled out a new order tracking sheet, made a copy for the record, and placed a copy in the transportation driver's box for the driver to set up the appointment and log in the transportation log book.
- She was unable to locate a Dermatology appointment that had been set up for the previous month or the upcoming month.
- The nurse produced a copy of a Dermatology request/order that was folded in the transportation log .
- The nurse stated she made the appointment, personally, today for Resident #9 to see a Dermatologist.
- She would make sure the transportation driver was informed of the appointment.

E. Review of Resident #16's current FL-2 dated 09/23/14 revealed diagnoses included cerebrovascular accident, hypertension, ischemic

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heart disease, diabetes type II, and depressive disorder.

1. Review of Resident #16's record revealed:
-A physician's order dated 03/05/15 for a psychiatry follow-up and to start an antipsychotic medication (Risperdal) "due to history of bipolar disorder".
-No documentation the psychiatry consult was obtained.

Interview on 04/09/15 at 11:30 am with the Nurse Practitioner (NP) revealed:
-The NP began seeing the resident in October 2014.
-The resident was already taking Klonopin (benzodiazepine used to treat anxiety) which had been prescribed by a previous physician.
-During a physician visit on 03/05/15, the resident informed the NP that he used to see psychiatry regularly until his psychiatrist retired in June 2014. He had not been assigned a new psychiatrist and therefore had not been seen by psychiatry since then.
-The resident also informed the NP that he used to be on Risperdal, so the NP ordered Risperdal to be started and to get psychiatry consult.
-When she saw the resident again last week, she asked him how his mood was doing and he told her he had not been seen by psychiatry.
-The NP then asked the facility staff today if the consult had been scheduled and learned it had not been scheduled.
-The NP assumed psychiatric services were "already in place or at least scheduled".

Interview on 04/09/15 at 11:19 am with a geriatric care manager (CM) revealed:
-She was hired by Resident #16's family "because they felt things weren't being done and

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they wanted someone to manage" the resident's care.
-The CM began managing the resident's care around 02/10/15.
-The CM stated the facility's physical therapist (PT) reported to her that the resident was "not progressing" in therapy because he had a manic spell followed by a significant decline, lethargy, uncontrollable laughter, and crying. The PT reported the resident's mood was "holding him back".
-The resident's family reported to the CM that the resident's previous psychiatry services had stopped in June 2014 because his doctor retired and he needed those services restarted. The family stated they and the resident had reported the need to facility staff but received no response to the request.
-The CM spoke with the physician onsite on 03/05/15 and relayed this information to the physician, who then ordered a behavioral health consult.
-On 03/20/15, the CM visited the facility and reviewed the resident's record. She found no information to indicate the consult had been scheduled.
-The CM called the facility and spoke with the nurse from a sister facility who was helping out in this facility. The CM asked the nurse about the appointment and the nurse told her she was "new" and would have to look it up, but provided no further information to the CM.
-On 03/23/15, the CM called the facility and spoke with the nurse again. The nurse told the CM she would "check on the appointment" to behavioral health, but did not provide any further information.
-On 04/09/15, the CM went to the facility to speak with the physician onsite and learned the behavioral health consult had not yet been

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scheduled.
-The CM requested the physician give her an order so she could schedule the referral herself.

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He had "been holding it together" but sometimes he had to "just go off by (himself) and pray".
-He had a stroke in 2014 which "wiped" his memory.
-He had been experiencing episodes of mania followed by severe depression to the point he could not listen to music without crying.
-Several weeks ago, he saw an ad on TV saying manic/depressive behavior could be a "byproduct" of stroke and the ad caused him to remember that he was previously being seen by psychiatry for bipolar disorder.
-He told the facility Nurse Practitioner (NP) the need for reinstating psychiatric services to get back on the medications he used to take. He also told the NP he used to be on Risperdal and needed some because he was nervous and the NP agreed to order some for him.
-He had been waiting for staff to schedule a psychiatry appointment but it had not been done, so his "boots on the ground lady" (CM) was going to ask the doctor for an order so she could schedule the appointment herself.

Interview on 04/14/15 at 11:20 am with a Medication Aide (MA) revealed:
-The resident had been more withdrawn over the past month and had become more "short" with staff.
-She was not aware the NP had ordered a psychiatry consult that had not been scheduled.

Interview on 04/14/15 at 12:00 pm with a Medication Aide (MA) revealed:

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-Resident #16 had been requesting his prn (as needed) Klonopin more over the "last few days" due to increased anxiety.
-He was not aware the NP had ordered a psychiatry consult that had not been scheduled.

2. Review of Resident #16's record revealed:
-A physician's order dated 04/02/15 for a dermatology consult "due to lesions on the scalp. They may need scraping or laser treatment".
-No documentation the dermatology consult was obtained.

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He had "pimply stuff" over his entire scalp.
-The physician ordered some cream for his scalp but it had never been started.
-He was experiencing severe itching that was "driving (him) crazy".
-He started wearing a hat so he could scratch his head through the hat so maybe he wouldn't pull out all his hair scratching his head.
-He was supposed to be going to see a dermatologist but was waiting for the staff to schedule the appointment.
-His "boots on the ground lady" (CM) was going to get the doctor to give her an order so she could schedule the appointment herself.

Interview on 04/10/15 at 11:30 am with a Medication Aide (MA) revealed it was the Resident Care Coordinator's (RCC's) responsibility to schedule all appointments and she did not know who was performing those tasks since the RCC left.

Interview on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
-It was the responsibility of the MA on duty to put

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a copy of orders for scheduling appointments in the Transportation Aide's box.
-The Transportation Aide was supposed to schedule the appointments.

Interview on 04/14/15 at 11:20 am with a Medication Aide (MA) revealed:
-It was the responsibility of the MA on duty when an order was received to schedule all appointments and write the appointment in the Transportation Aide's "book" so he could transport the resident to the appointment.
____

The facility provided the following Plan of Protection on 04/10/15:
-Immediate audit of residents charts will be done to determine any outstanding health care needs needing followup.
-Staff will be inserviced prior to the next scheduled shift.
-The Executive Director, Health and Wellness Director, and designee will monitor for ongoing compliance.

CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015

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10A NCAC 13F .0909 Resident Rights

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE B VIOLATION

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Based on interviews and record reviews, the facility failed to ensure every resident was free from neglect, related to the mistreatment of residents by 1 staff member (Staff A).

The findings are:

Confidential interview with a resident revealed:
-Staff had informed the resident that Staff A was the reason that "all of the staff are leaving."
-Staff told the resident that Staff A was difficult to work for, told the staff what to do and then went out to smoke."
-Staff told the resident that if Staff A would leave, maybe they would be able to keep staff.
-The resident did not name the staff that had informed the resident of this.

Confidential interview with a second resident revealed:
-Staff A was administering medications to the resident.
-Staff A told the resident "you're either going to take the medication now or I will throw it in the trash and you will still have to pay for it."
-The resident took the pills and then went into the bathroom and threw up because taking all of the medicines at one time made her sick.
-Staff A never said anything directly to the resident that was rude, but her attitude was never friendly.
-The resident felt Staff A purposely gave her medications late because she had the power to do so.
-The resident always took her pain pill and thyroid pill about 5:30 am and her other pills after she ate breakfast, but Staff A would not give her pain pill sometimes until 2 hours after it was scheduled to be given.
-On one occassion, the resident went looking for

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Staff A to get her medications and Staff A was eating.
-When she asked Staff A for her medications, Staff A told her she would give them to her after she finished eating and she got her pills late.
-She never reported these situations to the ED because Staff A was always sitting in the ED's office, even during times when she was supposed to be passing medications, so she felt nothing would be done about it.

Confidential interview with a third resident revealed:
-Staff A would go outside to smoke instead of passing medications which caused the medications to be late.
-Many times Staff A "could not be found, so the boss lady" (the Executive Director) would give her the medication.
-Resident requested the information that was spoken about regarding Staff A not be shared with anyone.

Confidential interview with a visiting staff person revealed:
-The morning medication pass was never completed before lunch.
-Residents' complaints were also about medications not being administered, medications being out of stock or medications being administered up to two hours late. Most residents blamed Staff A and complained this happened only when Staff A worked.
-Staff A was heard by residents saying she was not coming to help one resident because "he curses at me."
-Several residents said that their medications were always late when Staff A worked.
-Residents complained that sometimes when Staff A worked they did not get their medications

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at all, especially at night.
-One resident expressed she was afraid of Staff A because she got "ill" with residents.
-Lots of residents complained that Staff A said hateful things to residents and staff.
-Staff reported to her they were leaving the facility because Staff A did things that were unethical and staff were afraid of losing their medication certification.
-Residents told her and validated the information with staff reports that a resident fell, Staff A knew about the fall told staff to check the resident's vitals. The resident was confused, had a responsible person, and the resident initially said she did not want to go out to the hospital.
-Staff A was the person in charge and Staff A said to not send the resident out because the resident had the right to refuse to go to the hospital. The resident's arm got worse overnight and the next morning the resident went to the hospital. The resident returned to the facility with a broken arm.
-These issues had not been discussed with the Executive Director (ED) because there was a close relationship with the ED, interim Resident Care Director (RCC) and Staff A.
-Also residents and staff expressed a great concern about retaliation from management if they complained about Staff A.

Interview on 04/10/15 at 10:51 am with a resident revealed:
-A couple of times Staff A forgot to give her medications.
-Most times when Staff A worked, the resident's medications were not administered.
-The resident said Staff A was on duty and she did not get her medications or insulin.
-The resident was unable to recall the specific date, but recalled it was about a month ago and it happened a couple of times when Staff A was on

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duty.
-The resident did not tell anyone for fear of retaliation.

Confidential interviews with three residents revealed:
-When Staff A worked they sometimes did not get their medications.
-One resident said one morning, Staff A forgot to her insulin injection and she had to ask for the injection. Staff A eventually gave her the insulin injection, but it was almost two hours later.
-One resident said one night Staff A forgot to give the resident's medication and insulin injection.
-The residents said this happened a lot lately, and it only happened when Staff A worked.
Interview on 4/10/15 at 3:50 pm with Staff A revealed:
- She administered medication on all shifts.
- Medications aides were responsible to reorder resident's medications in time to assure the resident did not run out of medication.
- She was instructed by the former RCC that medication aides were not to document residents' medication as being out of stock because the residents should not run out of medication.
- She had occasionally documented medications as administered when there was no medication available, but she was not sure of which residents.

Confidential interview with a resident revealed:
-The resident did not get evening scheduled medications (8:00 pm) until after 9:00 pm on numerous occasions.
-The late medications occurred most frequently when Staff A was working.
- Staff A was observed taking long smoke breaks while residents were waiting for scheduled evening medications.

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-The resident had told Staff A that residents' medication should come before breaks.

Confidential telephone interview with a resident's family member revealed:
-A family member resided at the facility.
-The resident had complained to the family member that the resident was receiving medications late, but most often when Staff A administered medications.
-The family member had spoken to Staff A about providing medication to the resident before taking smoke breaks and assuring the resident received medications as ordered.

Interview on 4/10/15 at 3:50 pm with Staff A revealed:
- She administered medication on all shifts.
- Medications aides were responsible to reorder resident's medications in time to assure the resident did not run out of medication.
- She was instructed by the former RCC that medication aides were not to document residents' medication as being out of stock because the residents should not run out of medication.
- She had occasionally documented medications as administered when there was no medication available, but she was not sure of which residents.

Further interview with Staff A on 04/14/15 at 4:00 pm revealed:
-The ED and RCC helped make the schedule.
-She had passed meds on many occasions alone when other staff did not show up.
-She never had difficulty passing medications alone for the entire building.
-She had found medications sitting inside the medication cart and would just throw them away.
- No one would admit to leaving medications on

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the medication cart.
-On one occasion another MA left medications on the medication cart, but she knew what resident they were for and she gave them to the resident.
-She was aware of residents complaining about staff being rude or disrespectful to them, but some would not report it due to possible retaliation from staff.
-Normally nothing would be done, but recently a MA was fired for poor treatment of a resident.
-She was aware residents were not getting their baths as scheduled.
-She came in a lot to help staff to keep just one person from working alone.
-She had decided to stop covering for others knowing she was probably going to get fired.
-She was aware "a lot of wrong things were going on".

Interview with the Administrator on 04/14/15 at 1:55 pm and at 5:00 pm revealed:
-She was unaware of any complaints from residents regarding residents' rights and, specifically, regarding the care and services provided by Staff A.
-The facility would conduct "our own investigation" and Staff A would be suspended.
-They would be interviewing all of the residents on 04/15/15.

____

The facility provided the following Plan of Protection on 04/14/15:
-All staff will be retrained on residents ' rights, ability to report concerns to management without fear of retaliation prior to the next scheduled shift.
-The Administrator will schedule the Ombudsman to come and provide information to residents regarding their rights and reporting concerns.
-Residents will also be reminded of their rights at the next resident council meeting and reporting

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concerns without fear of retaliation.
-This will be verified ongoing by the Executive Director.

THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2015.

D 358 10A NCAC 13F .1004(a) Medication Administration D 358

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 2 of 7 residents (#9, and #10) observed during medication administration which included errors with medications for vitamin supplementation, elevated lipids, allergies, skin disorders, and convulsion, and 5 of 10 residents (#9, #12, #18, #22, #16) sampled which included errors with medications for chest pain, pain, insomnia, allergies, skin disorders, and convulsions.

The findings are:

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A. Review of Resident #9's current FL2 dated 11/07/14 revealed:
- Diagnoses included chest pain, coronary artherosclerosis, diabetes, retinopathy, glaucoma, and hypertension.
- An order for Nitroglycerin 0.4 mg sublingual tablet one under the tongue every 5 minutes as needed for chest pain. (Nitroglycerin tablets are used to treat episodes of chest pain.)

Review of Resident #9's record revealed physician's orders dated 12/19/14 prescribing Nitroglycerin 0.4 mg sublingual tablet one under the tongue every 5 minutes as needed for chest pain.

1. Observation on 04/13/15 at 11:15 am revealed:
-Resident #9 was coming out of her bathroom and said she was feeling dizzy.
-Resident sat on her bed and stated that sitting down seemed to help.
-Resident's eyes were reddened.

Interview with Resident #9 on 04/13/15 at 11:20 am revealed:
-She was admitted to the facility in November 2014 following a heart attack.
-On the morning of 04/13/15, a family member had asked her to make sure that two tables in the activities room were clean for a luncheon the resident was having for friends and family.
-At approximately 9:25 am on 04/13/15, Resident #9 wiped off both tables and began to have chest and arm pain.
-She had not requested that facility staff clean the tables for her.
-Resident #9 went into the hallway outside of the activity room at approximately 9:30 am on 04/13/15 and told the nurse from a sister facility, who was passing medications, that she was

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having chest pain and arm pain from wiping tables.
-Resident #9 requested a Nitroglycerin tablet from the nurse at the time of informing her that she was having chest pain and arm pain.
-The nurse from a sister facility asked her room number, and then informed Resident #9 that the medication aide for her hall was supposed to give Resident #9 her medications.
-The nurse from a sister facility had Resident #9 to sit down on her walker seat and to inhale and exhale for a few minutes.
-"When I felt a little better, I went back to my room." (Measured by the surveyor as approximately 400 feet from activity room to resident's room.)
-She returned to her room without assistance after sitting for a few minutes.
-Resident #9 stated she rested in her bed and the chest pain eased off.
-She did not understand why the facility nurse did not give her the nitroglycerin, because she had had a previous heart attack and knew that Nitroglycerin was ordered by her doctor to help if she had chest pain.

One of the morning Medication Aides(MA) was notified on 4/13/15 at 11:40 am that Resident #9 had complained of being dizzy and previous chest pain.

Observation on 4/13/15 at 12:15 pm revealed 2 MAs were standing next to the medication cart outside Resident #9's room.

Interview on 4/13/15 at 12:15 pm with one of the MAs (first MA) revealed:
- She was assigned to administer morning medications to residents on the hall.
- She had checked on Resident #9 after being

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told the resident felt dizzy.

Interview on 4/13/15 at 12:15 pm with the second MA revealed:
- She was working as a Resident Care Assistant (RCA) today, but had joined first MA to assist with medications and checking on Resident #9.
- She had taken Resident #9's blood pressure at 11:49 am (175/102) and administered a nitroglycerin 0.4 mg SL tablet per the resident's request, took a blood pressure reading at 11:54 am (220/127) and administered a second nitroglycerin 0.4 mg SL tablet per the resident's request.
- The second MA stated the resident told her chest pain was much better after these doses, but requested a third nitroglycerin 0.4 mg SL tablet.
- The resident's blood pressure was down to 175/80 and the resident was feeling better.
- The resident told the MA she wanted to get ready for her guest that were coming for lunch at 1:00 pm.

Interview on 4/13/15 at 12:30 pm with Resident #9 revealed:
- She was feeling much better.
- She had a slight headache from the nitroglycerin, but she really wanted to have time with her friends.

Interview on 4/13/15 at 12:35 pm with the first MA revealed:
- The facility did not currently have a Health and Wellness nurse or Resident Care Coordinator due to staff turnover
- She had informed the nurse from a sister facility that was helping out at the facility of the administration of nitroglycerin to Resident #9.
- The nurse had instructed the first MA to take the

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resident's blood pressure in both arms and provided no further instruction.

Interview on 4/13/15 at 12:40 pm with the nurse from a sister facility revealed:
- She was passing medications on a hall earlier in the day when Resident #9 came out of the activity room.
- The resident told her that resident's right shoulder was hurting from wiping down the table.
- She stated she did not hear the resident say she was having chest pain as well as shoulder pain.
- She did not take the resident's blood pressure but took her pulse (72) and suggested she sit on her rolling walker/seat for a couple of minutes and do deep breathing.
- The nurse stated she was not aware the resident was taking nitroglycerin as needed, because she did not have her medications on the cart she was working.

Observation on 4/13/15 at 12:48 pm revealed the nurse from a sister facility came to the hall for Resident #9, went in the room with a manual blood pressure cuff and came back out of the room. (She stated Resident #9's blood pressure was 160/72 and the resident was not complaining of any chest pain.)

Interview on 4/13/15 at 12:48 pm with the Administrator revealed:
- The MA told her (a few minutes ago) that she gave a resident nitroglycerin. (She was in the dining room at the time assisting with lunch.)
- The Administrator told the MA she did not know the resident and she needed to talk to the nurse from the sister facility.
- She was not aware Resident #9 stated she had requested nitroglycerin tablets at 9:40 am.

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Observation on 4/13/15 at 2:55 pm revealed Resident #9 was in the activity room with 3 people playing cards at a table.

Interview on 4/13/15 at 3:00 pm with the nurse from a sister facility revealed:
- The MA had come to her earlier to tell her Resident #9's blood pressure was up.
- The MA was using an automatic blood pressure cuff.
- She instructed the MA to take the blood pressure manually, in both arms.
- The nurse stated the MA never came back to let her know the blood pressure.
- The nurse stated the MA did not tell her she had given nitroglycerin to the resident.

Interview on 4/13/15 at 4:30 pm with the Administrator revealed:
- She had faxed information about the administration of nitroglycerin to Resident #9's Nurse Practitioner (NP).
- The NP had instructed her to give the resident an anxiety medication, monitor the resident, and take her blood pressure 3 times a week in the afternoon.
- The NP did not request the resident be sent out to hospital.

2. Review of Resident #9's record revealed a physician's order dated 3/5/15 for Vitamin B complex one daily.

Observation of medication administration on 04/08/15 from 10:08 am to 10:25 am revealed:
- Sixteen medications were administered to Resident #9.
- Vitamin B complex was not administered.
- The medication aide documented no vitamin B complex was available for Resident #9.

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Review of Resident #9's April 2015 Medication Administration Record (MAR) revealed:
- Vitamin B complex one daily was listed and scheduled for administration at 8:00 am daily.
- Vitamin B complex was documented for "not given- on order" on 4/05, 4/07, and 4/08.

Observation on 4/08/14 at 10:08 am revealed Resident #9 had no vitamin B complex for administration on the medication cart.

Interview on 4/08/15 at 10:15 am with the Medication Aide (MA) revealed:
- She had only been working as a MA for a few days.
- The facility had an overstock cart for residents' medication as well as the regular cart.
- She had checked the overstock cart and no vitamin B complex was in the overstock.
- The resident had been out of the medication when she worked yesterday (4/07/15).
- She had not checked with the pharmacy for why the medication was not here.

Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-She worked in another facility but had been working in this facility for a couple of weeks to provide temporary assistance.
-It was the responsibility of the MA on duty to reorder medications when the supply was low.
-If a MA found a medication supply depleted, she was supposed to call the pharmacy.
- The MA could also get the medication sent from the back up pharmacy, in which case the medication would be delivered to the facility within 2 hours.
-Medication cart audits were supposed to be done weekly by the Resident Care Coordinator

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(RCC) to ensure the availability of medications, but she did not know if they had been completed.
-The facility currently had no RCC and no staff had been designated to perform those duties.

Interview on 4/10/15 at 11:15 am with a first shift MA revealed:
- It was the responsibility of the MA working the medication cart to order medications when they ran out.
- She was not aware of any system for medication cart audits to assure residents had medication on hand for administration.
- The facility had a lot of medications not on hand for different residents.

Interview on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
- When a medication supply was low, it was the MA's responsibility to reorder the medication.
- There was currently no monitoring system in place for ensuring medications were reordered timely.

Interview on 4/13/15 at 12:30 pm with Resident #9 revealed:
- She received her medications at varying times in the morning.
- She was aware her Nurse Practitioner had added a vitamin a while back.
- It was hard for her to keep up with all her medications.
- She was not aware she had not been receiving her vitamin B complex for the last few days.

Interview on 4/14/15 at 11:19 am with the Executive Director revealed:
-She began working at the facility in February 2015.
-When a medication supply was low, it was the

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MA's responsibility to reorder the medication.
-She was not aware medications were not being ordered timely, and were therefore unavailable for administration.
-She was not aware whether or not there was a process for auditing medication carts to ensure medications were in the facility and available for administration.
-She recently learned from the nurse who came to assist her, that the night shift staff were supposed to be conducting medication cart audits to ensure the availability of medications.

Interview on 4/14/15 at 12:50 pm with the pharmacy provider revealed was dispensed 30 vitamin B complex on 3/05/15, and on 4/05/15 for Resident #9.

B. Review of Resident #10's current FL2 dated 2/25/15 revealed diagnoses included Myasthenia Gravis, hypothyroidism, and allergic rhinitis.

Review of Resident #10's record revealed a physician's order dated 8/14/14 for vitamin B complex one daily.

Review of Resident # 10's Medication Administration Record (MAR) for April 2015 revealed:
- Vitamin B complex one daily was listed and scheduled for administration at 8:00 am daily.
- Vitamin B complex was documented for "not given- on order" on 4/07, and 4/08.

Interview on 4/08/15 at 9:55 am with Resident #10 revealed:
- Staff administered medications to her according to the physician's orders.
- She was not aware of being out of any of her medications.

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Interview on 4/08/15 at 10:15 am with the Medication Aide (MA) revealed:
- She had only been working as a MA for a few days.
- The facility had an overstock cart for residents' medication as well as the regular medication cart.
- She had checked the overstock cart and no vitamin B complex was in the overstock.
- The resident had been out of the medication when she worked yesterday (4/07/15).
- She had not checked with the pharmacy as to why the medication was not here.

Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-She worked in another facility, but had been working in this facility for a couple of weeks to provide temporary assistance.
-It was the responsibility of the MA on duty to reorder medications when the supply was low.
-If a MA found a medication supply depleted, she was supposed to call the pharmacy.
- The MA could also get the medication sent from the back up pharmacy, in which case the medication would be delivered to the facility within 2 hours.
-Medication cart audits were supposed to be done weekly by the Resident Care Coordinator (RCC) to ensure the availability of medications, but she did not know if they had been completed.
-The facility currently had no RCC and no staff had been designated to perform those duties.

Interview on 4/10/15 at 11:15 am with a first shift MA revealed:
- It was the responsibility of the MA working the medication cart to order medications when they ran out.
- She was not aware of any system for

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medication cart audits to assure residents had medication on hand for administration.
- The facility had a lot of medications not on hand for different residents.

Interview on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
- When a medication supply was low, it was the MA's responsibility to reorder the medication.
- There was currently no monitoring system in place for ensuring medications were reordered timely.

Interview on 4/14/15 at 11:19 am with the Executive Director revealed:
-She began working at the facility in February 2015.
-When a medication supply was low, it was the MA's responsibility to reorder the medication.
-She was not aware medications were not being ordered timely, and were therefore unavailable for administration.
-She was not aware whether or not there was a process for auditing medication carts to ensure medications were in the facility and available for administration.
-She recently learned from the nurse who came to assist her, that the night shift staff were supposed to be conducting medication cart audits to ensure the availability of medications.

Interview on 4/14/15 at 12:50 pm with the pharmacy provider revealed Resident #10 was dispensed 30 vitamin B complex on 3/09/15, and on 4/05/15.

C. Review of Resident #12's current FL2 dated 6/14/14 revealed diagnoses included other specified rehab procedure, other specified aftercare following surgery, aftercare healing

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pathologic fracture vertebrae, pathologic fracture of vertebrae, thoracic spondylosis without myelopathy, and Diabetes without complication Type II.

Review of Resident #12's record revealed an order 2/04/15 for oxycodone with acetaminophen 5mg/325mg one tablet every morning. (Acetaminophen 5mg/325mg is a narcotic pain reliever.)

Review of Resident #12's signed physician's orders dated 2/04/15, and physician's prescription orders dated 2/23/15 and 3/30/15 revealed fentanyl 25 microgram/hour (mcg/hr) patch apply one patch every 3 days was prescribed. (Fentanyl is a narcotic pain reliever. Fentanyl patch is a transdermal controlled release form of administration.)

Review of Resident #12's February 2015 Medication Administration Records (MAR) and controlled medication utilization record revealed:
- Fentanyl 25 mcg/hr was documented as administered on 2/23, and 2/26.
Review of Resident #12's March 2015 and April 2015 MARs and controlled medication utilization record revealed:
- Fentanyl 25 mcg/hr was documented administered 3/01, 3/07, 3/10, 3/13, 3/16, 3/19, 3/22, and last on 3/25/15.
- Fentanyl 25 mcg/hr was document as "on order" for 3/28, 3/31, 4/03, and 4/06.

Observation of the medication on hand for administration for Resident #12 on 4/08/15 revealed no fentanyl 25 mcg/hr patches were available for the resident.

Telephone interview on 4/09/15 at 10:30 am with

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the pharmacy provider revealed:
- The pharmacy last dispensed a month supply quantity of 10 patches (two boxes of 5) fentanyl 25 mcg/hr on 2/23/15.
- The pharmacy required a new written prescription for each dispensing of fentanyl.
- The procedure for ordering fentanyl was for the facility to fax the new order and send the original prescription order to the pharmacy provider.
- The original prescription would be forwarded to the pharmacy compliance department and the pharmacy would fill the order from the the faxed copy of the prescription when the fax was received.
- The pharmacy had no documentation for receiving a faxed prescription for fentanyl dated 3/30/15, therefore the pharmacy had not sent any medication.

Interview on 4/9/15 at 11:30 am with Resident #12 revealed:
- She took pain medication for chronic hip pain.
- She stated she received oxycodone with acetaminophen 5mg/325mg one tablet every morning.
- She was aware staff had not been applying her patch recently, but the pain seemed no worse than when she wore the patch.

Interviews on 4/09/15 at 11:04 am and on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
- When a medication supply was low, it was the MA's responsibility to reorder the medication.
- She was not responsible to do routine medication cart audits for medications being available for administration.
- The Resident Care Coordinator or the Health and Wellness Nurse were responsible to assure residents have medication available to

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administer.
- Both positions were currently vacant due to recent staff turnover.
- There was currently no monitoring system in place for ensuring medications were reordered timely.

Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-She worked in another facility, but had been working in this facility for a couple of weeks to provide temporary assistance.
-It was the responsibility of the MA on duty to reorder medications when the supply was low.
-If a MA found a medication supply depleted, she was supposed to call the pharmacy.
- The MA could also get the medication sent from the back up pharmacy, in which case the medication would be delivered to the facility within 2 hours.
-Medication cart audits were supposed to be done weekly by the Resident Care Coordinator (RCC) to ensure the availability of medications, but she did not know if they had been completed.
-The facility currently had no RCC and no staff had been designated to perform those duties.
- She was not aware Resident #12 did not have fentanyl 25 mcg/hr patch for 4 doses (12 days); it appeared the 3/30/15 order was faxed but there was no confirmation the fax was received by the pharmacy with the paperwork.
- The fax may not have gone through to the pharmacy; it appeared no one had checked on the medication not being available.
- She stated she would immediately check on the medication.
- Later on 4/10/15 the nurse stated the physician had discontinued the resident's fentanyl patch (She presented a telephone order for the same.)

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Interview on 4/10/15 at 11:15 am with a first shift MA on revealed:
- It was the responsibility of the MA working the medication cart to order medications when they ran out.
- She was not aware of any system for medication cart audits to assure residents had medication on hand for administration.
- The facility had a lot of medications not on hand for different residents.

Interview on 4/14/15 at 11:19 am with the Executive Director revealed:
-She began working at the facility in February 2015.
-When a medication supply was low, it was the MA's responsibility to reorder the medication.
-She was not aware medications were not being ordered timely, and were therefore unavailable for administration.
-She was not aware whether or not there was a process for auditing medication carts to ensure medications were in the facility and available for administration.
-She recently learned from the nurse who came to assist her, that the night shift staff were supposed to be conducting medication cart audits to ensure the availability of medications.

D. Review of Resident #18's current FL2 dated 8/14/14 revealed:
- Diagnoses included diabetes, hyperlipidemia, obstructive hydrocephalus, and paraplegia.
- An order for Temazepam 15 mg at night for insomnia.

Interviews with Resident #18, during the initial tour, on 4/08/15 at 8:15 am, and on 4/10/15 at 10:30 am revealed:
- She was not sure of the name of all the

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medications she received.
- She received her medications late on some days.
- The facility had been out of her "sleep medication" recently.
- She needed her "sleep medication" to help her fall asleep.

Review of Resident #18's March 2015 and April 2015 Medication Administration Record (MAR) and controlled medication utilization records revealed temazepam 15 mg was documented as administered except from 4/06/15 to 4/08/14 when temazepam was documented on the back of the MAR as "on order".

Review of Resident #18's controlled medication utilization records for March 2015 and April 2015 revealed temazepam 15 mg was documented as administered except from 4/06/15 to 4/08/14.

Telephone interview on 4/14/15 at 12:50 pm with the pharmacy provider revealed dispensing dates for temazepam 15 mg for Resident #18 as follows:
- 1/31/15 quantity of 30 capsules,
- 3/03/15 quantity of 30 capsules,
- 4/08/15 quantity of 30 capsules.

Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-She worked in another facility, but had been working in this facility for a couple of weeks to provide temporary assistance.
-It was the responsibility of the Medication Aide (MA) on duty to reorder medications when the supply was low.
-If a MA found a medication supply depleted, she was supposed to call the pharmacy.
- The MA could also get the medication sent from

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the back up pharmacy, in which case the medication would be delivered to the facility within 2 hours.
-Medication cart audits were supposed to be done weekly by the Resident Care Coordinator (RCC) to ensure the availability of medications, but she did not know if they had been completed.
-The facility currently had no RCC and no staff had been designated to perform those duties.

Interview on 4/10/15 at 11:15 am with a first shift MA revealed:
- It was the responsibility of the MA working the cart to order medications when they ran out.
- She was not aware of any system for medication cart audits to assure residents had medication on hand for administration.
- The facility had a lot of medications not on hand for different residents.

Interview on 4/10/15 at 3:50 pm with Lead Supervisor (LS) revealed:
- She administered medication on all shifts.
- MAs were responsible to reorder resident's medications in time to assure the resident did not run out of medication.
- If medication ran out on a Saturday, it would be Monday before the medication was sent from the pharmacy provider unless the medication was ordered from the back-up pharmacy.
- She was instructed by the former RCC that MAs were not to document residents' medication as being out of stock, because the residents should not run out of medication.
- She had occasionally documented medications as administered when there were no medication available, but she was not sure of which residents.

Interview on 4/14/15 at 11:19 am with the

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Executive Director revealed:
-She began working at the facility in February 2015.
-When a medication supply was low, it was the MA's responsibility to reorder the medication.
-She was not aware medications were not being ordered timely, and were therefore unavailable for administration.
-She was not aware whether or not there was a process for auditing medication carts to ensure medications were in the facility and available for administration.
-She recently learned from the nurse who came to assist her, that the night shift staff were supposed to be conducting medication cart audits to ensure the availability of medications.

E. Review of Resident #22's current FL2 dated 3/12/15 revealed:
- Diagnoses including gait abnormality, anxiety, mild aphasia, anemia, history of cerebrovascular accident and hypertension.
- An order for Norco 5/325 mg with no directions specified. (Norco is a narcotic pain reliever.)
- An order for tramadol 50 mg with no direction specified. (Tramadol is a pain reliever used to treat moderate to moderately severe pain.)

Review of Resident # 22's record revealed a previous FL2 dated 9/14/14 with medication orders as follows:
- Norco 5/325 mg two times a day.
- Tramadol 50 mg one every 6 hours as needed for pain.

Interview on 4/10/15 at 10:30 am with Resident #22 revealed:
- She had a wound on her leg which was being managed by home health that was healing slowly, but caused her some lingering pain.

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- She had a prescription for pain medication.
- She stated her pain was "stingy, burning pain-worse kind of pain" when she was hurting.
- She did not have pain medication for 3 days, recently.
- She did not know why the facility let her run out of pain medication because the Nurse Practitioner had told her she would write her a prescription whenever she needed it.
- The medication aide did not order her medication in time, before she ran out.
- She asked for tramadol the days she did not have her other pain medication.
- The staff got her pain medication, but she "just made out the best she could."

Review of Resident # 22's Medication Administration Record (MAR) for March 2015 revealed:
- Norco 5/325 mg one tablet 2 times a day was handwritten with administration scheduled at 8:00 am and 8:00 pm.
- Norco was documented as administered at 8:00 am and 8:00 pm daily from 3/01 to 3/20/15.
- Norco was documented as not administered (initials circled on the MAR and documentation on the reverse side of the MAR) on 3/21, 3/22, and 3/23/15.
- Norco was documented as administered from 3/24 to 3/31/15.

Review of Resident #22's controlled medication utilization records revealed:
- A prescription for 60 Norco 5/325 mg tablets dispensed on 2/18/15 had documentation for administration from 2/19/15 to 3/20/15 (Review of a calendar revealed 3/20/15 was on a Friday.)
- A prescription for 90 Norco 5/325 tablet dispensed on 3/23/15 (Monday) was documented from 3/24 to 4/14 (8:00 am).

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Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-She worked in another facility, but had been working in this facility for a couple of weeks to provide temporary assistance.
-It was the responsibility of the Medication Aide (MA) on duty to reorder medications when the supply was low.
-If a MA found a medication supply depleted, she was supposed to call the pharmacy.
- The MA could also get the medication sent from the back up pharmacy, in which case the medication would be delivered to the facility within 2 hours.
- Medication cart audits were supposed to be done weekly by the Resident Care Coordinator (RCC) to ensure the availability of medications, but she did not know if they had been being completed.
-The facility currently had no RCC and no staff had been designated to perform those duties.

Interview on 4/10/15 at 3:50 pm with Lead Supervisor (LS) revealed:
- MAs were responsible to reorder resident's medications in time to assure the resident did not run out of medication.
- If medication ran out on a Saturday, it would be Monday before the medication was sent from the pharmacy provider unless the medication was ordered from the back-up pharmacy.

Telephone interview on 4/13/15 at 4:30 pm with the pharmacy provider revealed:
- The pharmacy confirmed prescription orders and dispensing dates of 2/18/15 and 3/23/15 for Resident #22's Norco 5/325.
- No additional dispensing for the time frame from 2/18/15 to 3/23/15.

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- The pharmacy did not deliver medications on the weekends. (The back up pharmacy would deliver prescriptions on the weekends with prescription orders.)

Interview on 4/14/15 at 11:19 am with the Executive Director revealed:
-She began working at the facility in February 2015.
-When a medication supply was low, it was the MA's responsibility to reorder the medication.
-She was not aware medications were not being ordered timely, and were therefore unavailable for administration.
-She was not aware whether or not there was a process for auditing medication carts to ensure medications were in the facility and available for administration.
-She recently learned from the nurse who came to assist her, that the night shift staff were supposed to be conducting medication cart audits to ensure the availability of medications.
F. Review of Resident #16's current FL-2 dated 09/23/14 revealed diagnoses included cerebrovascular accident, hypertension, ischemic heart disease, diabetes type II, and depressive disorder.

1. Review of Resident #16's record revealed a physician's order dated 10/16/14 for cetirizine 10 mg at bedtime as needed for nasal congestion and allergy symptoms. (Cetirizine is an antihistamine.)

Review of the October 2014 Medication Administration Record (MAR) revealed:
-A handwritten entry for Cetirizine 10 mg was transcribed to the MAR with instructions to administer as needed.
-The entry did not include instructions to

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administer at bedtime.
-The cetirizine was documented as administered twice on 10/20/14, and once on 10/21/14, 10/24/14, 10/25/14, 10/26/14, and 10/27/14 with no documentation of administration times.

Continued review of the October 2014 MAR revealed:
-A second handwritten entry for cetirizine 10 mg was transcribed to be administered nightly at 8:00 pm.
-The cetirizine was documented as administered nightly from 10/24/14 through 10/31/14.

Review of pharmacy-generated MARs for November 2014 through April 2015 revealed:
-Cetirizine 10 mg was scheduled for administration at 8:00 pm nightly.
-The cetirizine was documented as administered nightly from 11/01/14 through 04/13/15.

Interview on 04/10/15 at 10:00 am with a representative from the facility's contracted pharmacy revealed the pharmacy staff incorrectly entered the order into the computer system as scheduled instead of prn (as needed).

Interview on 04/10/15 at 10:35 am with the facility nurse revealed:
-The MAs were responsible for reviewing MARs and physician orders at the end of each month as well as comparing the current MARs with the new ones sent out by the pharmacy to ensure accuracy.
-The Resident Care Coordinator (RCC) was responsible for ensuring the MAR checks were completed and for completing a second check of the MARs at the end of each month to ensure accuracy.
-The facility currently had no RCC and no staff

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had been designated to perform those duties.

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He relied on the facility staff to administer his medications as ordered by the physician.
-He experienced problems with his eyes tearing and "fluid down the back of (his) throat" on a daily basis.
-The physician told him his sinuses were overactive.
-He was not aware the cetirizine was ordered "as needed" but was glad the staff had been giving it to him every night.

2. Review of Resident #16's record revealed:
-A physician's order dated 04/02/15 for a dermatology consult and to start hydrocortisone 1% topical solution to scalp every night "until he sees dermatology".

Review of the April 2015 Medication Administration Record (MAR) on 04/10/15 revealed the hydrocortisone was transcribed to the MAR for administration at 8:00 pm nightly, but no doses were documented as administered.

Observation on 04/10/15 at 9:08 am of Resident #16's medications on hand revealed:
-A tube of hydrocortisone was dispensed from the pharmacy on 04/03/15.
-The tube was unopened with an unbroken paper seal across the top of the tube.

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He had "pimply stuff" over his entire scalp.
-The physician ordered some cream for his scalp, but it had never been started.
-He was experiencing severe itching that was

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"driving (him) crazy".
-He started wearing a hat so he could scratch his head through the hat so maybe he wouldn't pull out all his hair scratching his head.

A second review of the April 2015 MAR on 04/14/15 revealed the hydrocortisone was documented as administered at 8:00 pm on 04/11/15, 04/12/15, and 04/13/15.

A second interview on 04/14/15 at 3:22 pm with Resident #16 revealed the staff had not administered the hydrocortisone.

Observation on 04/14/15 at 3:45 pm of Resident #16's medications on hand revealed the hydrocortisone was still unopened with unbroken seal intact.

Interview on 04/14/15 at 3:50 pm with a Medication Aide (MA) revealed:
-He administered the hydrocortisone on at 8:00 pm on 04/11/15, 04/12/15, and 04/13/15 and documented the administration on the MAR.
-When informed the seal on the tube was unbroken, the MA stated he thought he administered the hydrocortisone and must have documented the administration by mistake.

3. Review of Resident #16's record revealed a physician's order dated 03/05/15 for gabapentin 300 mg nightly "due to probable neuropathic pain to right side of head and forehead he has had since his stroke". (Gabapentin is an anticonvulsant.)

Observation on 04/10/15 at 9:08 am of Resident #16's medications on hand revealed there was no gabapentin available for administration to the resident.

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Interview on 04/10/15 at 10:00 am with a representative from the facility's contracted pharmacy revealed:
-The pharmacy dispensed 30 capsules of gabapentin on 03/05/15.
-At the resident's ordered dosage, the gabapentin supply would have been depleted after the scheduled 8:00 pm dose on 04/03/15.
-The facility had not requested a refill of the medication.

Review of the March 2015 MAR revealed the gabapentin was documented as administered at 8:00 pm nightly from 03/06/15 through 03/31/15.

Review of the April 2015 MAR revealed:
-The gabapentin was documented as administered at 8:00 pm nightly from 04/01/15 through 04/09/15 with the exception of the 04/04/15 and 04/07/15 doses, which were circled as not administered.
-Documentation on the back of the MAR revealed the resident refused all his 8:00 pm medications on 04/04/15 and the gabapentin was not administered on 04/07/15 because it was "on order".

Interview on 04/14/15 at 11:15 am with the Executive Director revealed:
-She began working at the facility in February 2015.
-When a medication supply was low, it was the MA's responsibility to reorder the medication.
-She was not aware medications were not being ordered timely and were therefore unavailable for administration.
-She was not aware staff were documenting medications as administered when they were unavailable for administration to the residents.

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-She was not aware whether or not there was a process for auditing medication carts to ensure medications were in the facility and available for administration.
-She recently learned from the nurse who came to assist her that the night shift staff were supposed to be conducting medication cart audits to ensure the availability of medications.

Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-She worked in another facility but had been here in this facility for a couple of weeks to provide temporary assistance.
-It was the responsibility of the Medication Aide (MA) on duty to reorder medications when the supply was low.
-If a MA found a medication supply depleted, she was supposed to call the pharmacy and get the medication sent from back up. The medication would be delivered to the facility within 2 hours.
-Medication cart audits were supposed to be done weekly to ensure the availability of medications, but she did not know if they had been completed.

Interviews with three Medication Aides (MA) revealed:
-Two MAs stated it was the responsibility of the MA on duty to reorder medications when the supply was low.
-One MA stated it was the responsibility of the Lead Supervisor (LS) to reorder medications.

Interview on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
-When a medication supply was low, it was the MA's responsibility to reorder the medication.
-There was currently no monitoring system in place for ensuring medications were reordered

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timely.

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He relied on the facility staff to administer his medications as ordered by the physician.
-He used to know what all his pills looked like, but they had changed so much he could no longer identify them.
-He had "no idea" if he had missed any doses of gabapentin or how many might have been missed.
-He did not voice any complaints of recent increase in head or facial pain.

____

The facility provided a plan of protection as follows:
- The MARs (Medication Administration Records) and medication carts will be audited to assure medications are given as ordered.
- Associates will be inserviced regarding expectations prior to next scheduled shift.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.

D 364 — 10A NCAC 13F .1004(g) Medication Administration — D 364

10A NCAC 13F .1004 Medication Administration
(g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.

This Rule is not met as evidenced by:
TYPE B VIOLATION

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Based on observation, interview, and record review, the facility failed to assure medications were administered to residents within one hour before or one hour after scheduled medications for 6 of 7 residents (Residents #10, #9, #11, #12, #13, and #14) observed during medication administration on 4/08/15.

The findings are:

Thirteen residents shared concerns during interview on 4/15/15 and 4/16/15 related to receiving medications late during the last several months.

Observation of a Medication Aide (MA) on 4/08/15 at 9:45 am revealed:
- She was administering medications scheduled at 8:00 am to residents.
- The MA was documenting administration in the 8:00 am area of the residents' Medication Administration Records (MARs).

Observation on 4/9/15 revealed the MA completed the morning medication pass at 12:35 pm.

Interview with the MA on 4/9/15 at 9:15 am revealed:
-MA had 3 more residents that needed to receive their am medications.
-MA stated, "I have to keep stopping and searching for things that are not on the cart "
-MA stated, "This is my first day on the cart and I am a little slow."

Observation on 4/10/15 revealed one MA finished the morning medication pass at 10:35 am and a second MA finished her morning medication pass at 10:45 am.

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Interview with a MA on 4/10/15 at 8:30 am revealed the MA had 7 more residents that needed to receive their am medications.

Interview with a second MA on 4/10/15 at 9:15 am revealed the MA had 3 more residents that needed to receive their am medications.

A. Review of Resident #10's current FL2 dated 2/25/15 revealed diagnoses included Myasthenia Gravis, hypothyroidism, and allergic rhinitis.

Review of Resident #10's record revealed a physician's order dated 8/14/14 for pyridostigmine 60 mg tablets one and one-half (90 mg) every morning, 2 tablets (120 mg) at noon, and 1 tablet (60 mg) at 5 pm daily. (Pyridostigmine is used to treat Myasthenia Gravis symptoms.)

For medications prescribed for multiple daily doses, the failure to administer the doses at constant intervals places residents at risk for adverse effects or therapeutic failure.

Observation of medication administration on 4/08/15 at 9:54 am revealed the Medication(MA) administered 4 oral medications, including pyridostigmine 60 mg tablets one and one-half (90 mg) to Resident #10.

Review of Resident #10's Medication Administration Record (MAR) for April 2015 revealed:
- Pyridostigmine 60 mg tablets one and one-half (90 mg) every morning, 2 tablets (120 mg) at noon, and 1 tablet (60 mg) at 5 pm daily was listed and scheduled for administration at 8:00 am, 12:00 pm, and 5:00 pm.

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Interview on 4/08/15 at 10:00 am with Resident #10 revealed:
- She was aware her medication was late this morning.
- She normally received her medications earlier in the morning, stating "This is unusual for the medications to be this late."
- She did not notice any side effects if she received her medication a little late.

Refer to confidential interview with a resident during the initial tour on 4/08/15.

Refer to confidential interview with a second resident.

Refer to confidential telephone interview with a resident's family member.

Refer to confidential interviews with 3 residents.

Refer to the interview on 4/08/15 at 10:25 am with the Medication Aide.

Refer to interview on 4/10/15 at 11:30 am with a staff.

Refer to the interview on 4/14/15 at 3:00 pm with the Administrator.

B. Review of Resident #9's current FL2 dated 11/07/14 revealed:
- Diagnoses included chest pain, coronary artherosclerosis, diabetes, retinopathy, glaucoma, and hypertension.
- An order for Metoprolol 12.5 mg 2 times a day. (Metoprolol is used to treat hypertension.)

Review of Resident #9's record revealed physician's orders as follows:

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- An order dated 11/17/14 prescribing Tylenol 325 mg 2 tablets 3 times a day for pain.
- An order dated 2/19/15 prescribing Azopt drops one drop in each eye 3 times a day. (Azopt is used to lower intraoccular pressure in glaucoma.)
- An order for Combigan drops one drop in each eye 2 times a day. (Combigan is a combination eye drop used to lower intraoccular pressure in glaucoma.)

Observation of medication administration on 04/08/15 from 10:08 am to 10:25 am revealed 16 medications were administered to Resident # 9 including the following:
- Metoprolol 12.5 mg.
- Tylenol 325 mg 2 tablets.
- Azopt drops one drop in each eye.
- Combigan drops one drop in each eye.

For medications prescribed for multiple daily doses, the failure to administer the doses at constant intervals places residents at risk for adverse effects or therapeutic failure.

Review of Resident #9's April 2015 Medication Administration Record (MAR) revealed:
- Metoprolol 12.5 mg was scheduled for 8:00 am and 8:00 pm..
- Tylenol 325 mg 2 tablets was scheduled for 8:00 am, 12:00 pm, and 8:00 pm.
- Azopt drops one drop in each eye was scheduled for 8:00 am, 2:00 pm, and 8:00 pm.
- Combigan drops one drop in each eye was scheduled for 8:00 am and 8:00 pm.

Interview on 4/08/15 at 10:20 am with Resident #9 revealed:
- She was aware her medications were late.
- She received her 8:00 am medications late almost every day for the last month.

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- She was very upset that her medications were late because she believed receiving her medications late affected her glaucoma control.
- She had not experienced any adverse symptoms from receiving her oral medications late.
- She thought the staff did not have enough help to administer the medications on time.

Refer to confidential interview with a resident during the initial tour on 4/08/15.

Refer to confidential interview with a second resident.

Refer to confidential telephone interview with a resident's family member.

Refer to confidential interviews with 3 residents.

Refer to the interview on 04/08/15 at 10:25 am with the Medication Aide.

Refer to interview on 4/10/15 at 11:30 am with a staff.

Refer to the interview on 4/14/15 at 3:00 pm with the Administrator.

C. Review of Resident #11's current FL2 dated 1/09/15 revealed diagnoses included carotid artery occlusion without infarction, unspecified hereditary and idiopathic peripheral neuropathy, depression, and history of intertrochanteric hip fracture.

Review of Resident #11's hospital discharge summary dated 3/13/15 revealed diagnoses including altered mental status, lower urinary tract infection, and anemia.

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Continued review of the hospital discharge summary revealed:
- An order for gemfibrozil 600 mg 2 times daily before meals. (Gemfibrozil is used to treat elevated lipids in the blood.)
- An order for calcium carbonate-vitamin D 600-400 tablet 2 times daily. (Calcium carbonate-vitamin D 600-400 is a calcium supplement.)
- An order for glucosamine-chondroitin 500-400 tablet 2 times daily. (Glucosamine-chondroitin is used to treat osteoarthritis.)
- An order for metoprolol 25 mg one-half tablet 2 times daily. (Metoprolol is used to treat high blood pressure.)
- An order for Senokot-S 2 times daily. (Senokot-S is a combination laxative used for constipation.)
- An order for fish oil 1000 mg 3 times a day. (Fish oil is a vitamin supplement.)

Observation of medication administration for Resident #11 on 04/08/15 at 10:30 am revealed 12 medications were administered to Resident #11 including the following:
- Gemfibrozil 600 mg (Gemfibrozil 600 mg was ordered before meals on the discharge summary),
- Calcium carbonate-vitamin D,
- Glucosamine-chondroitin 500-400,
- Metoprolol 25 mg one-half tablet,
- Senokot-S,
- Fish oil 1000 mg.

For medications prescribed for multiple daily doses, the failure to administer the doses at constant intervals places residents at risk for adverse effects or therapeutic failure.

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Review of Resident #11's April 2015 Medication Administration Record (MAR) revealed:
- Gemfibrozil 600 mg was scheduled for administration at 7:30 am and 4:30 pm.
- Calcium carbonate-vitamin D was scheduled for administration at 8:00 am and 8:00 pm.
- Glucosamine-chondroitin 500-400 was scheduled for administration at 8:00 am and 8:00 pm.
- Metoprolol 25 mg one-half tablet was scheduled for administration at 8:00 am and 8:00 pm.
- Senokot-S was scheduled for administration at 8:00 am and 8:00 pm.
- Fish oil 1000 mg was scheduled for administration at 8:00 am, 12:00 pm and 8:00 pm.

Interview on 4/08/15 at 10:32 am with Resident #11 revealed:
- The resident had breakfast earlier in the day at 8:30 am.
- The resident usually received her medications on time.
- Resident declined further comment.

Refer to confidential interview with a resident during the initial tour on 4/08/15.

Refer to confidential interview with a second resident.

Refer to confidential telephone interview with a resident's family member.

Refer to confidential interviews with 3 residents.

Refer to the interview on 04/08/15 at 10:25 am with the Medication Aide.

Refer to interview on 4/10/15 at 11:30 am with a

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staff.

Refer to the interview on 4/14/15 at 3:00 pm with the Administrator.

D. Review of Resident #12's current FL2 dated 6/14/14 revealed diagnoses included other specified rehab procedure, other specified aftercare following surgery, aftercare healing pathologic fracture vertebrae, pathologic fracture of vertebrae, thoracic spondylosis without myelopathy, and diabetes without complication Type II.

Review of Resident #12's signed physician's orders dated 2/04/15 revealed:
- An order for calcium carbonate-vitamin D 600-400 tablet 2 times daily. (Calcium carbonate-vitamin D 600-400 is a calcium supplement.)
- An order for carvedilol 3.125 mg 2 times daily. (Carvedilol is used to treat heart failure.)
- An order for Lisinopril 10 mg 2 times a day. (Changed to Lisinopril 5 mg 2 times daily with signed physician order dated 2/10/15.) (Lisinopril is used to treat high blood pressure.)
- An order for metaloxone 800 mg one-half tablet twice a day. (Metaloxone is a muscle relaxer.)
- An order for Senokot-S two times a day. (Senokot-S is a combination laxative.)
- An order for oxycodone with acetaminophen 5mg/325mg one tablet every morning. (Acetaminophen 5mg/325mg is a narcotic pain reliever.)

Observation of medication administration for Resident #12 on 04/08/15 at 10:45 am revealed 8 medications were administered to Resident #12 including the following:
- Calcium carbonate-vitamin D 600-400 tablet.

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D 364	Continued From page 122 - Carvedilol 3.125 mg. - Lisinopril 5 mg. - Metaloxone 800 mg. - Senokot-S. - Oxycodone with acetaminophen 5mg/325mg. For medications prescribed for multiple daily doses, the failure to administer the doses at constant intervals places residents at risk for adverse effects or therapeutic failure. Review of Resident #12's April 2015 Medication Administration Record (MAR) revealed: - Calcium carbonate-vitamin D 600-400 tablet was scheduled at 8:00 am and 8:00 pm. - Carvedilol 3.125 mg was scheduled at 8:00 am and 8:00 pm. - Lisinopril 5 mg was scheduled at 8:00 am and 8:00 pm. - Metaloxone 800 mg was scheduled at 8:00 am and 8:00 pm. - Senokot-S was scheduled at 8:00 am and 8:00 pm. - Oxycodone with acetaminophen 5mg/325mg was scheduled for 8:00 am. Interview on 4/8/15 at 10:50 am with Resident #12 revealed: - Medication Aide staff usually administer her medications between 8:00 am and 8:30 am. - Resident #12 stated she was hurting. - The resident stated "been waiting for you". Refer to confidential interview with a resident during the initial tour on 4/08/15. Refer to confidential interview with a second resident. Refer to confidential telephone interview with a	D 364		

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resident's family member.

Refer to confidential interviews with 3 residents.

Refer to the interview on 04/08/15 at 10:25 am with the Medication Aide.

Refer to interview on 4/10/15 at 11:30 am with a staff.

Refer to the interview on 4/14/15 at 3:00 pm with the Administrator.

E. Review of Resident #13's current FL2 dated 10/14/14 revealed:
- Diagnoses included vertigo, lack of coordination, chronic kidney disease stage III, depressive disorder, gastroesophageal reflux disease (GERD), hypertension, and benign prostatic hypertension (BPH).
- An order for tamsulosin 0.4mg twice a day. (Tamsulosin is used to treat BPH.)
- An order for Prilosec 20 mg twice a day. (Prilosec is used to treat GERD.)

Observation of medication administration for Resident #13 on 04/08/15 at 10:45 am revealed 9 medications were administered to Resident #13 including tamsulosin 0.4 mg and Prilosec 20 mg.

Review of Resident #13's April 2015 Medication Administration Record (MAR) revealed:
- Tamsulosin 0.4mg was scheduled at 8:00 am and 8:00 pm.
- Prilosec 20 mg was scheduled at 8:00 am and 8:00 pm.

For medications prescribed for multiple daily doses, the failure to administer the doses at constant intervals places residents at risk for

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adverse effects or therapeutic failure.

Based on observation, and attempted interview on 4/08/15, Resident #13 was unable to provide reliable information.

Refer to confidential interview with a resident during the initial tour on 4/08/15.

Refer to confidential interview with a second resident.

Refer to confidential telephone interview with a resident's family member.

Refer to confidential interviews with 3 residents.

Refer to the interview on 04/08/15 at 10:25 am with the Medication Aide.

Refer to interview on 4/10/15 at 11:30 am with a staff.

Refer to the interview on 4/14/15 at 3:00 pm with the Administrator.

F. Review of Resident #14's current FL2 dated 02/19/15 revealed:
- Diagnoses included muscle weakness, hypertension, and heart disease.
- An order for oyster shell calcium 500 mg twice a day. (Oyster shell calcium is a calcium supplement.)
- An order for Tylenol 1000 mg (2 of 500 mg) at 8:00 am and 2:00 pm. (Tylenol is used to treat mild to moderate pain.)

Observation of medication administration for Resident #14 on 04/08/15 at 11:00 am revealed 5 medications were administered to Resident #14

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including oyster shell calcium and Tylenol.

Review of Resident #14's April 2015 Medication Administration Record (MAR) revealed:
- Oyster shell calcium 500 mg was scheduled at 8:00 am and 8:00 pm.
- Tylenol 500 mg tablet take 2 tablets (1000mg) was scheduled at 8:00 am and 2:00 pm.

For medications prescribed for multiple daily doses, the failure to administer the doses at constant intervals places residents at risk for adverse effects or therapeutic failure.

Interview on 4/08/15 at 11:08 am with Resident #14 revealed:
- She normally received her medications on time.
- She was not in a lot of discomfort even though she did not receive her Tylenol at 8:00 am.
- She did not have complaints about her medications being late today.

Refer to confidential interview with a resident during the initial tour on 4/08/15.

Refer to confidential interview with a second resident.

Refer to confidential telephone interview with a resident's family member.

Refer to confidential interviews with 3 residents.

Refer to the interview on 04/08/15 at 10:25 am with the Medication Aide.

Refer to interview on 4/10/15 at 11:30 am with a staff.

Refer to the interview on 4/14/15 at 3:00 pm with

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the Administrator.

____

Confidential interview with a resident during the initial tour on 4/08/15 revealed:
- Scheduled medications were administered at times that were not consistent with the scheduled times.
- The inconsistent times for medication administration had been most noticeable for the last 2 months.
- The facility did not have adequate medication aide staff to administer medications on time.
- Morning medications scheduled for 8:00 am were administered as late as 11:00 am on some days.

Confidential interview with a second resident revealed:
- Medications scheduled for administration at 8:00 pm were not administered until after 9:00 pm on numerous occasions.
- Late medications occurred most frequently when the Lead Supervisor (LS) was working.
- The LS was observed taking long smoke breaks while residents were waiting for scheduled evening medications.

Confidential telephone interview with a resident's family member revealed:
- The resident had complained to the family member about receiving medications late, but most often when the LS administered medications.
- The family member had spoken to the LS about providing medications to residents before taking smoke breaks and assuring the resident received medications as ordered.

Confidential interviews with three residents

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D 364	Continued From page 127 revealed: -When the LS worked the residents sometimes did not get their medications at the scheduled times. - Medications, including insulin, were sometimes almost two hours later. -The residents said this happened a lot lately. -Residents said it only happened when the LS worked. Interview on 4/8/15 at 10:25 am with morning medication aide revealed: - She was scheduled as a personal care aide (PCA) on 4/08/15. - She had not been scheduled to administer medications today (4/8/15). - She was aware medications should be administered one hour before up to one hour after the scheduled time of administration or as directed on the MAR. - The facility had only one medication aide scheduled to pass medications for 50 plus residents and most of the medications were scheduled at 8:00 am. - She got a late start passing medications because she was pulled from PCA duties by the Supervisor and started passing medications at 8:00 am. - The morning medication aide would routinely start passing medications scheduled for 8:00 am at 7:00 am. - She was not able to complete the medication pass on time due to the length of time required to spend with each resident during medication administration. - She was responsible to do the 12:00 pm medication pass as well as the 8:00 am medication pass. - She was aware residents' receiving medications scheduled more often than once a day could be	D 364		

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scheduled too close to the late morning medications.
- She delayed giving residents their 12:00 pm dose of medications until at the end of the one hour grace to allow for more time between the doses.
- Administration staff were aware she was running behind on the medication pass because the Lead Supervisor had walked pass her medication cart 2 times after 10:30 am and could see she was still passing medications.

Interview on 4/10/15 at 11:30 am with a staff revealed:
- Staff stated, "At 7:00 am I get on the medication cart after counting narcotics. We were told not to start administering 8:00 am medications before the designated time. I do not wait until 8:00 am to start my med pass. I have blood sugars to do when I come on duty. I do not have enough time to complete med pass because the med pass is too heavy."
- She did not receive assistance from management when she asked for help with medication pass, or task such as wound care.

Interview on 4/14/15 at 3:00 pm with the Administrator revealed:
- The facility had recently experienced staff vacancies in the Resident Care Coordinator (RCC) position and the Health and Wellness Nurse (HWN) position.
- The RCC and HWN had been responsible for monitoring medication administration.
- The facility had scheduled residents' morning medications at 8:00 am, 9:00 am, and 10:00 am at one time; she did not know when the times were switched to 8:00 am.
- She and the nurse from a sister facility had worked the last 3 days (4/11, 4/12, and 4/13) on

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D 364	Continued From page 129 modifying the scheduled morning medication administration times on the MARs to allow for staggered times. - She felt the staggered administration times would allow staff to meet the one hour before or after scheduled administration time. __________________ The facility provided a Plan of Protection as follows: -Immediately, medication administration times were reviewed with administration intervals made in administration times to allow for medication administration to be within the hour before and after per regulation. -Medication administration will be observed on an ongoing basis with adjustments made accordingly by the ED, HWD or designee. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2015.	D 364		
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;	D 367		

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(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure accuracy of the Medication Administration Record (MAR) including documentation of any omission of medications or treatments and the reason for the omission, including refusals, for 3 of 3 sampled residents (Residents #4, #7 and #16).

The findings are:

A. Review of Resident #7's current FL-2 dated 5/19/14 revealed:
- Diagnoses included coronary artery disease s/p (status post) coronary artery bypass graft, hypertension, chronic obstructive pulmonary disease, and hyperlipidemia.
- An order for Senokot (a laxative used to treat constipation) one daily.

Observation of medication administration during the initial tour on 4/08/15 at 7:15 am revealed:
- Resident #7 was standing at the medication cart.
- Resident #7 was holding a plastic souffle cup with a trace amount of red liquid and a tablet (brownish gray) inside the cup.
- Resident #7 disposed of the cup in the trash bin on the side of the medication cart.
- The medication aide was documenting medication administration on the resident's

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Medication Administration Record (MAR).

The surveyor removed the cup and identified the medication from the resident's medications on hand for administration and the MAR as generic Senokot.

Review of Resident #7's record revealed a signed physician's order dater 12/04/14 ordering medications including:
- Senokot S (A combination laxative used to treat constipation) one tablet every morning.
- Robitussin DM (A combination expectorant and cough suppressant) liquid 10 milliliters 4 times daily.

Review of Resident #7's record revealed a subsequent physician's order dater 3/5/15 for Senokot one tablet twice a day.

Review of Resident #7's April 2015 MAR revealed:
- Senokot one tablet twice daily daily was preprinted on the MAR and scheduled for administration at 8:00am and 8:00 pm..
- In addition, as entry for Senokot one tablet 2 times a day, scheduled for 8 am and 8 pm was handwritten on the MAR.
- Administration of Senokot was documented for 4/01/15 to 4/08/15 at 8:00 am on both entries.
- The medication aide (MA) documented on both entries for 4/08/15 at 8:00 am.

Interview on 4/08/15 at 7:15 am with Resident #7 revealed:
- He had just taken his medications for the morning.
- He had taken a liquid cough syrup, but did not take the "laxative" pill because he had already taken it.

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- He knew what medications he was supposed to be taking.

Later interview on 4/08/15 at 4:10 pm with Resident #7 revealed:
- He refused the morning dose of Senokot because he had some diarrhea.
- He was aware what medications he routinely received and normally only received one "laxative" pill with his medications.

Interview on 4/08/15 at 7:25 am with the night shift Medication Aide(MA) revealed:
- She had worked the night shift and stayed over to assist with medication administration for the day shift.
- She did not routinely administer residents' morning medications.
- The facility had been short of MA staff for about one month due to recent staff turnover.
- She was assisting with the morning medication pass for the hall Resident #7 resided.
- She was not sure why Senokot was on the MAR 2 times.
- She had overlooked that Senokot was listed two times on the MAR since the entries were on separate pages.
- She routinely went straight down the MARs and punched medications, so she felt certain she would have punched the Senokot two separate times.
- Resident #7 sometimes did not take his Senokot, but she thought he took all his medications this morning. (She did not see the resident put the Senokot in the cup before he discarded the cup.)
- Staff were supposed to circle their initials and document on the back of the MAR when a resident refused a medication.
- She did not document the medication as

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refused since she did not see the resident place the Senokot in the cup before he threw it away,

Interview on 4/08/15 at 3:00 pm with the Lead Supervisor (LS) revealed:
- The facility had been experiencing an unusual amount of staff turnover.
- The facility did not currently have a full time Health and Wellness Director(HWD) or Resident Care Coordinator (RCC).
- The review of the MAR from previous month to current month was currently being done by a MA on the night shift.
- The RCC was supposed to double check the MARs for completeness.
- No one had been routinely monitoring the MARs since the RCC position was currently vacant.
- Resident #7 had a recent hospital stay and was ordered medications that had to be transcribed to the April 2015 MAR.
- Based on documentation on the MAR, it appeared Resident #7 was receiving 2 Senokot tablets.

Observation on Resident #7's medication on hand for administration revealed:
- Four bingo cards of Senokot generic dispensed on 3/05/15 labeled one tablet twice a day with 1 card dispensed for 30 tablets with 24 remaining, one card dispensed for 30 with 20 remaining, one card dispensed for 30 having 27 remaining, and one card dispensed for 30 having 18 remaining.
- One bingo card of Senokot generic dispensed for 60 on 3/30/15 with 56 remaining.
- A total of 35 tablets were used from the bingo cards.

Reconciliation of the Senokot documented on the MARs from 3/05/15 to 4/08/15 revealed:
- Forty two tablets were documented as

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administered in March 2015.
- Thirty tablets were documented as administered (15 tablets if do not count the second entry).

Based on record review and observation, Resident #7 had Senokot that was refused but not documented on the MAR, and it could not be determined if Senokot transcribed on the MAR twice was administered as one tablet or 2 tablets.

B. Review of Resident #16's current FL-2 dated 09/23/14 revealed diagnoses included cerebrovascular accident, hypertension, ischemic heart disease, diabetes type II, and depressive disorder.

1. Review of Resident #16's record revealed a physician's order dated 10/16/14 for cetirizine 10 mg at bedtime as needed for nasal congestion and allergy symptoms. (Cetirizine is an antihistamine.)

Review of the October 2014 Medication Administration Record (MAR) revealed:
-A handwritten entry for Cetirizine 10 mg was transcribed to the MAR with instructions to administer as needed.
-The entry did not include instructions to administer at bedtime.
-The cetirizine was documented as administered twice on 10/20/14, and once on 10/21/14, 10/24/14, 10/25/14, 10/26/14, and 10/27/14 with no documentation of administration times.

Continued review of the October 2014 MAR revealed:
-A second handwritten entry for cetirizine 10 mg was transcribed to be administered nightly at 8:00 pm.
-The cetirizine was documented as administered

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nightly from 10/24/14 through 10/31/14.

Review of pharmacy-generated MARs for November 2014 through April 2015 revealed:
-Cetirizine 10 mg was scheduled for administration at 8:00 pm nightly.
-The cetirizine was documented as administered nightly from 11/01/14 through 04/13/15.

Interview on 04/10/15 at 10:00 am with a representative from the facility's contracted pharmacy revealed the pharmacy staff incorrectly entered the order into the computer system as scheduled instead of prn (as needed).

Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-The MAs were responsible for reviewing MARs and physician orders at the end of each month as well as comparing the current MARs with the new ones sent out by the pharmacy to ensure accuracy.
-The Resident Care Coordinator (RCC) was responsible for ensuring the MAR checks were completed and for completing a second check of the MARs at the end of each month to ensure accuracy.
-The facility currently had no RCC and no staff had been designated to perform those duties.

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He relied on the facility staff to administer his medications as ordered by the physician.
-He experienced problems with his eyes tearing and "fluid down the back of (his) throat" on a daily basis.
-The physician told him his sinuses were overactive.
-He was not aware the cetirizine was ordered "as

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needed" but was glad the staff had been giving it to him every night.

2. Review of Resident #16's record revealed:
-A physician's order dated 04/02/15 for a dermatology consult and to start hydrocortisone 1% topical solution to scalp every night "until he sees dermatology".

Review of the April 2015 Medication Administration Record (MAR) on 04/10/15 revealed the hydrocortisone was transcribed to the MAR for administration at 8:00 pm nightly, but no doses were documented as administered.

Observation on 04/10/15 at 9:08 am of Resident #16's medications on hand revealed:
-A tube of hydrocortisone was dispensed from the pharmacy on 04/03/15.
-The tube was unopened with an unbroken paper seal across the top of the tube.

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He had "pimply stuff" over his entire scalp.
-The physician ordered some cream for his scalp but it had never been started.
-He was experiencing severe itching that was "driving (him) crazy".
-He started wearing a hat so he could scratch his head through the hat so maybe he wouldn't pull out all his hair scratching his head.

A second review of the April 2015 MAR on 04/14/15 revealed the hydrocortisone was documented as administered at 8:00 pm on 04/11/15, 04/12/15, and 04/13/15.

A second interview on 04/14/15 at 3:22 pm with Resident #16 revealed the staff had not

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administered the hydrocortisone.

Observation on 04/14/15 at 3:45 pm of Resident #16's medications on hand revealed the hydrocortisone was still unopened with unbroken seal intact.

Interview on 04/14/15 at 3:50 pm with a Medication Aide (MA) revealed:
-He administered the hydrocortisone on at 8:00 pm on 04/11/15, 04/12/15, and 04/13/15 and documented the administration on the MAR.
-When informed the seal on the tube was unbroken, the MA stated he thought he administered the hydrocortisone and must have documented the administration by mistake.

3. Review of Resident #16's record revealed a physician's order dated 03/05/15 for gabapentin 300 mg nightly "due to probable neuropathic pain to right side of head and forehead he has had since his stroke". (Gabapentin is an anticonvulsant.)

Observation on 04/10/15 at 9:08 am of Resident #16's medications on hand revealed there was no gabapentin available for administration to the resident.

Interview on 04/10/15 at 10:00 am with a representative from the facility's contracted pharmacy revealed:
-The pharmacy dispensed 30 capsules of gabapentin on 03/05/15.
-At the resident's ordered dosage, the gabapentin supply would have been depleted after the scheduled 8:00 pm dose on 04/03/15.
-The facility had not requested a refill of the medication.

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Review of the March 2015 MAR revealed the gabapentin was documented as administered at 8:00 pm nightly from 03/06/15 through 03/31/15.

Review of the April 2015 MAR revealed:
-The gabapentin was documented as administered at 8:00 pm nightly from 04/01/15 through 04/09/15 with the exception of the 04/04/15 and 04/07/15 doses, which were circled as not administered.
-Documentation on the back of the MAR revealed the resident refused all his 8:00 pm medications on 04/04/15 and the gabapentin was not administered on 04/07/15 because it was "on order".

Interview on 04/14/15 at 11:15 am with the Executive Director revealed:
-She began working at the facility in February 2015.
-She was not aware staff were documenting medications as administered when they were unavailable for administration to the residents.
-She was not aware whether or not there was a process for auditing MARs to ensure accuracy of documentation.

Interview on 04/10/15 at 10:35 am with the nurse from a sister facility revealed:
-She worked in another facility but had been here in this facility for a couple of weeks to provide temporary assistance.
-Medication cart audits were supposed to be done weekly to ensure the availability of medications but she did not know if they had been being completed.
-She was not aware staff were documenting medications as administered when they had not been administered.
-Previous management had "threatened" staff

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and "punished" them for documenting medications as not administered or unavailable.

Interview on 04/10/15 at 3:17 pm with the Lead Supervisor (LS) revealed:
-There was currently no system in place for auditing MARs to ensure accuracy of documentation.
-"Older" MAs who were trained by prior management were "punished" for circling medications or documenting a medication was not available.
-MAs were instructed by prior management to document medications as administered regardless of whether or not they were actually administered.
-Punishment for documenting a medication as unavailable included having their scheduled working hours decreased or being pulled from the medication cart and scheduled to work as a Personal Care Aide (PCA).
-On one occasion, the LS was pulled from the cart and put "on the floor" because she circled a medication as not administered and documented that it was unavailable.

Interview with a Medication Aide (MA) revealed:
-She had been instructed by the previous Resident Care Coordinator (RCC) as well as the current LS not to circle medications as not administered or document they were unavailable for administration.
-The MA stated she was told to "go ahead and sign it".

Interview on 04/10/15 at 9:30 am with Resident #16 revealed:
-He relied on the facility staff to administer his medications as ordered by the physician.
-He used to know what all his pills looked like, but

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they had changed so much he could no longer identify them.
-He had "no idea" if he had missed any doses of gabapentin or how many might have been missed.
-He did not voice any complaints of recent increase in head or facial pain.

C. Review of Resident #4's current FL2 dated 01/25/15 revealed:
-Diagnoses of diabetes mellitus, chronic renal insufficiency, gout, hypertension, hypothyroid, osteoarthritis, and bradycardia.
-Medication orders included multi-vitamin (MVI) three times weekly.

Review of Resident #4's Medication Administration Records (MARs) for March and April 2015 revealed:
-MVI was printed on the MAR as "Tab-a-vite with iron tablet, take 1 by mouth three times weekly."
-The MVI was documented administered as order in March, 2015.
-The last entry for the administration of MVI was documented on 03/27/15.
-The medication should have been administered on March 30th, April 1st, April 3rd, April 6th, and April 8th, 2015.

Observation on 04/10/15 at 5:36 pm of Resident #4's medications on hand at the facility revealed:
-MVI was available for administration.
-According to the pharmacy printed label the medication was filled on 03/27/15 for 10 tablets.
-Two tablets were left in the package.
-There was no unused medication on the med-cart.

Interview on 04/13/15 at 3:50 pm with the pharmacy revealed:

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-On 12/3/14 they received an order for MVI for Resident #4.
-The pharmacy dispensed 10 tablets of MVI on 12/23/14, 01/31/15, 03/04/15, and 03/27/15.
-If the medication was administered as ordered the MVI dispensed on 03/27/15 should lasted the resident until March 17th, unless tablets were wasted.

Interview on 04/09/15 at 9:40 am with the Resident #4 revealed:
-She was aware that MVI was ordered.
-When medication were administered she did not specifically look for the MVI and was unaware if the mediation was in the cup when other medications were administered.
-She was often out of medications because staff did not order medications in advance.
-Staff usually told her when she was out of a medication.
-To her knowledge she had not been out the MVI, and did not know why it was not documented as administered on the MAR.

Interview on 04/10/15 at 11:15 am with a Medication Aide (MA) revealed:
-Today she administered Resident #4's MVI and documented on the MAR.
-She was unsure why the medication was not documented administered on March 30th, April 1st, April 3rd, April 6th, and April 8th, 2015.
-The MA checked the medication on the cart and observed two tablets left to administer to the resident.
-The MA stated she did not know why staff did not document the administration of the MVI March 30th, April 1st, April 3rd, April 6th, and April 8th, 2015.
-No medication cart audits were conducted to compare medications on hand with MARs and

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D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure physician contact regarding 1 of 1 resident (Resident #5) sampled who was non-compliant with self-administered medications. The findings are: Review of Resident #5's current FL2 dated 04/22/14 revealed: -Diagnoses of post stroke left side paralysis. -Physician orders: May self-administer medications, and keep medication in room. -Medication orders were Vitamin B12 1,000mg daily (vitamin supplement used for Vitamin B12 deficiency), Vitamin D3 1,000mg daily (vitamin supplement used for Vitamin D deficiency), Ultram 50mg as needed for pain, Aleve 220mg as 12 hours as needed for pain.	D 376		

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Review of Resident #5's Resident Register revealed an admission date of 12/16/13.

Review of Resident #5's record revealed:
-The resident had documentation of a self-administration medication assessment dated 12/20/14.
-There was no current documentation of a self-administration medication assessment in the resident's record.
-Staff documented on the Medication Administration Records (MARs) the administration of all medications excluding the as needed medications.

Observation on 04/09/15 at 4:21 pm of Resident #5's medications on hand in the resident's room revealed:
-The medications were in a locked box in the resident's closet.
-The resident did not have the B12 Vitamin, Aleve, and Ultram.
-The resident had three bottles of the Vitamin D3.

Interview on 04/09/15 at 4:34 pm with Resident #5 revealed:
-She did not take the Vitamin B12 anymore. She got enough B vitamin in her multi-vitamin, and there was no need for additional B12.
-She took 2,000 mg of the D3 vitamin, because in the winter and spring she needed the extra coverage to prevent getting sick.
-She did not have any more of the Ultram. She did not need the pain medication (Ultram) so she gave it away to a friend.
-She was out of the Aleve and had not went to the store to purchase any more.
-She did not inform the physician or facility staff that she was not taking the B12 anymore and that

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she doubled up on the Vitamin D3.
-The resident thought it was okay to give away the Ultram because she no longer needed the medication.
-Sometimes facility staff verbally asked her if she took all her medications.
-No one at the facility came to her and checked on medications or observed her take her medications.

Interview on 04/09/15 at 4:49 pm with the Lead Supervisor (LS) revealed:
-Medication aides did not observe Resident #5 taking her medications.
-The medication aides daily asked the resident if she took medication, then aides documented on the Medication Administration Record (MAR).
-No one checked the resident's medications to ensure the resident was taking her medication as ordered.
-It was the Resident Care Coordinator (RCC) responsibility to assess the resident's compliance and ability to self-administer her own medications.
-She was previously trained to initial the MARs and don't leave holes.
-Even if the medication was not available, so she told all medication aides the same thing.

Interview on 04/13/15 at 3:35 pm with two medication aides (MAs) revealed:
-Both MAs had not observed Resident #5 take her medications daily.
-Both MAs verbally asked the resident if she took her medications and then initialed the MAR.
-Both MAs had been instructed that they would get in trouble if there were holes on the MARs, so they initialed for all medications on the MARs.

Interview on 04/13/15 at 9:50 am with the interim

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D 376	Continued From page 145 Health and Wellness Director revealed: -The RCC was supposed to assess Resident #5 quarterly. -The facility's policy was to assess resident's who self-administer their own medications. -Also orders for self-administering medication was to be updated quarterly.	D 376		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding management of facilities, personal care, infection prevention, medication administration, staffing, and staff qualifications. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to ensure the Administrator was responsible for the total operation of the facility to maintain compliance in the rule areas of health care, medication administration, staff qualifications, staffing, training in cardiopulmonary resuscitation, personal care and supervision, infection prevention, resident rights, housekeeping,	D912		

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accuracy of medication administration records, and self-administration of medications. [Refer to Tag 176, 10A NCAC 13F .0601 (Type A2 Violation).]

B. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 8 sampled staff who administered medications had completed the clinical skills validation portion of the competency evaluation prior to the administration of medications (Staff C and Staff I). [Refer to Tag 935 G.S.& 131D-4.5B(b) (Type B Violation).]

C. Based on observations, interviews, and record reviews, the facility failed to ensure minimal staffing requirements were being met for all shifts from 02/01/15 through 04/08/15. [Refer to Tag 201, 10A NCAC 13F .0604 Personal Care and Other Staffing (Type B Violation).]

D. Based on observation, record review, and interview the facility failed to provide bathing assistance for 4 of 9 sampled residents who were unable to attend to personal care needs independently (Residents #7, #18, #22, and #23). [Refer to Tag 269, 10A NCAC 13F .0901(a) (Type B Violation).]

E. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the use of "house" glucometers for multiple residents and sharing labeled glucometers for 2 of 2 sampled residents (Residents #3 and #4). [Refer to Tag 932, G.S. 131D-4.4A(b) (Type B Violation).]

F. Based on observation, interview, and record

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D912	Continued From page 147 review, the facility failed to assure medications were administered to residents within one hour before or one hour after scheduled medications for 6 of 7 residents (Residents #10, #9, #11, #12, #13, and #14) observed during medication administration on 4/08/15. [Refer to Tag 364, 10A NCAC 13F .1004(j) Medication Administration (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that every resident be free from neglect, as related to residents' rights, medication administration, supervision, and health care. The findings are: A. Based on observation, record review and interviews, the facility failed to schedule appointments for referrals as ordered by the physician for 5 out of 10 sampled residents with mental health and new physician referral (Resident #2), dermatologist and mental health referral (Resident #16), ENT and GI referral (Resident #4), dermatologist referral and response to chest pain (Resident #9), and order for hospital bed (Resident #17). [Refer to Tag 273, 10A NCAC 13F .0902(b) (Type A2 Violation).] B. Based on interview, observation and record review, the facility failed to assure supervision for	D914		

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3 of 3 sampled residents (Resident #19, #17, and #8) who were at risk for frequent falls resulting in injury to Residents #19, #17, and #8.[Refer to Tag 270, 10A NCAC 13F .0901(b) (Type A2 Violation).]

C. Based on interviews and record reviews, the facility failed to ensure every resident was free from neglect related to the mistreatment of residents by 1 staff member (Staff A). [Refer to Tag 0338 10A NCAC 13F.0909 (Type B Violation).]

D. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 of 7 residents (#9, and #10) observed during medication administration which included errors with medications for vitamin supplementation, elevated lipids, allergies, skin disorders, and convulsion, and 5 of 10 residents (#9, #12, #18, #22, #16) sampled which included errors with medications for chest pain, pain, insomnia, allergies, skin disorders, and convulsions. [Refer to Tag 358, 10A NCAC 13F .1004(a) (Type A2 Violation).]

D932 G.S. 131D-4.4A (b) ACH Infection Prevention Requirements D932

G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012:
(1) Implement a written infection control policy

Division of Health Service Regulation

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D932	Continued From page 149 consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D932		

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reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the use of "house" glucometers for multiple residents and sharing labeled glucometers for 2 of 2 sampled residents (Residents #3 and #4).

The findings are:

Observation on 04/09/15 at 11:40 am of glucometers on the medication cart revealed:
-Six Brand A glucometers.
-The glucometer cases were labeled with each residents' name.
-The glucometers inside the cases were labeled with the residents' name.
-The glucometer case with Resident #4's name had Resident #3's glucometer inside.

Review of Resident #4's current FL2 dated 1/25/15 revealed:
-A diagnosis of diabetes.
-A physician's order for blood sugar checks twice daily.

Review of notes in Resident #4's record revealed:
-On 03/16/15 at 8:00 pm; staff documented the resident stated "I did not get my insulin this morning, they just left the little black pouch in my room with the syringe and stuff in there, they had my insulin ready in the syringe, why didn't they give it to me."
-The resident told the medication aide "when I went to lunch and came back the black pouch was gone."
-The medication aide checked the medication cart for the Resident #4's insulin and found two syringes filled with insulin and recapped.
-The medication aide that Resident #4 reported

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the pouch to, notified ED as to what happened.

Review of Resident #3's current FL2 dated 6/24/14 revealed:
-A diagnosis of diabetes.
-A physician's order to check fasting blood sugars daily at 7am, 4:30 pm and 9:00 pm

A comparison of the glucometer (Brand B) results in Resident #3 and #4's glucometer memory with documentation on the blood glucose monitoring forms revealed:
-Some days Resident #4's glucometer was used to obtain blood sugars (BS) results for Resident #3.
-Some days Resident #3's glucometer was used to obtain BS for Resident #4.
-Some day's one glucometer was used to obtain BS results for both Resident #3 and #4.

Examples of fingerstick blood sugar (FSBS) results obtained from Resident #3 and #4 using one glucometer were as follows:
-On 04/07/15 at 7:32 am FSBS 172, on Resident #4's blood glucose monitoring sheet.
-On 04/07/15 at 7:35 am FSBS 70, on Resident #3's blood glucose monitoring sheet.
-On 04/03/15 at 8:28 am FSBS 197, on Resident #4's blood glucose monitoring sheet.
-On 04/03/15 at 8:31 am FSBS 205, on Resident #3's blood glucose monitoring sheet.

Review of the Brand B house glucometer memory revealed:
-The date and time were not accurately set.
-There were multiple readings in the glucometer's memory occurring at various times throughout the day.

Examples of Brand B house glucometer memory

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recorded FSBS results obtained within 14 minutes on 4/7/15 were as follows:
-On 4/7/15 at 5:36 am, FSBS 129; (6 minutes later) at 5:42 am, FSBS 99; (8 minutes later) at 5:50 am, FSBS 78.

Example of Brand B house glucometer memory FSBS results from 3/24/15 through 3/26/15 were as follows:
-There were 2 BS results recorded in the glucometer memory that matched FSBS results documented on 3/26/15 on 2 different residents' blood glucose monitoring sheets.
-There were 3 FSBS results recorded on 03/24/15 with 2 FSBS recorded within 3 minutes apart as follows:
-On 03/24/15 at 8:46 pm FSBS 226.
-On 03/24/15 at 8:49 pm FSBS 183.
-On 03/24/15 at 9:00 pm FSBS 238.
-There were 8 FSBS results on 03/25/15 with 6 FSBS recorded within 2 to 5 minutes apart at as follows:
-On 03/25/15 at 10:17 am FSBS 266.
-On 03/25/15 at 10:19 am FSBS 138.
-On 03/25/15 at 4:03 pm FSBS 152 (recorded on another resident's blood glucose monitoring form on 3/26/15 at 4:00 pm).
-On 03/25/15 at 4:08 pm FSBS 112.
-On 03/25/15 at 4:31 pm FSBS 182.
-On 03/25/15 at 4:33 pm FSBS 127.
-On 03/25/15 at 8:54 pm FSBS 154 (recorded on another resident's blood glucose monitoring sheet on 3/26/15 at 8:00 pm).
-On 03/25/15 at 8:57 pm FSBS 163.

Interview on 04/10/15 at 12:50 pm with the manufacturer's of Brand A and Brand B glucometers revealed:
-The glucometers were designed for multiple use.
-The glucometers must be disinfected with

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approved PDI disinfecting wipe between each use.
-Carefully follow instructions.

Review of both Brand C house glucometer memory revealed:
-The date accurately set, but the time was off by 21 hours.
-There were multiple readings in the glucometer's memory occurring at various times throughout the day.

Example of both Brand C house glucometers' memory with 27 FSBS results in from 3/16/15 through 3/28/15 were as follows:
-There were 5 FSBS results recorded in the glucometer memory for the same day on 03/26/15.
-There were with 2 FSBS recorded less than 1 minute apart on 03/16/15 at 2:56 (138) and at 2:56 pm (178) pm.
-On 03/16/15 at 3:58 am FSBS 212.
-On 03/16/15 at 4:04 am FSBS 158.
-On 03/26/15 at 4:36 am FSBS 153.
-On 03/26/15 at 11:58 am FSBS 70.
-On 03/26/15 at 2:56 pm FSBS 178.
-On 03/26/15 at 2:56 pm FSBS 138.
-On 03/26/15 at 5:46 pm FSBS 148.
-On 03/27/15 at 3:46 pm FSBS 172.
-On 03/27/15 at 4:01 pm FSBS 154.
-On 03/27/15 at 12:10 pm FSBS 103
-On 03/27/15 at 7:37 pm FSBS 108.
-On 03/28/15 at 3:32 am FSBS 183.
-On 03/28/15 at 11:36 am FSBS 71.
-On 03/28/15 at 3:41 pm FSBS 172.
-On 03/28/15 at 6:22 pm FSBS 78

Review of the instructions on the name brand disinfectant wipes revealed:
-To disinfect surfaces contacting blood borne

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pathogens, saturate the surface so that it remains visibly wet for 2 minutes, and let air dry.

Review of online instructions for Brand C glucometers revealed the machine was designed for single use only, do not share the glucometer with anyone.

Interview on 04/09/15 at 1:40 pm with the Lead Supervisor (LS) revealed:
-About one and one-half weeks ago the business office manager ordered new glucometers for all residents in the facility.
-The business office manager ordered the wrong strips and they did not work in the glucometer.
-The facility had three house glucometers (one Brand B and two Brand C).
-The LS said she was not sure if the glucometers were approved for multiple use.
-She had instructed medication aides to use one glucometer to check residents' blood sugars.
-She was unaware the glucometers could not be shared unless disinfected.
-There was no system in place to check glucometers with documented blood sugars to ensure they were not being shared.
-The facility had approved EPA (Environmental Protection Agency) approved name brand disinfectant wipes.
-She had instructed the medication aides to use the wipes to clean the medication cart after each medication pass.

Interview on 04/10/15 at 10:51 am with Resident #4 revealed:
-She saw the LS check her roommate's BS and then the LS used the same glucometer to check her BS.
-The resident told the LS she did not think the same glucometer should be used to check her

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BS and other residents' BS.
-The LS told the resident it was okay to use the same glucometer to check her blood sugar and other residents' blood sugar.
-The resident did not observe the LS clean or disinfect the glucometer after checking her roommate's blood sugar.

Interview on 04/10/15 at 11:08 am with Resident #3 revealed:
-She thought the glucometer used by staff to check her blood sugar had her name on it.
-The resident said a name was on the glucometer, she could not clearly see the name, but thought it was her name.

Interview with two medication aides revealed:
-One medication aide said the LS told her to use one glucometer to check three residents' blood sugars.
-A second medication aide said the LS told her to use one glucometer to check the blood sugar of all residents ordered fingerstick blood sugars.
-The facility had disinfectant wipes, but the LS did not instruct medication aides to use disinfectant wipes on the glucometers between each resident. The LS had instructed the MAs to use alcohol wipes to clean the glucometers after each use.
-The glucometers were cleaned with alcohol wipes between each resident use.

Review of the facility's policy on how to clean and maintain a blood glucose glucometers revealed:
-Staff should disinfect after each use following the manufacturer's directions using a cloth/wipe with an Environmental Protection Agency (EPA) registered detergent/germicide with a tuberculocidal or HBV/HIV label claim.
-When using the EPA approved disinfectant wipes wait 2 minutes for bactericidal, tuberculocidal and

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virucidal to become effective.

Interview on 04/13/15 at 10:48 am with a day shift medication aide revealed:
-The weekend past she was instructed by the business office manager to use the same glucometer for all residents in the facility.
-There were no strips available for the Brand A glucometers.
-She cleaned each glucometer between collecting BS results by wiping the glucometer down with alcohol wipes.
-No one had instructed her to use or informed her how to use the EPA disinfectant wipes that were in the medication room.
-She never used the disinfectant wipes before.
-She was unable to recall infection control training.
-She was unaware how or why Resident #3's glucometer was located in Resident #4's case.

Interview on 04/13/15 at 4:50 pm with an evening medication aide revealed:
-About one week a little over a week ago the facility did not have strips for the Brand A glucometers.
-He used one of the house glucometers to check all the resident's blood sugars.
-He was unaware if the Brand A glucometer was designed for multiple use.
-He cleaned the glucometer after each resident using an alcohol wipes.
-He was told by the LS to use alcohol wipes to clean the glucometers.
-No one had informed him how to disinfect the glucometer.
-He recalled taking the infection control training, but was unable to recall the process how to disinfect glucometers.
-He was unaware how or why Resident #3's

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D932	Continued From page 157 glucometer was in Resident #4's case. ______________________________ The facility provided the following Plan of Protection on 04/10/15 as follows: -Glucometers will be immediately replace with designated glucometers for each resident. -Staff will be in-serviced prior to the next scheduled shift of sharing glucometers. -Health and Wellness Director will monitor. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2015.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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	HAL034035	A. BUILDING: ______ B. WING ______	C 04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE REYNOLDA ROAD	2980 REYNOLDA ROAD WINSTON SALEM, NC 27106

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(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.
(3) Within 60 days from the date of hire, the individual must have completed the following:
a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 8 sampled staff who administered medications had completed the clinical skills validation portion of the competency evaluation prior to the administration of medications (Staff C and Staff I).

The findings are:

A. Review of Staff C's personnel file revealed:
-Hire date 03/04/13 as Resident Care Aide (RCA).
-Staff C later became a Medication Aide (MA), but there was no documentation in the personnel file to indicate when the change was made.

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-Clinical skills validation dated 04/07/15.

Review of the April 2015 Medication Administration Records (MARs) revealed Staff C administered medications on 04/03/15, 04/04/15, 04/05/15, and 04/07/15.

Interview on 04/10/15 at 2:25 pm with Staff C revealed:
-She had worked at the facility since March 2013 as a Resident Care Aide (RCA) but recently became a MA.
-She was checked off by a nurse to administer medications on 04/07/15.
-She administered all the medications from 04/03/15 through 04/05/15 and 04/07/15 prior to being validated by the nurse.
-She was validated by the nurse to administer medications at approximately 11:00 am after she completed the morning medication pass on 04/07/15.
-She knew she had to be approved to administer medications but did not know a nurse had to complete the skills validation prior to administering medications.
-She received a text message at 5:30 am on the morning of 04/03/15 from the Lead Supervisor (LS) saying that Staff C was to administer medications.
-Staff C informed the LS that she had not yet been checked off to administer medications.
-The LS told Staff C it had "already been approved" by the ED (Executive Director) and the facility nurse.

Interviews on 04/10/15 at 3:45 pm and 04/14/15 at 3:45 pm with the Lead Supervisor (LS) revealed:
-She and the ED were responsible for staff scheduling and the ED and RCC reviewed and

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D935	Continued From page 160	D935		

approved every schedule.
-She was aware of each staff person's qualifications and placed them on the schedule accordingly.
-When she sent the text message to Staff C on 04/03/15, she was aware Staff C had not yet been validated by a nurse to administer medications.
-The nurse from a sister facility, who was helping in this building, instructed her to tell Staff C to administer the medications.
-She did not question the facility nurse.

Refer to interview on 04/09/15 at 10:35 am with the nurse from a sister facility.

Refer to interview on 04/14/15 at 11:15 am with the Executive Director.

B. Observation on 04/08/15 at 7:15 am revealed:
-Staff I was in front of the medication cart with the Medication Administration Record (MAR) open preparing to administer medications.
-She stated she was the only Medication Aide (MA) scheduled to work the day shift today.
-She had not started passing the medications yet.

Review of Staff I's personnel file revealed:
-Hire date of 03/23/15 as a MA.
-No documentation of a clinical skills validation.

Interview on 04/08/15 at 8:10 am with Staff I revealed:
-She had been in training to be a MA in the facility and had not administered any medications in this facility.
-When she arrived at the facility this morning at 7:00 am, she was told by the night shift MA that she was supposed to count off with her and administer the morning medications.

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-The night shift MA stated the directive came from the Lead Supervisor (LS).
-Staff I knew she was not supposed to administer medications because she had not been validated by the nurse.
-She was standing in front of the medication cart trying to decide what to do when surveyors arrived.
-She had been a MA for 10 years prior to working at this facility and wanted to continue to be a MA.
-When staff notified the ED that surveyors had arrived, they informed her that Staff I was scheduled to administer the morning medications and had not been validated by a nurse.
-The ED asked to speak with Staff I and instructed her to "switch with (Staff C), who was working as a Resident Care Aide (RCA).
-Staff C took over the MA duties and Staff I took over the RCA duties.

Interview on 04/08/15 at 8:30 am with the night shift MA revealed:
-The LS instructed her to count off with Staff I at the end of her shift.
-Staff I was to administer the morning medications.

Interviews on 04/10/15 at 3:45 pm and 04/14/15 at 3:45 pm with the LS revealed:
-She was aware of each staff person's qualifications and placed them on the schedule accordingly.
-Newly hired MAs were supposed to "shadow" another MA for three days, then be "shadowed" for three days, and then be validated by a nurse.
-Whenever she made adjustments to the schedule, it was always with the approval of the ED or the facility nurse.

Refer to interview on 04/09/15 at 10:35 am with

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D935	Continued From page 162 the nurse from a sister facility. Refer to interview on 04/14/15 at 11:15 am with the Executive Director. ______ Interview on 04/09/15 at 10:35 am with the nurse from a sister facility revealed: -When a new MA was hired, they were supposed to "shadow" with another MA for a minimum of 3 days, then get validated by a nurse prior to administering medications. -The nurse did not instruct any MAs to administer medications prior to being validated by a nurse. Interview on 04/14/15 at 11:15 am with the ED revealed she was not aware there were MAs administering medications who had not yet been validated by a nurse. ______ On 04/10/15, the Administrator submitted a Plan of Protection as follows: -An immediate audit of all staff personnel files would be conducted to ensure qualification requirements were met. -The Executive Director or designee would ensure qualifications have been met prior to administering further medications. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2015.	D935		