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
	HAL053027	A. BUILDING: _____ B. WING _____	R-C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Lee County Department of Social Services conducted an annual survey, complaint investigation and follow-up survey on 08/19/15 and 08/20/15. The complaint investigation was initiated by the Lee County Department of Social Services on 07/15/15.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the hot water for 7 of 26 sink fixtures and 5 of 26 shower fixtures in the resident bathrooms were maintained between 100 degrees Fahrenheit (F) and 116 degrees F, with hot water temperatures ranging from 128 degrees to 138 degrees F. The findings are: Observations of the facility during the initial tour on 08/19/15 between 10:45 am and 11:50 am revealed:	D 113	A Robinson	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: A Robinson | Alfreda Robinson | TITLE: Administrator | (X6) DATE: 9/13/2015

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D 113	Continued From page 1 - The hot water on the East Hall (Rooms #1-#13) ranged from 128 to 136 degrees F. - The hot water on the West Hall (Rooms #14-#26) ranged from 128 to 138 degrees F. Examples of hot water temperatures measured between 10:45 am and 11:50 am included the following: - Room #11, at the sink was 128 degrees F. - Room #14, at the sink was 132 degrees F. - Room #14, at the shower was 128 degrees F. - Room #15, at the sink was 130 degrees F. - Room #5, at the sink was 130 degrees F. Interview on 08/19/15 at 11:35 am with the resident in Room #5 revealed: - She was able to adjust the hot water temperatures. - She bathed independently. - She had no concerns with the hot water temperatures. - She had not been burned by the hot water in the bathroom. Interview on 08/19/15 at 12:17 pm with a resident in Room #4 revealed: - Staff assisted him with showers. - He had no concerns with the hot water temperatures. Interview on 08/19/15 at 11:24 am with a resident of Room #15 revealed: - He had no concerns with the hot water temperatures. - He thought the water wasn't too hot or too cold, that it was "just average". Interview on 08/19/15 at 11:00 am with residents in Room #11 revealed: - Sometimes the hot water was "too hot".	D 113		

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D 113	Continued From page 2 - The hot water "takes a while to regulate". - Neither had been burned by the hot water. Interview on 08/19/15 at 11:20 am with a resident who resided in Room #14 revealed: - The hot water temperature was comfortable. - He would put the handle in the middle for warm water, he would put the handle toward the "H" for hot water and toward the "C" for cold water. - He had not been burned by the hot water in the bathroom. Interview on 08/19/20 at 4:45 pm with the resident in Room #17 revealed: - He was able to regulate the hot water. - He had not noticed the hot water being too hot. Interview on 08/19/15 at 2:45 pm with the Maintenance Director revealed: - He had worked at the facility for 7 months. - He checked hot water temperatures every week, usually on Thursday. - He checked 2 random resident rooms on the East and West halls weekly. - He had not been aware of any elevated hot water temperatures. - He had documentation of the water temperature logs. Review of the water temperature logs provided by the Maintenance Director revealed: - Hot water temperatures were checked in a total of 110 sinks and 2 showers weekly. - The hot water temperature documentation ranged from 111 to 115 degrees F the last time it was checked, last Thursday on August 13, 2015. - There were no documented elevated hot water temperatures. Interview on 08/19/15 at 3:15 pm with the	D 113		

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D 113	Continued From page 3 Administrator revealed: - She had not been aware of any elevated hot water temperatures until today. - She posted caution signs at 12:00 pm, warning residents and staff of the elevated water temperatures, once she was aware of the elevated hot water temperatures. - A plumber was scheduled to arrive shortly to work on the hot water heater. The plumber arrived at 4:00 pm on 08/19/15 and worked with the maintenance staff concerning the hot water temperatures. Interview on 08/19/20 at 3:00 with the Maintenance Director revealed: - Water temperatures were still recording in the 130 to 135 degree F range. - A plumber was on site and working on the hot water issues. - There was a problem with the mixing valve causing the hot water temperature to be too high. - The mixing valve was designed to lower the temperatures to the desired range, but it was not allowing enough hot water into the system. - The hot water thermostat had a low range of only 120 degrees. - The Administrator had posted signs at every sink notifying staff and residents of the hot water problems and for them to use caution. Recheck of hot water temperatures between 4:45 pm and 5:15 pm revealed: - Room #21, at the sink was 118 degrees F. - Room #20, at the sink was 118 degrees F. - Room #17, at the sink was 118 degrees F. - Room #19, at the sink was 118 degrees F. - Room #4, at the sink was 134 degrees F. - Room #5, at the sink was 134 degrees F.	D 113		

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D 113	Continued From page 4 Interview with the plumber on 8/19/15 at 4:14 pm revealed: -He was checking the hot water system to see if the problem with the hot water temperatures could be the mixing valve. -If the problem was with the mixing valve, then the mixing valve would need to be replaced. -He was working on getting the hot water temperatures down now. Interview on 08/19/15 at 5:20 with the Administrator revealed: - The hot water would be turned off in the rooms that still had the elevated temperatures. - Hot water would still be available in the facility, in the common bath rooms and the resident bathrooms with acceptable temperatures. Interview on 08/19/15 at 6:00 pm with the Maintenance Director revealed he would continue to monitor the hot water temperatures throughout the night and document the findings. Review on 08/20/15 at 7:15 am of documentation provided by Maintenance staff revealed: - 5 resident bathroom sinks were checked at 6:41 pm and temperatures ranged from 108 degrees to 120 degrees F. - 6 resident bathroom sinks were checked at 9 pm and the temperatures ranged from 108 to 127 degrees F. - 4 resident bathroom sinks were checked at 1 am and the temperatures ranged from 107 degrees to 123 degrees F. - 4 resident bathroom sinks were checked at 3 am and the temperatures ranged from 118 to 126 degrees F. - 4 resident bathroom sinks were checked at 5 am and the temperatures ranged from 115 to 125 degrees F.	D 113	10A NCAC13F .0331(d) Other requirements Rule has been meet as evidenced by Water temperatures are within range as of 8/20/2015,with provided documentation Plumber returned on 9/09/2015 to insure system is functioning properly. Maintenance will continue to check water temperatures weekly and record all findings. Maintenance will report all noncompliant ranges to Administrator immediately. Resident Care Director will monitor water temparature logs monthly and Administrator will monitor as needed.	8/20/2015

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D 113	Continued From page 5 - 4 resident bathroom sinks were checked at 7 am and the temperatures ranged from 118 to 124 degrees F. Recheck of hot water temperatures on 08/20/15 between 9:38 am and 9:48 am revealed: - Room #4, at the sink was 110 degrees F. - Room #5, at the sink was 114 degrees F. - Room #7, at the sink was 110 degrees F. - Room #14, at the sink was 112 degrees F. - Room #15, at the sink was 110 degrees F. - Room #17, at the sink was 114 degrees F. A plan of protection was provided by the facility on 08/19/15 as follows: - Staff were notified immediately of elevated hot water temperatures. - Caution signs were posted warning residents and staff of the hot water temperatures. - Hot water temperatures will continue to be checked by maintenance on a weekly basis. - If hot water temperatures are found to be out of compliance, warning signs will be posted to make staff and residents aware. - The Resident Care Director will monitor the temperature log monthly. - The Administrator will monitor as needed. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2015.	D 113		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs,	D 270		

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D 270	Continued From page 6 care plan and current symptoms. This Rule is not met as evidenced by TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with each resident assessed needs, care plan and current symptoms for 1 resident (Resident #1) who was locked in the bathroom overnight and subsequently expired in the bathroom. The findings are: The facility census on 7/15/15 was 23 residents. Review of the facility staffing schedule for 7/15/15 revealed: -On 7/15/15 from 7:00 pm to 7:00 am there was one Personal Care Aide (PCA) and one Medication Aide (MA) on the schedule to work the building that shift. Review of Resident #1's current FL2 dated 5/7/15 revealed diagnosis included hypertension, hyperlipidemia, depression, chronic pain and history of pulmonary embolism. Review of Resident #1's record revealed no DNR in record. Review of Resident #1's Care Plan dated 7/10/2014 revealed: Assistance with ADLs (activities of daily living) listed as eating, toileting, ambulation, bathing, dressing, grooming and transfer.	D 270	10A NCAC 13F .0901 (b) Personal Care and Supervision. Rule met as evidenced by direct care staff educated on supervising residents according to resident's assessed needs, care plan and current symptoms. Direct care staff will monitor residents according to assessed needs, care plan and current needs. Resident care coordinator will communicate all resident needs to Medication aides and direct care staff and on admission of new resident or change in status of any resident. Newly hired staff will be educated by medtech of all resident needs during training period. Medtech will oversee daily, RCC will monitor weekly administration will oversee PRN. Updated impromptu with staff completed on 8/20/2015.	7/16/2015 8/20/2015

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D 270	Continued From page 7 listed as eating, toileting, ambulation, bathing , dressing, grooming and transfer. Confidential interview with a resident on 7/15/15 revealed: - The resident last saw Resident #1 between 10:00 pm and 12:30 am. - The resident awoke in the middle of the night to go to the restroom. - He was unsure of the time. - The resident found the restroom door in the room locked. - The resident assumed Resident #1 was using the restroom, so the resident went down the hallway to a shared restroom. - It was normal for Resident #1 to stay in the bathroom for 30 minutes or more when using the restroom. - The resident returned to the room and went back to bed. - The resident stated when he went to the bathroom down the hallway, he looked for a staff member for about 20 minutes so he could tell them Resident #1 was not in the room and the bathroom door was locked. - Resident reported seeing no staff members on the hall or at the front desk. - The resident awoke the following morning between 7:00 am to 8:00 am. - He went outside to smoke a cigarette. - The resident notified the maintenance staff when they arrived for work that the bathroom door was locked. Confidential interview with a staff member on 7/15/15 revealed: - Staff member arrived for work at approximately 8:00 am on 7/15/15. - Staff member was informed by a resident that their bathroom door was locked and they could	D 270		

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D 270	Continued From page 8 not get in. - Staff member went to the resident's room and unlocked the door to find Resident # 1 lying on the floor. - Staff member immediately notified staff who were in the building and they came to assist. - Staff member did not remember if anyone performed CPR. - Staff member stated the local Emergency Medical Services (EMS) came and pronounced the resident dead shortly after 8:30 am on 7/15/15. Confidential interview with a second resident on 7/15/15 revealed: - Resident stated staff on night shift sleep a lot. - Resident revealed observing staff sitting in the T.V. room sleeping at times, during the night shift. - One particular staff member did nothing but sit at the front desk and never checked on the residents at night. - Resident revealed there were long periods of waiting after ringing the call bell for staff assistance to be changed. - Resident revealed lying in urine for more than an hour waiting for someone to come change them. - Resident stated the Resident #1 could have been lying on the bathroom floor all night because no one checked on the residents at night. - Staff members were more observant and checked on residents more during the day shift. - On the night shift there was only one staff member in the building most of the time. - Resident revealed the other nighttime staff member spent time "up the hill" at the sister facility and went back and forth between facilities at night. Confidential interview with a second staff member	D 270		

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D 270	Continued From page 9 on 7/15/15 revealed: - Staff member stated reported to work at 7:00am on 7/15/15 and began getting residents ready for breakfast. - Some residents required more attention than others in getting ready. Some residents needed help dressing or completing the morning hygiene routine. - Resident #1 normally got up on his own and got himself ready for breakfast. - Resident #1 required minimal staff assistance which usually consisted of verbal reminders it was time for breakfast. - Resident #1 could dress himself, and perform basic grooming which consisted of combing hair, brushing teeth and shaving on his own without assistance. - The staff member heard another staff member calling for help and upon arrival to Resident #1's room with other staff members was told the resident was deceased. Confidential interview with a staff member on 7/21/15 revealed: - Resident #1 normally sat up watching television late at night. - Resident #1 was visually observed, by staff member on 07/15/15 at 1:00 am sitting in his chair in his room watching television. - The facility policy was to complete two hour bed checks on all residents. - The staff member did not remember seeing Resident #1 again that night. - The staff member had been busy that night checking on residents that required changing and checking to see if they were wet, but did not recall visually checking on Resident #1 after 1:00 am. Confidential interview with a second staff member on 7/21/15 revealed:	D 270		

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D 270	Continued From page 10 - The facility policy was to complete two hour bed checks on residents on the evening shift. - Some residents required more attention than others and more time was spent with them than with others. - Staff were to make observations of residents every two hours and to report any physical or behavioral changes to the MA or to the supervisor. - Two staff members were on duty the night of 07/15/15. - The physical changes could be staying in bed, becoming lethargic, or not wanting to eat. - The staff member did not report having observed any such changes in behavior in Resident #1 prior to his passing away. Interview with a social worker on 7/21/2015 at 1:00 pm from a local hospital revealed: - Resident #1's time of death was noted at 8:44 am. - There was no autopsy ordered at this time. Review of the facility Incident and Accident Report for Resident #1 dated 7/15/15 revealed: - A staff member was notified by maintenance staff a resident reported his bathroom door was locked and wanted to get inside and upon entering the bathroom found Resident #1 lying on the bathroom floor unresponsive and did not answer to name being called. EMS was called immediately. - No time was noted on the incident report. Review of the EMS incident report dated 7/15/15 revealed: - The call to the facility was received at 8:07 am. - EMS arrived at 8:16 am. - Resident #1 was found lying on his side with his head against the wall and his legs in a bent	D 270		

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D 270	Continued From page 11 position. - Resident # 1's roommate reported having woke up at some time to use the bathroom and realized the roommate was still in the bathroom and went and got staff to open the door. - Staff reported the resident was last seen at 10:00 pm the previous night. - EMS report stated the skin was cold and the body stiff. Interview with the local EMS Director on 7/30/15 at 11:00 am revealed the report included: - The resident was found lying on the floor in the bathroom. - The door was shut and the air conditioning was on. - The room temperature was cold and the floor was cold. - The temperature of the room would have affected the cooling of the body, but the extent could not be determined without an autopsy. - Standard rule of thumb is if the body is warm and stiff death has been within 3 to 6 hours. - If the body is cold and stiff then death could be anywhere from 8 to 24 hours. - It was reported to him the body was found to be cold and stiff with blood pooling on the underside of the body. Interview with an EMS responder on 7/30/15 at 1:00 pm revealed: - The EMS responders arrived at the facility at 8:16 am and observed Resident #1 lying on his side on the floor of the resident's restroom. - The resident was holding a shaving razor and there was a pack of wet wipes sticking out from under the body near the other hand. - No pulse was found and the resident was noted to be cold and stiff. - The resident was officially pronounced dead at	D 270		

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D 270	Continued From page 12 8:44 am. - The resident's roommate stated the resident (Resident #1) got up during the night to use the restroom and stayed in there all night. - The roommate stated at some time he got up to use the bathroom and realized Resident # 1 was still in the bathroom and went to notify staff. - Staff reported the last time they saw Resident #1 was around 10:00 pm. - Staff reported Resident #1 had not been complaining of any problems. Interview with Administrator 7/30/15 at 1:30 pm revealed: - Resident #1 was not "looking well" approximately one week prior to death. - Resident was pale and sweating but had been sitting outside on a hot day. - Resident #1 was questioned about how he was feeling and asked if he wanted to see the doctor and the resident refused. - The next day Resident #1 was seen and observed to be acting and feeling better. - Resident #1 required minimal assistance with ADLs which consisted mostly of verbal prompting and reminders. - Resident #1 did not require extensive assistance in getting up and preparing for breakfast in the mornings and would get up and get ready on his own when staff would notify him that breakfast was ready. - The facility policy was to provide personal care and supervision to residents according to each residents assessed needs care plans and current symptoms. - There was no facility policy requiring two hour checks on all residents. Interview with Resident #1's family member on 7/31/15 at 2:00 pm revealed:	D 270		

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D 270	Continued From page 13 - The family member stated other residents at the facility had said Resident #1 had laid on the floor of the bathroom all night and no one checked on him during the night. - A resident had said that staff members routinely sleep while on duty on the night shift, but no names were given. - Facility staff had said the resident had not been acting right the previous day and was having difficulty ambulating and sweating a lot and having trouble breathing. - Resident # 1 was not taken to the doctor to be checked out or sent to the hospital. Staff reported to family member that Resident #1 had refused to go to the doctor. Confidential interview with a resident on 7/31/15 revealed: - Staff on duty during the day were very attentive to the needs of the residents. - Staff on duty at night were rarely found and have to be hunted down for assistance. - The resident had to wait long periods of time during the night when they rang the call bell for staff assistance. - The resident had to lay in urine for two hours one night waiting for staff to come change the resident. - Staff on night shift had been observed sleeping by the residents during working hours. - The resident had reported this to staff on day shift and was told "that's not my shift I can't do anything about it". Confidential interview with a resident on 8/19/15 revealed: - The resident recently asked a staff member to assist in changing his undergarment due to having soiled himself. - The resident was told to wait until they finished	D 270		

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D 270	Continued From page 14 doing what they were doing. - The resident had waited over three hours and had to ask again before undergarment was changed. - The resident had observed staff members sleeping on the night shift while sitting at the front desk, and the resident did not report this to management. - There was only one staff member in the building at night and another staff member that traveled back and forth to the other facility "up the hill". Confidential interview with a staff member on 8/19/15 revealed: - The facility policy was to conduct two hour checks on each resident. - Staff were to provide individual care according to each residents' assessed care needs. - Some residents required more attention than others such as bathing, toileting, and grooming while other residents could do these tasks with only prompting and minimal observation. - Staff were to observe residents for changes in mood or physical appearance and report to the supervisor if needed. - Resident #1 did not require extensive assistance and could perform bathing, toileting, grooming, and personal hygiene with minimal prompting and observation. - Resident #1 could ambulate without assistance. Interview with a resident on 8/19/15 at 10:30 am revealed: - Staff checked on her about 3 to 4 times a day. - Staff did not check on her that much at night. - When she closed the room door and went to bed, she had never seen staff come into the room at night because she was asleep. Interview on 8/19/15 with a second resident	D 270		

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D 270	Continued From page 15	D 270		

revealed:
- He had been Resident #1's roommate.
- He had been told by staff that Resident #1 had a heart attack.
- On the night Resident #1 died, (7/15/15) he remernbered seeing Resident #1 sitting in his chair watching television between 11:30 pm -12:00 am.
- He was sure of the time because he had looked at his watch to see what time it was, and he had already gone to bed.
- Resident #1 liked to stay up late to watch television.
- At some point during the night (sometime around 2:00 am), the resident got up to use the bathroom and noticed Resident #1 was not sitting in the chair or in the bed. The resident noticed the bathroom door was locked, so he knocked on the door and no one answered when he knocked on the door.
- The resident went up the hall to use the bathroom and walked around for about 20 minutes because he wanted to let staff know Resident #1 was not in the room and that the bathroom door was locked.
- The resident was unable to locate any staff in the facility.
- The Personal Care Aide that had been on duty that night never came back to work, but he did not know why.
- The resident woke up the next morning sometime between 6:00 am and 7:00 am.
- When he went outside to smoke, the first staff member he saw was the maintenance staff.
- He told the maintenance staff that the bathroom door was locked and Resident #1 was not in the room.
- He walked back to his room with the maintenance staff and when the maintenance staff unlocked the door of the bathroom, they

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D 270	Continued From page 16 found Resident #1 lying on the bathroom floor. - The maintenance staff alerted other staff members and EMS was immediately called. A Staff member took "me out of the room". - When EMS arrived, they said Resident #1 "was already dead". Confidential interview with a second staff member on 8/20/15 revealed: - When working at night staff member had to alternate working between the sister facility "up the hill" and this facility, traveling from one facility to the other about every two hours checking on residents. - The last time staff member saw Resident #1 on the night of 7/15/15 was around 1:00am. - The staff member could not remember seeing Resident #1 at any other time during that shift. - The facility policy was to check on residents every two hours or more often as needed. - Some residents required more direct care than others. Some had to be checked during the night to see if they had wet the bed and needed to be changed. - Some residents had to have blood sugars checked during the night. - Resident #1 did not require additional direct observations. - Resident #1 could get up and go to the bathroom on his own and did not require blood sugar checks or medications at night. - The staff member was not notified by the previous shift of any concerns or of any changes in behavior regarding Resident #1 at the beginning of the shift on 7/15/15. Confidential interview with a resident on 8/20/15 revealed: - The resident was satisfied with the care and supervision being given by the staff members that	D 270		

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D 270	Continued From page 17 work during the day. - Staff that worked at night often slept while on duty or watched television and did not do much work at all. - During the night, residents often had to walk up and down the hallway trying to locate staff for assistance. - The resident had to wait long periods of time at night for assistance. Not with all staff just particular ones. Resident could not remember names. - Some staff members were very good at helping residents but others did not do anything but sit around at night. You can always tell who was working because you did not have to wait for help. Interview with a daytime staff member on 8/20/15 revealed: - Staff were supposed to check on all residents every 2 hours. - This included daytime staff and night time staff. Interview on 8/20/15 at 3:00 pm with the Administrator revealed: -There was no policy in place for staff to monitor residents every 2 hours. - She did not require staff to check on residents every 2 hours, only on an as needed basis. - She did not know why staff were saying they were supposed to check on the residents every 2 hours. - Due to low census and reduction in staff, the night time MA had been traveling back and forth from this facility to the sister facility "up the hill" to assist with the night time medication pass for both facilities. The facility provided a plan of protection on 08/20/15 as follows:	D 270		

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D 270	Continued From page 18 by use of CNAs and PCAs frequently during all shifts. Medications Aides will monitor daily and Administration will monitor as needed CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED: September 19, 2015	D 270	10A NCAC 13F .0902(b) Health Care The facility shall assure referral and follow-up meet the routine and acute healthcare needs of resident. Rule has been met as evidenced by facility modifying the current tracking system for the future physicians orders. RCC will record all labwork, when ordered by physician and ensure resident is taken to the lab or report and document all refusals to the ordering physician. RCC will monitor daily. Administration will oversee quarterly and PRN	9/20/2015
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 Based on observation, record review and interview, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 1 of 5 sampled residents (#5) as related to not obtaining physician ordered lab work The findings are: A. Review of Resident #5's current FL2 dated 5/22/15 revealed: -Diagnoses included diagnoses of diabetes mellitus type 2, dementia, hypertension, depression/bipolar, coronary artery disease, hyperlipidemia, hypothyroidism, overactive bladder. -Physician's orders that included: Januvia 25mg (an oral medication to decrease blood sugar) Levemir Flextouch inject 45 units at bedtime (a slow-acting insulin used to reduce elevated blood	D 273		

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D 273	Continued From page 19 Levemir Flextouch inject 45 units at bedtime (a slow-acting insulin used to reduce elevated blood sugars). Humalog Kwikpen inject 8u at 12:00 pm and 5 units at 5:00 pm (a fast acting insulin to reduce elevated blood sugars) Levothyroxine 125 mcg 1 tablets by mouth daily (a medication to supplement Thyroid Hormone) Atorvastatin 40mg 1 tablet daily (a medication used to decrease cholesterol) Vitamin D3 1000 IU daily (a medication used to supplement levels of Vitamin D in the blood). Review of Resident Record on 8/19/15 revealed: -Physician orders dated 7/23/15 to obtain a Lipid Panel (a test to measure cholesterol, Hemoglobin A1C (a test to measure average blood sugars), a Vitamin D level (a test to measure Vitamin D level in the blood stream), and a Thyroid Stimulating Hormone level (TSH) (a test used to measure the level of thyroid stimulating hormone to determine dosage of thyroid medication). -No laboratory results in the resident record for the ordered tests. Interview with a Nurse at Resident #5's primary care physician's office on 8/20/15 at 10:53 am revealed: -Resident #5 did not have laboratory results in the patient's chart for a Vitamin D level, a Hemoglobin A1C, a TSH or a Lipid Panel. -The last labwork that was on file at the physician's office was dated 6/03/15. Interview with the Administrator on 8/20/15 at 9:45 am revealed: -Resident #5 refused to get her labwork drawn and she got combative. -Her friend took her to the hospital and she had labwork done and those were the labs provided	D 273		

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D 273	Continued From page 20 yesterday. -She was not aware the labwork done at the hospital was not the labwork ordered by the physician on 7/23/15. Second interview with the Administrator on 8/20/15 at 3:25 pm revealed: -The ordered labwork was written on the calendar and the labwork was drawn when they were due. -Once the labwork results were faxed to the facility the labwork results were placed in the physician's folder for him to review. -Once they were reviewed and signed by the physician the labwork results were filed in the residents' records. -The Resident Care Coordinator (RCC) was responsible for making sure all labwork was complete and faxed from the laboratory. -Labwork results that did not get faxed to the facility were to be requested by the the RCC. Interview with the RCC on 8/20/15 at 9:50 am revealed: -She could not find documentation in the resident record that Resident #5 refused the labwork. -She could not find documentation that staff informed the physician that Resident #5 refused the labwork. -There was no documentation in the behavioral log that Resident #5 refused to have the labwork drawn. Second interview with the RCC on 8/20/15 at 1:25 pm revealed: -There were times she was not at the facility when the lab work results were faxed to the facility. -The Medication Aides (MA) were responsible for to placing the lab work results in the laboratory box.	D 273		

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D 273	Continued From page 21 -She did not know where Resident #5's lab work results were, but she would call the laboratory and have them fax the results to the facility. -She was unable to obtain the results of the labwork the physician ordered on 7/23/15 as they were not drawn. Interview with the physician on 8/20/15 at 11:45 am revealed: -He was not aware that the lab work he ordered was not obtained. -He was going to re-order the lab work to be drawn during his next visit at the facility. Interview with Resident #5 on 8/20/15 at 11:15 am revealed: -She had never refused to have lab work drawn. -She has had lab work drawn at the facility since her admission, but can not recall the date.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure table service included a non-disposable place setting	D 287	10A NCAC 13F.094(b)(2) Nutrition and Food service. Rule has been meet as evidenced by All residents unless otherwise indicated has been served beverages in nondisposable drinkware with each meal. To prevent further occurence Dietary manager will monitor meals daily. Rcc will monitor weekly and Administration will monitor as needed.	8/21/15

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D 287	Continued From page 22 consisting of at least a knife, fork, spoon, plate, and beverage containers for residents' meals. The findings are: Interview with the Administrator on 08/19/15 at 10:15am revealed the current census was 23 residents. Observation on 08/19/15 of the lunch meal service from 12:15pm to 12:50pm revealed: -Residents' beverages were prepared by the Personal Care Assistants (PCA) working in the dining room during the meal. -Six of 21 residents were served tea in 12-ounce styrofoam cups during the meal service. Observation on 08/19/15 of the dinner meal service from 5:15pm to 5:45pm revealed: -Residents' beverages were prepared by the PCAs working in the dining room during the meal. -Four of 19 residents were served tea in 12-ounce styrofoam cups during the meal service. Observation on 08/20/15 of the breakfast meal service from 8:15am to 8:45am revealed: -Residents' beverages were prepared by the PCAs working in the dining room during the meal. -Four of 21 residents were served beverages in 12-ounce styrofoam cups during the meal service. Observation of the kitchen on 08/19/15 at 2:40pm revealed: -There were 16 8-ounce non-disposable cups available. -There were 30 6-ounce non-disposable cups available -There were two packages of 12-ounce styrofoam	D 287		

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D 287	Continued From page 23 cups available. Interview with 3 residents on 08/20/15 at 8:20am revealed: -They received styrofoam cups on a regular basis. -The residents did not know why they received styrofoam cups and the other residents received non-disposable glasses. -They did not ask for styrofoam cups. -They did not mind using styrofoam cups. Interview with a PCA on 08/19/15 at 12:32pm revealed: -She had worked at the facility for one year. -The PCAs were responsible for preparing the beverages for the residents. Interview on 08/19/15 at 2:45 pm with the Food Service Director revealed: -She had been employed for two years with the facility. -She was the Food Service Director for this facility and another facility located on the adjacent property managed by the same company. -The 6-ounce non-disposable cups were used for water and juice. -The 8-ounce non-disposable cups were used for tea. -They also used the 12-ounce disposable cups if they did not have enough non-disposable cups. -Since they did not have enough 8-ounce cups, she had obtained the 12-ounce non-disposable cups because she want to make sure the residents received the required 8 ounces of beverage. A second interview on 08/20/15 at 11:45am with the Food Service Director revealed: -She had requested additional 8 ounce	D 287		

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D 287	Continued From page 24 non-disposable cups from the Administrator last week, but the Administrator sent 6-ounce cups instead of 8-ounce cups. -They had not received any additional 8-ounce non-disposable cups. Interview with the Administrator on 08/20/15 at 11:15am revealed: -The Food Service Director had requested and she provide additional non-disposable cups for the facility. -She had sent one dozen "real glasses" to the facility last week. -She thought the facility now had enough non-disposable cups on hand.	D 287		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure residents were provided 8 ounces of pasteurized milk at least twice a day. The findings are:	D 299	10A NCAC 13F .094(d)(3)(A) Nutrition and Food Service. This rule is met as evidenced by dietary staff has made (8 ounces) of pasteurized milk available to all residents at least twice a day. Dietary manager will oversee daily and RCc will monitor weekly,administration will monitor prn.	8/21/2015

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D 299	Continued From page 25 Review of the menu for 08/19/15 revealed: -Milk was to be served at breakfast. -Milk was not to be served at lunch. -Milk was to be served at dinner. -Residents' beverage of choice was to be served in addition to the milk. Observation on 08/19/15 of the lunch meal service from 12:15pm to 12:50pm revealed: -Staff served 8 ounces of milk to one resident during the meal service. -Only 1 out of 21 residents was served 8 ounces of milk. -None of the residents requested milk. -Staff did not ask residents if they wanted milk. -All residents were served water. -Other beverages served were tea and juice (to one resident who requested juice). Observation on 08/19/15 at 2:40pm of the milk on hand in the refrigerator in the kitchen revealed: -There was one gallon of 2% milk that was 3/4 full. -No other milk was available. Observation on 08/19/15 of the dinner meal service from 5:15pm to 5:45pm revealed: -Residents' beverages were prepared by the Personal Care Assistant (PCA) working in the dining room during the meal. -Staff were observed to have served 8 ounces of milk to the same resident that received milk at lunch. -Only 1 out of 19 residents was served 8 ounces of milk. -None of the residents requested milk. -Other beverages served were tea, juice, and coffee. Review of the menu for 08/20/15 revealed one	D 299		

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D 299	Continued From page 26 cup (8 ounces) of milk was to be served at breakfast with residents' beverage of choice. Observation on 08/20/15 of the breakfast meal service from 8:15am to 8:45am revealed: -Staff were observed to have served 8 ounces of milk to one resident during the meal service. -The PCAs prepared the beverages for the residents on a tray in the dining room at the entrance of the kitchen. -Only 1 out of 22 residents was served 8 ounces of milk. -None of the residents requested milk. Observation on 08/20/15 at 8:45am of the kitchen revealed: -The food service delivery person was in the kitchen unloading boxes of food. -There were 8 unopened gallons of 2% milk in the refrigerator. -No other types of milk were available. Interview on 08/19/15 at 2:45 pm with the Food Service Director revealed: -She had been employed for two years with the facility. -She was the Food Service Director for this facility and another facility located on the adjacent property managed by the same company. -She was responsible for ordering food and beverages for the facility, including milk. -She ordered milk weekly. -Sometimes the facility ran out of some items "because the cooks don't always cook what is on the menu when I am not here." -The cooks prepared "what they want to" instead of following the menu. -She ordered food and beverages based on what was on the menu and what they needed based on their current supply.	D 299		

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D 299	Continued From page 27 -She was the dietary manager for two facilities (located on the same campus) and it was difficult to "keep up with both buildings." -She was not aware that there was only 3/4 gallon of milk available. -There was no other milk available in the facility at this time. -The facility only had one resident that wanted milk and she was served milk at every meal. -The "food truck will make a delivery at 6:00am in the morning, so they will get what they are supposed to have." Interviews with three residents on 08/20/15 at 9:30am revealed: -One resident "usually gets milk at breakfast, but for the last few months I don't get it." -They would like to have milk with their meals. -Some "shifts" gave them milk and some do not. -One resident received milk with every meal. Interview with a PCA on 08/19/15 at 12:32pm revealed: -She had worked at the facility for one year. -The PCAs were responsible for preparing the beverages for the residents. -The dietary prepares the sweet tea and unsweet tea. -"The sweet tea is in an urn and the unsweet tea is in a jug." -The PCAs pour the teas, water, and juice into the glasses for the residents. -There was no difference in the types of cups used for sweet tea and unsweet tea. -"We have one resident that likes juice and one that likes milk." Second interview with the Food Service Director on 08/20/15 at 11:00am revealed: -"The food truck delivered milk this morning."	D 299		

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D 299	Continued From page 28 -"We offer them milk, but a lot of them do not drink milk." -She was not aware the residents were not served milk for breakfast on 08/20/15. -The residents should have received milk for breakfast. Interview with the Administrator on 08/20/15 at 11:15am revealed: -The Food Service Director was responsible for ordering food and beverages, including milk. -She was not aware that there was not enough milk on hand to serve the residents according to their menus. -She would ensure the facility had enough milk on hand in the future.	D 299		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record review, and interviews the facility failed to contact the physician for	D 344	10A NCAC 13F .1002(a) Medication Orders This rule is met as evidenced by Adultcare home will assure contact with the resident's physician or prescribing practitioner for verification or clarification of all orders for medication and treatments. Staff will be in accordance with all orders for admission or readmission of a resident if orders are not dated and signed within 24 hrs of admission or readmission,or if orders are not clear or complete or if multiple admission forms are recieved upon admission or readmission and orders are not the same. The facility will ensure that this verification or clarification is documented in the resdent's record. Admitting staff in-serviced on medication orders and procedures for admissions, clarification	8/20/2015

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D 344	Continued From page 29 clarification of orders for 1 of 5 sampled residents with multiple admission forms received on admission with inconsistent physician's medication orders (Resident #5). The findings are: Review of Resident #5's current FL-2 dated 05/22/15 revealed: -An original FL2 signed by the physician on 5/22/15. -Diagnoses included diabetes type 2, hypertension, depression/bipolar disorder, coronary artery disease, hyperlipidemia, hypothyroidism, dementia and overactive bladder. Review of the original FL-2 signed by the physician dated 5/22/15 revealed physician's orders as follows: -Atorvastatin 40mg 1 tablet daily (used to lower cholesterol). -Clopidogrel 75mg 1 tablet daily (used to reduce risk for blood clots). -Donepezil HCL 5mg 1 tablet (used to reduce or slow the symptoms of dementia). -Humalog Kwikpen inject 8 units at 12:00 pm and 5:00 pm and hold if blood sugar is less than 80 (a rapid-acting insulin used to reduce elevated blood sugars in the blood). -Levemir Flextouch inject 45 units at bedtime (a slow-acting insulin used to reduce elevated blood sugars). -Levothyroxine 125 mcg 1 tablet daily (used to supplement the hormone produced by the thyroid). -Metoprolol 25mg 1/2 tablet twice daily (used to treat high blood pressure). -Oxybutynin 5mg 1/2 tablet twice daily (used to treat bladder spasms in efforts to prevent bladder incontinence)	D 344	verification and documentation.RCC will monitor daily ,administrator will monitor as needed.	

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D 344	Continued From page 30 -Pantoprazole sodium 40mg 1 tablet daily (used to decrease stomach acid). -Potassium Chloride ER 10meq 1 tablet daily (used to supplement potassium in the blood). -Preservision 1 tablet daily (used to slow the progression of macular degeneration). -Ramipril 5mg 1 tablet daily (used to lower blood pressure) -Sertraline 100mg 1 tablet daily (used to reduce symptoms of depression). -Tobradex eye drops one drop to both eyes four times daily (an antibiotic used to treat bacterial infections of the eye). -Vitamin D3 2000 units 1 tablet at bedtime (used to treat elevated blood pressure and high cholesterol and conditions of the heart and blood vessels). -Lorazepam 0.5mg 1 tablet every 12 hours as needed for anxiety -Acetaminophen 325mg 2 tablets every 6 hours as needed for pain/fever. -Blood sugar check 3 times daily before meals -Colestipol 1 gm 1 tablet three times daily (used to decrease blood cholesterol). -Bismuth liquid 2 tablespoons 4 times daily as needed for diarrhea (a medication used to slow bowel motility) Review of Resident #5's record revealed: -Resident #5 was admitted to the facility on 5/22/15. -There were two FL-2's dated 5/22/15 with orders that were not the same. -The second FL-2 dated 5/22/15 had been completed by the Resident Care Coordinator (RCC) and signed by the same physician. Review of an additional FL-2 completed by the RCC dated 5/22/15 revealed physician's orders as follows: -Fludrocortisone 0.1mg daily (used to help control	D 344		

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D 344	Continued From page 31 the amount of sodium and fluids in the body). -Januvia 25mg 1 tablet daily (an oral diabetic medication used to help control blood sugar levels). -Levemir Flextouch 10 units every morning (a slow-acting insulin used to reduce elevated blood sugars). -Levemir Flextouch 50 units at bedtime. -Metoprolol tartrate 25mg 1/2 tablet twice daily (used to treat high blood pressure). -Oxybutynin 5mg tablet 1/2 tablet every morning (used to treat symptoms of overactive bladder). -Sertraline 50mg 1 tablet daily (used to treat depression). -Vitamin D 1000 IU 1 tablet daily (used to treat elevated blood pressure and high cholesterol and conditions of the heart and blood vessels). -Temazepam 15mg 1 capsule as needed for insomnia. Review of both FL-2s revealed inconsistencies as follows: -Colestipol 1 gm 1 tab three times daily was not listed on the second FL-2 dated 5/22/15 completed by the RCC. -Bismuth liquid 2 tablespoons 4 times daily as needed for diarrhea was not listed on the second FL-2. -Fludrocortisone 0.1mg daily was not listed on the original FL-2 signed by the physician. -Januvia 25mg 1 tablet daily was not listed on the original FL-2. -Levemir dosage and frequency were different from the original FL-2 compared to the second FL-2 both dated 5/22/15. (Original ordered Levemir 45 units at night and second Fl-2 had orders for Levemir 10 units in the morning and 50 units at night). -Oxybutynin 5mg 1/2 tablet frequency was different from the original FL-2 compared to the	D 344		

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D 344	Continued From page 32 second FL-2 both dated 5/22/15. (Original ordered Oxybutynin 5mg 1/2 tab twice daily and second Fl-2 had orders for every morning). -Sertraline 100mg daily was ordered on the original FL-2 and the second FL-2 had orders for 50mg once daily. -Vitamin D 2000 IU daily was ordered on the original FL-2 and the second FL-2 had orders for 1000 IU daily. -Temazepam was not listed on the original FL-2. Review of Resident #5's May 2015 Medication Administration Record (MAR) revealed: -A hand written Medication Administration Record (MAR) dated 05/22/15-05/26/15 and all medication entries on the MAR were consistent with the original FL-2 dated 05/22/15 and signed by the physician. Review of a computer generated MAR dated 05/26/15-05/31/15 revealed: -An entry for Levemir Flextouch 45 units at bedtime consistent with the original FL-2 dated 5/22/15 with a discontinued date of 5/29/15. -An entry for Levemir Flextouch 50 units at bedtime consistent with the second FL-2 and staff initialed documentation of administration on 5/29/15. -An entry for Metoprolol 25mg 1/2 tablet once daily inconsistent with both FL-2s listed to be given twice daily. Review of Resident #5's June 2015 computer generated MAR revealed: - Handwritten written entry to discontinue Colestipol, Donepezil, Oxybutynin and a change in Levemir dosage from 45 units to 50 units all dated 5/29/15. -An entry for Metoprolol 25mg 1/2 tablet daily.	D 344		

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D 344	Continued From page 33 Review of Resident #5's July 2015 computer generated MAR revealed: -An entry for Colestipol with a hand written discontinue entry dated 5/29/15. -An entry for Metoprolol 25mg 1/2 tablet once daily. -An entry for Levemir 50 units daily entered and documented as administered from 7/01/15-7/27/15 with a hand written discontinue entry dated 5/29/15 and a hand written "Duplicate Order" written over the spaces for 7/28/15-7/31/15, not dated. -An entry for Levemir 50 units at bedtime initialed by staff as administered starting on 7/09/15 with nightly administrations documented from 7/09/15-7/31/15. -An entry for Levemir 10 units each morning initialed by staff as administered starting on of 7/15/15 with documentation of administration through 7/31/15. -A handwritten entry for Sertraline 50mg tablet once daily initialed by staff as administered starting on 7/24/15. -A handwritten entry for Sertraline 50mg 1 and 1/2 tablets (75mg) daily for 14 days initialed by staff as administered starting on 7/25/15. -A hand written entry for Aspirin 81mg 1 tablet at bedtime with no documentation of administration for July 2015. -A hand written entry for Aspirin 81mg 1 tab daily initialed by staff as administered starting on 7/14/15 with daily administrations though 7/31/15. -A hand written entry for Donepezil 5mg 1 tablet daily initialed by staff as administered starting on 7/15/15. Review of Resident #5's August 2015 computer generated MAR revealed: -An entry for Levemir 50 units daily entered and documented as administered from 8/01/15 to	D 344		

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D 344	Continued From page 34 8/19/15. -An entry for Levemir 10 units each morning entered and documented as administered from 8/01/15 to 8/19/15. -An entry for Sertraline 50mg tablet once daily entered and documented as administered from 8/01/15 to 8/19/15. -An entry for Sertraline 25mg 3 tablets (=75mg) daily for 14 days entered and documented as administered from 8/01/15. -An entry for Donepezil 5mg 1 tablet daily entered and documented as administered from 8/01/15 to 8/19/15. Review of Resident #5's record revealed: -No physician's order to discontinue Colestipol until 7/23/15. -No order to discontinue Aricept 5mg. -No order to re-start Aricept 5mg on 7/15/15. -No order to discontinue Oxybutynin 5mg 1/2 tablet twice daily. -No physician's order to change Levemir from 45 units to 50 units. -No physician's order to add Levemir 10 units every morning. -No physician's order for Metoprolol 25mg 1/2 tablet administered once daily. -A physician's order to decrease Sertraline from 100mg to 75mg daily for 14 days; then 50mg daily. (Resident #5 was administered 125mg daily for at least 7 days). -A physician's order dated 6/9/15 for Fludrocortisone 0.1mg daily not documented as administered on MAR until 6/11/15. -No physician's order for Aspirin 81mg. Interview with Resident #5 on 8/19/15 at 10:50 am revealed: -She worried about what medications she was taking and felt she was taking too much.	D 344		

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D 344	Continued From page 35 -The number of medications she is given changes frequently. -Some mornings she gets 3 blue pills and some mornings she will only get one. -Some mornings she get two yellow pills and some mornings she only gets one. -The number of pills in the cup and the color of pills in the cup frequently changed without explanation. -Staff can not tell her what the pills are and why they change in number. -She had lost trust with the staff because they could not explain the medicine changes. -She knew what medications she was taking before she came to the facility. -She had requested a list of medications and no one would tell her what she was taking. -Her medications had changed many times since she was admitted to the facility. Interview with the Administrator on 8/19/15 at 3:36 pm revealed she was unaware there were two FL-2s with the same date and deferred the question to the RCC. Interview with RCC on 8/19/15 at 3:45 pm revealed: -She wrote the FL-2 so she could understand the orders for herself and so she could assure they were correct. -She did not re-write the subsequent FL-2 to clarify the orders with the physician. -The facility used the subsequent FL-2 as current orders for Resident #5 and this was the FL-2 she had faxed to the pharmacy upon admission. -She had re-written the subsequent FL-2 on 5-22-15. Interview with RCC on 8/20/15 at 2:25 pm revealed:	D 344		

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D 344	Continued From page 36 -She re-wrote the second FL-2 because she didn't know who wrote the original FL-2. -She knew the original FL-2 was signed by the physician. -She did not know that the original FL-2, with physician's signature, was valid despite her not knowing the author of the original FL-2. -She was unable to explain why the orders on the FL-2 she devised, dated 5/22/15, were not written until after 5/22/15. -She was not aware that there were inconsistencies in the two FL-2's and in turn the MAR's in regards to: Metoprolol, Fludrocortisone, Januvia, Levemir, Sertraline, Vitamin D3, Oxybutynin, Temazepam, Colestipol, Bismuth and Donepezil. -She did not seek clarification for the discrepancies because she was unaware of them. -She did not regularly clarify orders from FL-2 upon admission. -She would clarify orders if they were unclear or incomplete. -She did not know where or if there was an order for Aspirin. -She was aware that there was a bottle of Aspirin in the med cart. -She did not notice the Metoprolol card on hand had a different set of administration instructions than the MAR's. -She did not know that the Sertraline 50mg titration was implemented incorrectly. -She does check the MAR's from one month to another to make sure all orders are correct and on MAR. -She does compare new orders that are in the resident record with the new MAR's to assure that have all been entered. -She does have MA on third shift re-check the MAR's from one month to the next.	D 344		

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D 344	Continued From page 37 Interview with Resident #5's physician on 8/20/15 at 11:45 am revealed: -He ordered the Metoprolol 25mg 1/2 tablet to be taken twice daily and he had not made changes to this. He never ordered Metoprolol to be administered once daily. -Was unaware that there were two FL-2's that had different medication orders. -He ordered Sertraline to be decreased from 100mg daily to 75mg daily for 14 days and then Sertraline was to decrease to 50mg daily. -He was unaware that the Sertraline titration was implemented incorrectly. -He has never wrote an order for Resident #5 to take aspirin 81mg. -He ordered Januvia 25mg on 7/23/15 for Resident #5 and never prior to that date. -He ordered Levemir to be increased to 50 units in the evening and 15 units in the morning on 7/23/15. -He decreased Oxybutynin 5mg 1/2 tab twice daily to once daily on 7/23/15. -He decreased Vitamin D3 from 2000 IU to 1000 IU on 7/23/15. -He did discontinue Pepto-Bismol (Bismuth) and Colestipol on 7/23/15. -He changed Temazepam 15mg from every evening routinely to every evening as needed for insomnia on 7/23/15 and this was a clarification. -The facility had not sought clarification in regards to the discrepancies between the two FL-2's.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358		

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D 358	Continued From page 38 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 B 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 5 sampled residents (#5, #7) which included medications for diabetes, high blood pressure, sodium and fluid levels, high cholesterol, depression, overactive bladder, dementia, thyroid replacement, decrease stomach acid, potassium supplement, macular degeneration, eye drops, pain, anxiety, constipation and insomnia. The findings are: A. Review of Resident #5's FL-2 signed by the physician dated 5/22/15 revealed physician's orders as follows: -Atorvastatin 40mg 1 tablet daily (used to lower cholesterol). -Clopidogrel 75mg 1 tablet daily (used to reduce risk for blood clots). -Donepezil HCL 5mg 1 tablet (used to reduce or slow the symptoms of dementia). -Humalog Kwikpen inject 8 units at 12:00 pm and 5:00 pm and hold if blood sugar is less than 80 (a rapid-acting insulin used to reduce elevated blood sugars in the blood). -Levemir Flextouch inject 45 units at bedtime (a slow-acting insulin used to reduce elevated blood sugars).	D 358	10A NCAC13F.1004(a) Medication Administration This rule is met as evidenced the preparation and administration of medications prescriptions and nonprescription, and treatments by staff are in accordance with: (1) orders by licensed prescribing practitioner which are maintained in the residents record and (2) rules in this section and the facility's policies and procedures. Staff in-servicing regarding medication administration by nurse consultant on 9/10/2015 and ongoing. (1) Medication Administration record will be used at all times when administering medication. (2) Read the label three times and check against the MAR. (A) The employee will compare the label to the MAR (1) When Collecting medication from the storage area (2) Prior to pouring the medication (3) After pouring and prior to returning the medication to the storage area (B) Medtech will monitor orders daily and PRN.	

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D 358	Continued From page 39 -Levothyroxine 125 mcg 1 tablet daily (used to supplement the hormone produced by the thyroid). -Metoprolol 25mg 1/2 tablet twice daily (used to treat high blood pressure). -Oxybutynin 5mg 1/2 tablet twice daily (used to treat bladder spasms in efforts to prevent bladder incontinence) -Pantoprazole sodium 40mg 1 tablet daily (used to decrease stomach acid). -Potassium Chloride ER 10meq 1 tablet daily (used to supplement potassium in the blood). -Preservision 1 tablet daily (used to slow the progression of macular degeneration). -Ramipril 5mg 1 tablet daily (used to lower blood pressure) -Sertraline 100mg 1 tablet daily (used to reduce symptoms of depression). -Tobradex eye drops one drop to both eyes four times daily (an antibiotic used to treat bacterial infections of the eye). -Vitamin D3 2000 units 1 tablet at bedtime (used to treat elevated blood pressure and high cholesterol and conditions of the heart and blood vessels). -Lorazepam 0.5mg 1 tablet every 12 hours as needed for anxiety -Acetaminophen 325mg 2 tablets every 6 hours as needed for pain/fever. -Colestipol 1 gm 1 tablet three times daily (used to decrease blood cholesterol). -Bismuth liquid 2 tablespoons 4 times daily as needed for diarrhea (a medication used to slow bowel motility) Review of Resident #5's record revealed: -Resident #5 was admitted to the facility on 5/22/15. -There were two FL-2s dated 5/22/15 with orders that were not the same.	D 358	Resident care coordinator will monitor weekly and as continuing education Nurse Consultant/Pharmacist will perform medication pass audits quarterly and pharmacy reviews. RCC will monitor all pharmacy reviews, administration will oversee PRN.	

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D 358	Continued From page 40 -The second FL-2 dated 5/22/15 had been completed by the Resident Care Coordinator (RCC) and signed by the same physician. Review of an additional FL-2 completed by the RCC dated 5/22/15 revealed physician's orders as follows: -Fludrocortisone 0.1mg daily (used to help control the amount of sodium and fluids in the body). -Januvia 25mg 1 tablet daily (an oral diabetic medication used to help control blood sugar levels). -Levemir Flextouch 10 units every morning (a slow-acting insulin used to reduce elevated blood sugars). -Levemir Flextouch 50 units at bedtime. -Metoprolol tartrate 25mg 1/2 tablet twice daily (used to treat high blood pressure). -Oxybutynin 5mg tablet 1/2 tablet every morning (used to treat symptoms of overactive bladder). -Sertraline 50mg 1 tablet daily (used to treat depression). -Vitamin D 1000 IU 1 tablet daily (used to treat elevated blood pressure and high cholesterol and conditions of the heart and blood vessels). -Temazepam 15mg 1 capsule by mouth has needed for insomnia. Review of both FL-2s revealed inconsistencies as follows: -Colestipol 1 gm 1 tab three times daily was not listed on the second FL-2 dated 5/22/15 completed by the RCC. -Bismuth liquid 2 tablespoons 4 times daily as needed for diarrhea was not listed on the second FL-2. -Fludrocortisone 0.1mg daily was not listed on the original FL-2 signed by the physician. -Januvia 25mg 1 tablet daily was not listed on the original FL-2.	D 358		

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D 358	Continued From page 41 -Levemir dosage and frequency were different from the original FL-2 compared to the second FL-2 both dated 5/22/15. (Original ordered Levemir 45 units at night and second FI-2 had orders for Levemir 10 units in the morning and 50 units at night). -Oxybutynin 5mg 1/2 tablet frequency was different from the original FL-2 compared to the second FL-2 both dated 5/22/15. (Original ordered Oxybutynin 5mg 1/2 tab twice daily and second FI-2 had orders for every morning). -Sertraline 100mg daily was ordered on the original FL-2 and the second FL-2 had orders for 50mg once daily. -Vitamin D 2000 IU daily was ordered on the original FL-2 and the second FL-2 had orders for 1000 IU daily. -Temazepam was not listed on the original FL-2. Review of Resident #5's May 2015 Medication Administration Record (MAR) revealed: -A hand written Medication Administration Record (MAR) dated 05/22/15-05/26/15 and all medication entries on the MAR were consistent with the original FL-2 dated 05/22/15 and signed by the physician. Review of Resident #5's 5/26/15-5/31/15 Medication Administration Record (MAR) revealed: -An entry for Metoprolol 25mg 1/2 tablet once daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 5/27/15 to 5/31/15 at 8:00 am. -An entry for Levemir 45 units subcutaneous at bedtime with a hand written change dated 5/29/15 -An entry for Levemir 50 units subcutaneous at bedtime transcribed onto the MAR and scheduled for administration at 8:00 pm. Documentation of	D 358		

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D 358	Continued From page 42 administration on 5/27/15 and 5/28/15 with a hand written entry dated 5/29/15 for medication to be discontinued. -An entry for Oxybutynin 5mg 1/2 tab twice daily transcribed onto the MAR and scheduled for administration at 8:00 am and 7:00 pm. Documentation of administration on 5/27/15 to 5/29/15 with a hand written entry dated 5/29/15 for medication to be discontinued. -An entry for Colestipol 1 tablet three times daily transcribed onto the MAR and scheduled for administration at 8:00 am, 2:00 pm and 8:00 pm. Documentation of administration on 5/27/15 to 5/29/15 with a hand written entry dated 5/29/15 for medication to be discontinued. -An entry for Donepezil 5mg 1 tablet daily transcribed onto the MAR and scheduled for administration at 8:00 pm. Documentation of administration on 5/27/15 and 5/28/15 with a hand written entry dated 5/29/15 for medication to be discontinued. Review of Resident #5's June 2015 Medication Administration Record (MAR) revealed: -An entry for Metoprolol 25mg 1/2 tablet once daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 6/01/15 to 6/30/15 at 8:00 am. -An entry for Levemir 45 units subcutaneous at bedtime transcribed onto MAR with a hand written entry to discontinue medication dated 5/29/15. No administrations documented. -An entry for Levemir 50 units subcutaneous at bedtime transcribed onto the MAR with a date of 5/30/15 and scheduled for administration at 8:00 pm. Documentation of administration from 6/01/15 to 6/30/15 at 8:00 pm. -An entry for Oxybutynin 5mg 1/2 tab twice daily transcribed onto MAR with a hand written entry to	D 358		

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D 358	Continued From page 43 discontinue medication dated 5/29/15. No administrations documented -An entry for Colestipol 1 tablet three times daily transcribed onto the MAR and scheduled for administration at 8:00 am, 2:00 pm and 8:00 pm with a hand written entry dated 5/29/15 for medication to be discontinued. No administrations documented. -An entry for Donepezil 5mg 1 tablet daily transcribed onto the MAR and scheduled for administration at 8:00 pm with a hand written entry dated 5/29/15 for medication to be discontinued. No administrations documented. Review of Resident #5's July 2015 Medication Administration Record (MAR) revealed: -An entry for Metoprolol 25mg 1/2 tablet once daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 7/01/15 to 7/31/15 at 8:00 am. -An entry for Levemir 50 units subcutaneous at bedtime transcribed onto the MAR and scheduled for administration at 8:00 pm. Documentation of administration 19 times from 7/01/15 to 7/24/15 at 8:00 pm. with a hand written entry "Duplicate order". An additional entry for Levemir 50 units subcutaneous at bedtime, transcribed onto the MAR and scheduled for administration at 8:00 pm, starting 7/09/15. Documentation of administration 23 times from 7/09/15 to 7/31/15 at 8:00 pm. There were 13 out of 23 documented occurrences of Levemir 50 units being administered twice from 7/14/15 and 7/31/15. -An entry for Levemir 10units every morning, dated 7/15/15, transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 7/16/15 to 7/31/15 at 8:00 am. -An entry for Sertraline 50mg 1 tablet daily, dated	D 358		

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D 358	Continued From page 44 7/24/15, transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 7/24/15 to 7/31/15 at 8:00 am. -An entry for Sertraline 50mg 11/2 tablets (=75mg) once daily, dated 7/24/15, transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 7/25/15 to 7/31/15 at 8:00 am. -An entry for Colestipol 1 tablet three times daily transcribed onto the MAR and scheduled for administration at 8:00 am, 2:00 pm and 8:00 pm, with a handwritten entry to discontinue dated 5/29/15. No documentation of administration. -An entry for Donepezil 5mg 1 tab let daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 7/16/15 to 7/31/15 at 8:00 am. -An entry for Aspirin 81mg 1 tablet at bedtime transcribed onto the MAR and scheduled for administration at 8:00 pm. No administrations. -An entry for Aspirin 81mg 1 tablet daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 7/14/15 to 7/31/15 at 8:00 am. Review of Resident #5's August 2015 Medication Administration Record (MAR) revealed: -An entry for for Levemir 10units every morning, dated 7/15/15, transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 8/01/15 to 8/19/15 at 8:00 am. -An entry for Sertraline 25mg 3 tablets (=75mg) once daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration on 8/01/15 at 8:00 am.	D 358		

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D 358	Continued From page 45 -An entry for Sertraline 50mg once daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 8/01/15 to 8/19/15 at 8:00 am. -An entry for Donepezil 5mg 1 tablet daily transcribed onto the MAR and scheduled for administration at 8:00 am. Documentation of administration from 8/01/15 to 8/19/15 at 8:00 am. Review of Resident #5's record revealed: -No physician's order to discontinue Colestipol until 7/23/15. -No order to discontinue Donepezil 5mg. -No order to re-start Donepezil 5mg on 7/15/15. -No order to discontinue Oxybutynin 5mg 1/2 tablet twice daily. -No physician's order to change Levemir from 45 units to 50 units. -No physician's order to add Levemir 10 units every morning. -No physician's order for Metoprolol 25mg 1/2 tablet administered once daily. -A physician's order to decrease Sertraline from 100mg to 75mg daily for 14 days; then 50mg daily. (Resident #5 was administered 125mg daily for at least 7 days). -A physician's order dated 6/9/15 for Fludrocortisone 0.1mg daily not documented as administered on MAR until 6/11/15. -No physician's order for Aspirin 81mg. Observation of medication on hand for administration on 8/19/15 at 4:15 pm revealed: -One card of Metoprolol 25mg dispensed 7/02/15 with 60 1/2 tablets dispensed. -Metoprolol medication card had administration instructions to take 1/2 tablet twice daily. -One card of Fludrocortisone 0.1mg tablets	D 358		

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D 358	Continued From page 46 dispensed on 7/02/15 with 2 tablets left. -One card of Januvia 25mg tablets dispensed 7/23/15 with 10 tablets remaining. -Levemir insulin pens both on the med cart and in med refrigerator. Not dated when opened. -One card of Sertraline 50mg tablets dispensed 7/23/15 with four tablets remaining. -One card of Donepezil 5mg tablets dispensed 7/15/15 with 2 tablets left. -One bottle of Aspirin 81mg -Vitamin D3 2000 IU dispensed 7/02/15. -Vitamin D3 1000 IU dispensed 7/23/15. -One card of Oxybutynin 5mg dispensed 7/23/15. -One card of Temazepam 15mg tablets dispensed 7/24/15. -No Preservision available for administration. -All other ordered medications were available for administration. Interview with Resident #5 on 8/19/15 at 10:50 am revealed: -The number of medications she is given changes frequently. -Some mornings she gets 3 blue pills and some mornings she will only get one. -Some mornings she get two yellow pills and some mornings she only gets one. -Staff can not tell her what the pills are and why they change in number. -She has requested a list of medications and no one will tell her what she is taking. -Her medications have changed many times since she has been at the facility. Interview with the Administrator on 8/19/15 at 3:36 pm revealed: -She was unaware that there were two FL-2's for Resident #5. -She was not aware that there were inconsistencies between the medications lists on	D 358		

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D 358	Continued From page 47 the FL-2's. -The Resident Care Coordinator was responsible for clarifying and verifying orders upon admission. Interview with Resident Care Coordinator (RCC) on 8/19/15 at 3:45 pm revealed: -She re-wrote the FL-2 on the day of admission so she could understand the orders for herself and to verify that the orders were correct. -The FL-2 she re-wrote is the FL-2 the facility goes by and it is the FL-2 that she faxed to the pharmacy. Interview with RCC on 8/20/2015 at 1:50 pm revealed: -The facility was to go by the FL-2 she re-wrote and physician signed 5/22/15 because she did not know who wrote the first FL-2 and was not sure it was correct. -She re-wrote the second FL-2 because she didn't know who wrote the original FL-2. -She knew the original FL-2 was signed by the physician. -She did not know that the original FL-2, with physician's signature, was valid despite her not knowing the author of the original FL-2. -She was unable to explain why the orders on the FL-2 she devised, dated 5/22/15, were not written until after 5/22/15. -She was not aware that there were inconsistencies in the two FL-2's and in turn the MAR's in regards to: Metoprolol, Fludrocortisone, Januvia, Levemir, Sertraline, Vitamin D3, Oxybutynin, Temazepam, Colestipol, Bismuth and Donepezil. -She did not seek clarification for the discrepancies because she was unaware of the inconsistencies. -She did not regularly clarify orders from FL-2 upon admission.	D 358		

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D 358	Continued From page 48 -She would clarify orders if they were unclear or incomplete. -She did not know where or if there was an order for Aspirin. -She was aware that there was a bottle of Aspirin in the med cart. -She did not notice the Metoprolol card on hand had a different set of administration instructions than the MAR's. -She did not know that the Sertraline 50mg titration was implemented incorrectly. -She does check the MAR's from one month to another to make sure all orders are correct. -She does compare new orders that are in the resident record with the new MAR's to assure medications have been entered correctly. -She does have MA on third shift re-check the MAR's from one month to the next. Interview with a representative from the facility pharmacy on 8/20/15 at 9:15 am revealed: -They had Metoprolol 25mg 1/2 tab entered in their system as twice daily and have been labeling the medication twice daily. -They had Metoprolol 25mg 1/2 tab entered the MAR as once daily. -It was possible a transcription error had been made when entering the Metoprolol on to the MAR. -They did send Sertraline 50mg tablets and Sertraline 25mg 3 tablets = 75mg on the same date, both dispensed 7/23/15. -They have no record of any Sertraline being returned to the pharmacy. -They never supplied Januvia prior to 7/23/15. -The pharmacy was going by the FL-2 that was only one page, signed and dated by the physician 5/22/15. -The pharmacy did not have the FL-2 that the RCC re-wrote on file.	D 358		

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D 358	Continued From page 49 Interview with Resident #5's physician on 8/20/15 at 11:45 am revealed: -He ordered the Metoprolol 25mg 1/2 tablet to be taken twice daily and he had not made changes to this. He never ordered Metoprolol to be administered once daily. -He was unaware that there were two FL-2's that had different medication orders. -He ordered Sertraline to be decreased from 100mg daily to 75mg daily for 14 days and then Sertraline was to decrease to 50mg daily. -He was unaware that the Sertraline titration was implemented incorrectly. -He has never written an order for Resident #5 to take Aspirin 81mg. -He ordered Januvia 25mg on 7/23/15 for Resident #5 and never prior to that date. -He ordered Levemir to be increased to 50 units in the evening and 15 units in the morning on 7/23/15. -He decreased Oxybutynin 5mg 1/2 tab twice daily to once daily on 7/23/15. -He decreased Vitamin D3 from 2000 IU to 1000 IU on 7/23/15. -He did discontinue Pepto-bismol (Bismuth) and Colestipol on 7/23/15. -He changed Temazepam 15mg from every evening routinely to every evening as needed for insomnia on 7/23/15 and this was a clarification. -The facility had not sought clarification in regards to the discrepancies between the two FL-2s. B. Review of Resident #7's current FL2 dated 02/13/15 revealed: - Diagnoses included osteoarthritis, glaucoma, chromic pain and constipation. - A physician's order for Miralax (used to treat constipation) mix 17 grams in 8 ounces of fluid	D 358		

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ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50 and drink on Monday, Wednesday and Friday. Hold for loose stools. Review of Resident #7's Resident Register revealed an admission date of 02/13/15. Review of Resident #7's subsequent physician's orders revealed a signed physician's order dated 06/01/15 for Miralax powder, mix 17 grams in 8 ounces of fluid and drink on Monday, Wednesday and Friday. Review of Resident #7's June 2015 MAR revealed: -An entry for Miralax 17 grams in 8 ounces of fluid on Monday, Wednesday, and Friday and scheduled for administration at 8:00 am. - The Miralax 17 grams had been administered every Monday, Wednesday and Friday for the entire month of June 2015. - The Miralax 17 grams had also been administered 4 additional days on Sunday, Tuesday, Thursday, and Saturday at 8:00 am. - The scheduled dates of administration had heavy black lines drawn around the dates for ease of visibility. - The dates when Miralax was not scheduled to be administered were not crossed out with an X. - The documented dates of administration were 06/01, 06/02, 06/03/, 06/04, 06/05, 06/06, 06/07, 06/08, 06/10, 06/12, 06/15, 06/17, 06/19, 06/22, 06/24, 06/26, and 06/29/15 at 8:00 am. - 17 doses were documented as administered and 13 doses were ordered. Review of Resident #7's July 2015 MAR revealed: -An entry for Miralax 17 grams in 8 ounces of fluid on Monday, Wednesday and Friday and scheduled for administration at 8 am. - The Miralax 17 grams in 8 ounces of fluid had	D 358		

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	HAL053027	A. BUILDING: _____ B. WING _____	R-C 08/20/2015

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D 358	Continued From page 51 been administered every day of the entire month of July 2015. - The dates when Miralax was not scheduled to be administered were not crossed out with an X. - The dates documented as administered were 07/01 - 07/31/15 at 8:00 am. - 31 doses were documented as administered. Review of the August 2015 MAR revealed: -An entry for Miralax 17 grams on Monday, Wednesday, and Friday and scheduled for administration at 8:00 am. - The Miralax 17 grams in 8 ounces of fluid had been administered every day through the 19th of August 2015. - The dates when Miralax was not scheduled to be administered were not crossed out with an X. - The dates documented as administered were 08/01 - 08/19/15 at 8:00 am. - 19 doses were documented as administered. Interview on 08/19/15 at 3:45 pm with the Resident Care Coordinator/Medication Aide (RCC/MA) revealed: - She was responsible for comparing the new pharmacy generated MARs each month to the existing pharmacy generated MARs and making sure all medications were recorded accurately on the MARs. - A total of 2 MAs, one from each 12 hour shift, checked the MARs, by comparing the new MAR to the existing MAR for accuracy, after she completed her check. - The MARs were checked for accuracy, one time monthly, by a total of 3 people. - The Miralax 17 grams in 8 ounces of fluid to be administered Monday, Wednesday and Friday must have been overlooked. Interview on 08/19/15 at 4:10 pm with a	D 358		

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D 358	Continued From page 52 representative from the physician's office revealed: - The current order was for Miralax 17 grams in 8 ounces of fluid to be given on Monday, Wednesday, and Friday. - The physician was not aware Resident #7 had been receiving the Miralax 17 grams every day. Interview on 08/19/15 at 4:20 pm with Resident #7 revealed: - He depended on the facility to provide his medications as orded by the physician. - The MA on duty brought the Miralax 17 grams in water every day and he drank it. - He stated he took the Miralax "for my bowel movements". - He denied having diarrhea, but he had been having as many as "2-3" bowel movements each day. Interview on 08/19/15 at 5:50 with the Administrator revealed: - The RCC/MA was responsible for making sure the MARs were accurate. - When the new MARs were printed each month, the RCC/MA checked them for accuracy. - A MA from each shift then checked each MAR also, for a total of 3 checks. - Each MA was responsible for administering the medication as ordered by the physician. _____ The facility provided a Plan of Protection as follows: On 08/20/15, the Executive Director submitted a Plan of Protection indicating all resident records would be immediately audited to ensure all orders are current and up to date. Any duplicate orders will be clarified. All Medication Administration	D 358		

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D 358	Continued From page 53 Records will be checked on delivery from pharmacy and physician. All Medication Administration Records will be checked by a Med Aide on each shift. The resident Care Coordinator will do a final check and compare all medication orders prior to releasing the Medication Administration Records. This will be on-going. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED, October 4, 2015.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure action was taken in response to pharmacist recommendations from the quarterly drug regimen review for 1 of 5 sampled residents (Resident #5). The findings are: A. Review of Resident #5's current FL2 dated 5/22/15 revealed: -Diagnoses included diagnoses of diabetes mellitus type 2, dementia, hypertension, depression/bipolar, coronary artery disease, hyperlipidemia, hypothyroidism, overactive bladder. -A physician's order for Metoprolol 25mg 1/2	D 406	10A NCAC 13F .1009 (b) Rule met as evidenced by quarterly pharmacy reviews sent to physcian for review and followup. RCC will monitor and document any changes or recomendations provided by the provider. All correspondence will be documented by RCC. Administrator or designee will oversee as needed.	

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D 406	Continued From page 54 tablet twice daily. Review of the pharmacy recommendation dated 6/23/15 to the facility revealed "Metoprolol on FI-2 says bid [twice daily], MAR has once daily. Please work to clarify". Review of Resident #5's 5/22/15-5/25/15 Medication Administration Record (MAR) revealed: -Metoprolol 25mg 1/2 tablet once daily transcribed onto the MAR twice daily. -Documentation of administration of Metoprolol twice daily from 5/22/15 to 5/25/15. Review of Resident #5's 5/26/15-5/31/15 Medication Administration Record (MAR) revealed: -Metoprolol 25mg 1/2 tablet once daily transcribed onto the MAR. -Documentation of administration of Metoprolol once daily 5/27-/15 to 5/31/15. Review of Resident #5's June 2015 Medication Administration Record (MAR) revealed: -Metoprolol 25mg 1/2 tablet once daily transcribed onto the MAR. -Documentation of administration of Metoprolol once daily in June. Review of Resident #5's July 2015 Medication Administration Record (MAR) revealed: -Metoprolol 25mg 1/2 tablet once daily transcribed onto the MAR. -Documentation of administration of Metoprolol daily in July. Review of Resident #5's August 2015 Medication Administration Record (MAR) revealed: -Metoprolol 25mg 1/2 tablet once daily	D 406		

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D 406	Continued From page 55 transcribed onto the MAR. -Documentation of administration of Metoprolol once a daily from 8/01/15-19/15. Observation of medication on hand for administration on 8/19/15 at 4:15 pm revealed: -One card of Metoprolol 25mg with a dispensing date of 7/02/15 with 60 1/2 tablets dispensed. Interview with RCC on 8/20/2015 at 1:50 pm revealed: -She was unaware that there was an inconsistency with the frequency of administration of Metoprolol 25mg. -She had not sought clarification on the Metoprolol order because she did not see the pharmacy recommendation. -She did not notice the Metoprolol card on hand had a different set of administration instructions than the MAR's. -She would fax all the pharmacy recommendations to the physician's office and put them in the visiting physician's folder for their review at the next visit. -She did not see these pharmacy recommendations when they came in and were likely picked up by one of the other MA's when she was off work and not placed in the right box. Interview with a representative from the facility pharmacy on 8/20/15 at 9:15 am revealed: -They had the order in their system as twice daily and have been labeling the medication twice daily. -It was possible a transcription error had been made when entering the Metoprolol on to the MAR. Interview with Resident #5's physician on 8/20/15 at 11:45 am revealed:	D 406		

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D 406	Continued From page 56 -He ordered the Metoprolol 25mg 1/2 tablet to be taken twice daily. -The facility had not sought clarification regarding the Metoprolol per pharmacy recommendation. B. Review of Resident #5's current FL-2 dated 5/22/15 revealed: -A physician's order for Tobradex eye drops 1 drop in both eyes four times a day with no stop date (used to treat eye infections and swelling with a typical duration of 7-10 days). Review of the pharmacy recommendation dated 6/23/15 to the physician revealed: -Resident #5 continued to take Tobradex 1 drop four times a day and pharmacist recommended to discontinue the Tobradex. Continued record review revealed there was no documentation the physician was notified of the pharmacy recommendation to discontinue Tobradex eye drops. Review of Resident #5's 5/22/15-5/25/15 Medication Administration Record (MAR) revealed: -Tobradex eye drops 1 drop every four times a day transcribed onto the MAR. -Documentation of administration of Tobradex eye drops as ordered from 5/22/15 to 5/25/15. Review of Resident #5's 5/26/15-5/31/15 Medication Administration Record (MAR) revealed: -Tobradex eye drops 1 drop four times a day transcribed onto the MAR. -Documentation of administration of Tobradex eye drops as ordered from 5/26/15 to 5/31/15. Review of Resident #5's June 2015 Medication	D 406		

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D 406	Continued From page 57 Administration Record (MAR) revealed: -Tobradex eye drops 1 drop four times a day transcribed onto the MAR. -Documentation of administration of Tobradex eye drops 1 drop in each eye four times daily in June. Review of Resident #5's July 2015 Medication Administration Record (MAR) revealed: -Tobradex eye drops 1 drop four times a day transcribed onto the MAR. -Documentation of administration of Tobradex eye drops 1 drop in each eye four times daily in July. Review of Resident #5's August 2015 Medication Administration Record (MAR) revealed: -Tobradex eye drops 1 drop four times a day transcribed onto the MAR. -Documentation of administration of Tobradex eye drops 1 drop in each eye four times daily from 8/01/15-8/19/15. Observation of medication on hand for administration on 8/19/15 at 4:15 pm revealed one opened, 5ml bottle of Tobradex Eye Drops with a dispensing date of 6/02/15.	D 406		
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:	D912	G.S.131D-21(2) Declaration of rights Refer to corrected tag 113 10A NCAC 13F .0311(d) Other Requirements Refer to corrected Tag 358 10A NCAC 13F .1004(a) Medication administration	

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D912	Continued From page 58 Based on observation, interview and record review, the facility failed to assure all residents receive care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to Other Requirements and Medicaton Administration. The findings are: 1.) Based on observations, interviews and record reviews, the facility failed to assure the hot water for 7 of 26 sink fixtures and 5 of 26 shower fixtures in the resident bathrooms were maintained between 100 degrees Fahrenheit (F) and 116 degrees F, with hot water temperatures ranging from 128 degrees to 138 degrees F. [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type A2 Violation)]. 2.) 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 5 sampled residents (#5, and #7) which included errors with medications for miralax, diabetes, high blood pressure, sodium and fluid levels, high cholesterol, depression, overactive bladder, dementia, thyroid replacement, decrease stomach acid, potassium suppliment, macular degeneration, eye drops, pain, anxiety, and insomnia. [Refer to Tag 358 10A NCAC 13F .1004(a) Medicaton 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:	D914		

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D914	Continued From page 59 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect related to Persosnal Care and Supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan and current symptoms for 1 resident (Resident #1) who was locked in the bathroom overnight and subsequently expired in the bathroom. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914	G.S.131D-21 (4) Declaration of Resident Rights Refer to corrected tag270 10A NCAC 13F.0901(b)	