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D 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an Annual Survey on October 6 - 7, 2015.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff A, C, and D) had no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. The findings are: A. Review of Staff A's personnel records revealed: -Staff A was hired on 09/01/15 as a Personal Care Aide (PCA). -Documentation of a completed HCPR check in Staff A's personnel record was dated 09/29/15 with no substantial findings. -Staff A's daily responsibilities included providing personal care to the residents. Interview with Staff A on 10/07/15 at 10/07/15 at 11:45 am revealed: -She was hired on 09/01/15 as a PCA.	D 137		

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D 137	Continued From page 1 -She began training as a Medication Aide (MA) on 10/05/15. -She had worked as a PCA at another facility prior to her hire at this facility. -Her current job duties included providing personal care to residents, including bathing, dressing, transfers, feeding, and activities. -She did not know if the facility had completed a HCPR check prior to her hiring. Refer to interview with the Director of Operations on 10/08/15 at 12:00 pm. Refer to interview with the Administrator on 10/08/15 at 4:30 pm. B. Review of Staff D's personnel records revealed: -Staff D was hired on 10/28/09. -Documentation of a completed HCPR check in Staff D's personnel record was dated 11/10/09 with no substantial findings. -Staff D's current position was a MA. -Staff D's daily responsibilities included passing medications to residents and performing care to the residents. Refer to interview with the Director of Operations on 10/08/15 at 12:00 pm. Refer to interview with the Administrator on 10/08/15 at 4:30 pm. C. Review of Staff C's personnel records revealed: -Staff C was hired on 06/22/15 as a PCA. -Documentation of a completed HCPR check in Staff C's personnel record was dated 07/19/15 with no substantial findings. -Staff C's daily responsibilities included providing	D 137		

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D 137	Continued From page 2 personal care to the residents when she was hired. -Staff C's current daily responsibilities included providing personal care to residents. Interview with Staff C on 10/07/15 at 4:45 pm revealed: -Upon hire, Staff C worked in the dietary department as a dietary aide. -Within approximately two days following her hiring, she was transferred to nursing care services. -Staff C had a background as a Certified Nursing Assistant, but her certification expired in 2013. -Staff C was provided "on-the-job training" by the Manager and a Medication Aide. -Staff C provided care of residents with another Nurse Aide (NA) helping her during her first one to two weeks of working in nursing care. Refer to interview with the Director of Operations on 10/08/15 at 12:00 pm. Refer to interview with the Administrator on 10/08/15 at 4:30 pm. Interview with the Director of Operations on 10/08/15 at 12:00 pm revealed: -She was responsible for checking the HCPR for new employees prior to hire. -The facility had experienced high volumes of staff turnover recently. -She knew she had not checked the HCPR prior to some employees beginning work, but checked them "as soon as she could". Interview with the Administrator on 10/08/15 at 4:30 pm revealed it was the facility's policy that HCPR checks were to be completed prior to hire.	D 137		

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D 139	Continued From page 3	D 139		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure a Criminal Background check was completed prior to hire on 3 of 4 sampled staff (Staff A, B, and C). The findings are: A. Review of Staff A's personnel records revealed: -Staff A was hired on 09/01/15 as a Personal Care Aide (PCA). -Documentation of a completed criminal background check in Staff A's personnel record dated 10/7/15. -Staff A's daily responsibilities included providing personal care to the residents. Interview with Staff A on 10/07/15 at 11:45 am revealed: -She began training as a Medication Aide (MA) on 10/05/15. -Her current job duties included providing personal care to residents, including bathing, dressing, transfers, feeding, and activities. -She signed a criminal background check consent when she came to work on 09/01/15. Refer to interview with the Director of Operations	D 139		

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D 139	Continued From page 4 on 10/08/15 at 12:10 pm. Refer to interview with the Administrator on 10/08/15 at 4:15 pm. B. Review of Staff B's personnel records revealed: -Staff B was hired on 06/01/15 as a PCA and then transitioned to dietary as a cook. -Documentation of a completed criminal background check in Staff B's personnel record dated 06/24/15. -Staff B's daily responsibilities included providing personal care to the residents when she was hired. -Staff B's current daily responsibilities included preparation of residents' meals, including therapeutic diets. Interview with Staff B on 10/07/15 at 1:05 pm revealed: -She worked as a cook in dietary. -She was hired as a PCA, but moved to dietary not long after she was hired. -She was responsible for preparing meals, including therapeutic diets, for residents. Refer to interview with the Director of Operations on 10/08/15 at 12:10 pm. Refer to interview with the Administrator on 10/08/15 at 4:15 pm. C. Review of Staff C's personnel records revealed: -Staff C was hired on 06/22/15 as a PCA. -Documentation of a completed criminal background check in Staff C's personnel record dated 07/13/15. -Staff C's daily responsibilities included providing	D 139		

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D 139	Continued From page 5 personal care to the residents. Review of the nursing employee schedule revealed Staff C began duties on 06/22/15. Interview with Staff C on 10/07/15 at 4:45 pm revealed: -Upon hire, Staff C worked in the dietary department as a dietary aide. -Within approximately two days following her hiring, she was transferred to nursing care services. -Staff C had a background as a Certified Nursing Assistant, but her certification expired in 2013. -Staff C provided care of residents with another Nurse Aide (NA) helping her during her first one to two weeks of working in nursing care. Refer to interview with the Director of Operations on 10/08/15 at 12:10 pm. Refer to interview with the Administrator on 10/08/15 at 4:15 pm. _____ Interview with the Director of Operations on 10/08/15 at 12:10 pm revealed: -She was responsible for obtaining criminal background checks for new employees prior to hire. -The facility had experienced high volumes of staff turnover recently. -She knew she had not checked the criminal background check prior to some employees beginning work, but checked them "as soon as she could". Interview with the Administrator on 10/08/15 at 4:15 pm revealed it was the facility's policy that criminal background checks were to be completed prior to hire.	D 139		

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D 139	Continued From page 6 The facility provided a Plan of Protection on 10/08/15 as follows: -All new employees will have criminal background checks completed prior to hiring. -The Director of Operations will review all current employee files to ensure criminal background checks have been completed. -The Manager will be responsible for monitoring monthly. CORRECTION DATE FOR THIS TYPE B VIOLATION IS NOVEMBER 21, 2015.	D 139		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 4 sampled staff (Staff A) was competency validated for Licensed Health Professional Support (LHPS) tasks. The findings are:	D 161		

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D 161	Continued From page 7 Review of Staff A's personnel record revealed: -A hire date of 09/01/15. -Staff A was hired as a Personal Care Aide (PCA). -There was no documentation of the LHPS competency validation. -On 10/06/15, the Facility Nurse completed an LHPS competency evaluation for Staff A. Interview with Staff A on 10/07/15 revealed: -She was hired as a PCA on 09/01/15. -She had worked as a PCA prior to her being hired at this facility. -Her current job duties included providing personal care to residents, including bathing, dressing, transfers from bed to wheelchairs, feeding assistance (including therapeutic diets), and activities. -She completed orientation training at the facility prior to working with the residents of the facility. -The Facility Nurse was to do her competency evaluation on 09/02/15, but was unable to return to the facility to complete it. -The facility had a new nurse to complete her LHPS competency evaluation on 10/06/15. -She had provided resident care, including transfers from bed to chair, repositioning residents every two hours, incontinence care, and feeding assistance (including therapeutic diets). Observation on 10/06/15 from 12:00 pm to 12:55 pm revealed: -Staff A provided feeding assistance to 6 residents in the dining room. -All six residents were in geri-chairs. -Staff A assisted the six residents with feeding assistance, including pureed, chopped, nectar-thick and honey-thick liquids.	D 161		

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D 161	Continued From page 8 Interview with the Director of Operations on 10/07/15 at 12:20 pm revealed: -She and the Manager were responsible for ensuring an LHPS competency evaluation was completed for new hires prior to them performing a task. -She could not verify if an LHPS competency evaluation had been completed for Staff A because the LHPS nurse came to the facility on 09/01/15 and was to return on 09/02/15 to complete the LHPS evaluation for Staff A, but was unable to return to the facility on 9/2/15. -She attempted to contact the nurse by telephone on 10/06/15 and 10/07/15, but was unable to reach her. -The facility hired a new nurse on 10/06/15 and she completed the LHPS competency evaluation for Staff A on 10/06/15. Review of an LHPS competency evaluation for Staff A revealed the evaluation was completed on 10/06/15 by an RN. Interview with the Administrator on 10/08/15 at 4:25 pm revealed it was the facility's policy that LHPS competency evaluations were to be completed prior to an employee performing a task.	D 161		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 309		

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D 309	Continued From page 9 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for 2 of 6 sampled residents prescribed therapeutic diets of soft mechanical, ground meats (Residents #4 and #5). The findings are: Observation on 10/06/15 at 11:15 am in the kitchen revealed: -A posted therapeutic diet list that included residents who must have egg whites, chopped meats, regular ground/mechanical soft diets. Observation on 10/06/15 at 11:50 am in the kitchen revealed: -23 color coded note cards that included the residents name, therapeutic diets, date of birth and admission date. -Resident #4 was listed to have egg whites. Observation on 10/06/15 at 6:10 pm the diet note cards posted in the kitchen revealed 28 color coded note cards that included the resident's name, therapeutic diets, date of birth and admission date. A. Review of Resident #4's current FL2 dated 08/18/15 revealed: -Diagnoses including dysphagia. dementia, history of falls, osteoporosis, weakness, history of urinary tract infection, cardiovascular accident, seizures, history of abdominal aortic aneurysm, hypertension, dyslipidemia and history of cerebral aneurysm. -An order for a mechanical soft diet, no table salt and honey thickened liquids.	D 309		

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D 309	Continued From page 10 Review of Resident #4's record revealed a diet order dated 8/21/15 for no table salt, Regular Ground, soft-mechanical, ground and honey thickened liquids. Review of the diet list posted in the kitchen revealed: -Resident #4 was listed to have egg whites. -Resident #4 was not listed on the resident diet list to receive a "regular, ground, soft-mechanical diet." -There was no section of this diet list that included thickened liquids. -Resident #4 did not have a diet card available with the other therapeutic diet cards. Observation of the lunch meal served to Resident #4 on 10/06/15 from 12:42 pm to 1:10 pm revealed: -The resident was served one 6 fluid ounce glass of tea and one 6 fluid ounce glass water both were thickened to honey consistancy. -The resident was served 1 piece of grilled chicken breast (4 ounces) which was ground. -Yellow squash (1/2 cup), sweet potatoes (1/2 cup), pears (1/2 cup) for dessert and 1 roll. -The resident consumed 25% of the chicken, 100% of the squash, 100 % of the sweet potato, one bite of the roll and 75% of the pears. Attempt to interview Resident #4 was unsuccessful. Refer to interview with the Kitchen Manager (KM) on 10/06/15 at 4:45 pm. Refer to interview with Resident Care Coordinator (RCC) on 10/07/15 at 11:15 am.	D 309		

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D 309	Continued From page 11 Refer to interview with the Dietary Aide (DA) serving lunch on 10/07/15 at 12:10 pm. Refer to interview with the Administrator on 10/07/15 at 4:03 pm. Refer to interview with the Dietary Manager (DM) on 10/07/14 at 4:45 pm. B. Review of Resident #5's current FL2 dated 2/25/15 revealed: -Diagnoses included history of pneumonia resolved, chronic edema, Alzheimer's Dementia, hypertension, osteoporosis, anxiety, depression, irritable bowel syndrome, history of chest pain. -An order for a regular ground diet. Review of Resident #5's Diet order dated 8/05/15 revealed a regular/soft mechanical diet with special instructions written by prescribing practitioner, "Resident prefers no meat, but if given meat must be chopped." Review of the diet list posted in the kitchen revealed: -The diet for Resident #5 listed as "Regular Ground Mechanical Soft". -There was no diet note card available for Resident #5. Observation on 10/06/15 at 6:10 pm of the diet note cards posted in the kitchen revealed: -28 color coded note cards that included the resident's name, therapeutic diets, date of birth and admission date. -The diet card for Resident #5 listed therapeutic diets as, "Regular Ground mechanical soft. No meat. NAS (No added Salt)." Interview with Resident #5 on 10/07/15 at 10:58	D 309		

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D 309	Continued From page 12 am revealed: -She did not often eat meat because it was hard for her to chew it because of her missing teeth. -She usually was not served meat. -When she was not served meat there was not a substitute served or offered. -When she was served meat it was not cut up, but if she asked staff they would cut it for her. -She did not know why she did not ask staff to cut her meat at lunch yesterday 10/06/15. -Sometimes she did want more food. Refer to interview with the Kitchen Manager (KM) on 10/06/15 at 4:45 pm. Refer to interview with Resident Care Coordinator (RCC) on 10/07/15 at 11:15 am. Refer to interview with the Dietary Aide (DA) serving lunch on 10/07/15 at 12:10 pm. Refer to interview with the Administrator on 10/07/15 at 4:03 pm. Refer to interview with the Dietary Manager (DM) on 10/07/14 at 4:45 pm. Interview with the Kitchen Manager (KM) on 10/06/15 at 4:45 pm revealed: -The cards were color coded according to the diet group the resident had. -The groups included mechanical soft, pureed, cardiac and no concentrated sweet diets. -The description of the diets were posted above each color section. -The nursing staff was responsible for updating the diet cards and the nursing staff did this on a weekly basis. -The diet cards were reviewed and updated last week.	D 309		

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D 309	Continued From page 13 Interview with RCC on 10/07/15 at 11:15 am revealed: -The RCC did inform the dietary staff when there was a new resident admitted and their diet before the first meal was served to that resident. -She did inform dietary staff verbally and in writing when there was a change in a resident or if thickened liquids were ordered. -She did inform the dietary staff that was working at the time of the dietary change or new admission. -There was not a designated Dietary Manager and they all worked together. Interview with the Dietary Aide (DA) serving lunch on 10/07/15 at 12:10 pm revealed: -She knew whose plate to prepare next and what she should be plating because the DA did so according to who was next on the list (pointing to the posted resident diet list). -The list was created and utilized as a quick reference or "cheat sheet". -She did not know who created the list but the nursing staff was good about telling her about changes. -The nursing staff had updated the DA last week on a change of seating in the dining room and this change was noted in her personal notebook. -She did not have an example of a therapeutic diet change Interview with the Administrator on 10/07/15 at 4:03 pm revealed: -They had been using the card system for years and it had served them well. -The RCC was responsible for notifying dietary staff of changes in resident diets. -There was a Dietary Manager that was responsible for the overall process in the dining	D 309		

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(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 309	Continued From page 14 room. -The business office manager ordered all the food, drinks and other necessary items for dietary. Interview with the Dietary Manager (DM) on 10/07/14 at 4:45 pm revealed: -The DM did not understand why the dietary cards were not present and posted on 10/06/15. -He checked all the diet cards last week all the residents' diets were posted and accurate. -He did get the diet information from the nursing staff and the updates were typically given to the dietary staff by the RCC. -The DA was not aware that the resident diet list was not accurate. -The card system had been used for years and it had worked well for them in the past.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to assure 1 of 6 sampled residents (Resident #5) with a physician's order for therapeutic diet of Mechanical Soft with Ground Meats was served as ordered. The findings are:	D 310		

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D 310	Continued From page 15 Observation on 10/06/15 at 11:15 am in the kitchen revealed: -A posted therapeutic diet list that included residents who must have egg whites, chopped meats, regular ground/mechanical soft diets. -The cook provided the therapeutic diet menus which were approved by a dietician. -The cook provided a week-at-a-glance menu for this week. -Resident Care Coordinator (RCC) provided a list of residents on therapeutic diets (not specified), a list of residents that were diagnosed as diabetic and a list of residents that required feeding assistance. Observation on 10/06/15 at 11:50 am in the kitchen revealed: -23 color coded note cards that included the resident's name, therapeutic diets, date of birth and admission date. Review of Resident #5's current FL2 dated 2/25/15 revealed: -Diagnoses included history of pneumonia resolved, chronic edema, Alzheimer's Dementia, hypertension, osteoporosis, anxiety, depression, irritable bowel syndrome, history of chest pain. -An order for a regular ground diet. Review of Resident #5's subsequent diet order dated 8/05/15 revealed: -A regular/soft mechanical diet with special instructions written by the prescribing practitioner, "Resident prefers no meat, but if given meat must be chopped." -There was no order for a no added salt diet. Review of the posted diet list posted in the kitchen revealed:	D 310		

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D 310	Continued From page 16 -The diet for Resident #5 was listed as "Regular Ground Mechanical Soft" . -There was no diet note card posted for Resident #5. Review of the therapeutic diet lunch menu to be served for the mechanical soft diet on 10/06/15 revealed: -Resident was to be served a 4 fluid ounce beverage. -Resident was to be served 1 ground, grilled chicken breast, 1/2 cup of sweet potatoes, 1/2 cup of squash, 1/2 cup of blushing pears, 1 white roll with margarine spread. Observation of the lunch meal served to Resident #5 on 10/06/15 from 12:42 pm to 1:10 pm revealed: -The resident was served one 6 fluid ounce glass of tea and one 6 fluid ounce glass of water. -The resident was served 1 piece of grilled chicken breast (4 ounces) which was not cut or ground, yellow squash (1/2 cup), sweet potatoes (1/2 cup), pears (1/2 cup) for dessert and 1 roll. -The resident independently cut and lightly salted the chicken with salt that was available at the table. -The resident was observed having difficulty cutting the chicken and chewing the chicken. -The resident did not have difficulty swallowing. -The resident consumed 25% of the chicken. -The resident consumed 50% of the squash, 50% of the roll and 75% of the sweet potato. -The resident consumed 75% of the pears. Observation of 10/06/15 at 6:10 pm the diet note cards posted in the kitchen revealed: -28 color coated note cards that included the resident's name, therapeutic diets, date of birth and admission date.	D 310		

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D 310	Continued From page 17 -The diet card for Resident #5's listed therapeutic diet of Regular Ground mechanical soft. No meat. NAS (No added Salt). -The posted, hand written diet list had no changes. Review of the therapeutic diet menu for the lunch meal for the mechanical soft diet on 10/07/15 revealed: -The resident was to be served 4 fluid ounces of beverage. -Chef's Entree of Choice, 1/2 cup of rice or pasta, 1/2 cup of Chef's Vegetable of Choice, 1/2 of Allowed Fruit, 1 slice of white/wheat bread with margarine spread. Observation of the lunch meal served to Resident #5 on 10/07/15 from 12:13 pm to 1:20 pm revealed: -The resident was served one 6 fluid ounce glass of tea and one 6 fluid ounce glass of water. -The resident was served 5 uncut meatballs (each approximately 1&1/2 inch in diameter), broccoli (1/2 cup), white rice (1/2 cup) and 1 roll. -Resident #5 cut up her meatballs independently with a fork. -Resident #5 consumed 75% of the meatballs and rice, 50% of the broccoli and ate 100% of her roll. -Resident #5 did not have any difficulty cutting up her meatballs and did not have difficulty chewing or swallowing. Interview with Resident #5 on 10/07/15 at 10:58 am revealed: -Resident #5 did not often eat meat because it was hard for her to chew it because of her impaired dentition. -Resident #5 had no teeth in the bottom front and was having trouble with the back as well.	D 310		

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D 310	Continued From page 18 -Resident #5 was going to get these dental issues resolved in the future. -Resident #5 was usually not served meat. -When Resident #5 was not served meat there was not a substitute served or offered. -When Resident #5 was served meat it was not cut up, but if she asked staff if they would cut it for her. -She did not know why she did not ask them to cut her meat at lunch 10/06/15. Interview with the Dietary Aide (DA) serving dinner on 10/06/15 at 4:43 pm revealed: -She knew what to serve each resident because the DA looked at the menu to prepare the meal. -She knew what to place on each plate because the DA looked at the list (pointing to the resident diet list) and the DA knew how many pureed diets she needed to prepare. Interview with the Dietary Manager (DM) on 10/06/15 at 4:45 pm revealed: -The cards were color coated according to the diet orders. -The groups included mechanical soft, pureed, cardiac and no concentrated sweet diets. -The description of the diets were posted above each color section. -The nursing staff were responsible for updating the diet cards and the nursing staff did this on a weekly basis. Interview with the Resident Care Coordinator on 10/07/15 at 11:15 am revealed: -She did inform the dietary staff when there was a new resident admitted and their diet order before the first meal was served to that resident. -She did inform dietary staff verbally and in writing when there was a change in a resident or if thickened liquids were ordered.	D 310		

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D 310	Continued From page 19 -She did inform the dietary staff that was working at the time of the dietary change or new admission. -She was not aware the meat for Resident #5 was not cut as ordered. -There was not a designated Dietary Manager. Interview with the Administrator on 10/07/15 at 4:03 pm revealed: -They had been using the card system for years and it had served them well. -The RCC was responsible for notifying dietary staff of changes in resident diets. Interview with the Dietary Manager (DM) on 10/07/14 at 4:45 pm revealed: -He did not understand why the dietary cards were not present and posted on 10/06/15. -He was not aware Resident #5 was served uncut chicken. -They checked all the diet cards last week all the residents diets were posted and accurate. -He was not aware that the current diet card posted for Resident #5 was inaccurate. -He did get the diet information from the nursing staff and the updates were typically given to the dietary staff by the RCC. -He said the resident diet list served to assist new employees in serving the resident their meals.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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D 358	Continued From page 20 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: Based on observation, interview and record review, the facility failed to assure a medication, Prozac 20mg, was administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 1 of 6 residents (Resident #3) observed during medication administration. The findings are: Observation during the 8:00 am medication pass on 10/07/15 at 7:23 am revealed: -The contract pharmacy packaged the medications in single dose bubble packs. -The Medication Aide (MA) used the Medication Administration Record (MAR) to compare the medications in the bubble pack and the MAR prior to administering the medications. -The MA administered Resident #3's 8:00 am medications which included: Prozac 10 mg, Levothyroxine 75 mcg, aspirin 81 mg, potassium chloride 20MEQ and two puffs of Symbicort 160/4.5 mcg inhalant to Resident #3. -The MA documented the administration of the 8:00 am medications on the October 2015 MAR immediately after administration of medications. Review of Resident #3's current FL2 dated 4/20/15 revealed: -Diagnoses of depression, hip fracture, diabetes mellitus type 2, chronic obstructive pulmonary disease, primary pulmonary hypertension and hypothyroidism. -A physician's order for Prozac 20mg one capsule daily. (Prozac is used to treat is used to treat	D 358		

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D 358	Continued From page 21 depression.) Review of Resident #3's Resident Register revealed an admission date of 2/12/15. Review of a hospital discharge summary dated 7/08/15 for Resident #3 revealed an order for Prozac 20mg one capsule daily. Review of Resident #3's October 2015 MAR revealed: -A computer generated entry for Prozac 10 mg - take one capsule once daily. -Administration of Prozac 10mg daily was documented from 10/01/15 to 10/07/15. Review of Resident #3's September 2015 MAR revealed: -A computer generated for Prozac 10mg - take one capsule once daily. -Administration of Prozac 10mg daily was documented from 9/01/15 to 9/30/15. Review of Resident #3's August 2015 MAR revealed: -A computer generated entry for Prozac 10 mg 1 capsule daily with a hand-written 20 over the number 10 changing the original entry from 10 mg to 20 mg. -Administration of Prozac 20mg daily was documented from 8/01/15 to 8/31/15. Review of Resident #3's July 2015 MAR revealed: -An entry for Prozac 20 mg 1 capsule once daily. -A computer generated entry for Prozac 10 mg 1 capsule daily with a "hand-written 20" over the number 10, changing the original entry from 10 mg to 20 mg. -Administration of Prozac 20mg daily was documented from 7/01/15 to 7/31/15 except for	D 358		

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D 358	Continued From page 22 7/06/15, 7/07/15 and 7/08/15 (resident was in the hospital on those days). Telephone interview on 10/07/15 at 9:45 am with the contract pharmacy representative revealed: -The order they had on file at the facility was for Prozac 10mg 1 capsule once daily. -They did not supply Resident #3 with her Prozac, but they did re-package the Prozac for Resident #3 and the Prozac was supplied by Resident #3's mail order pharmacy. -The pharmacy generated the MARs for all of the residents at the facility. -The pharmacy generated Resident #3's MARs based on the medication list that was supplied to them by the facility on 2/13/15 which did have an order for Prozac 10mg once daily. -They did not have any subsequent orders to increase the Prozac from 10mg to 20mg. -They never supplied Resident #3's Prozac and only re-packaged the Prozac 10mg. Observation of the medication on hand for administration for Resident #3 on 10/07/15 revealed: -The contract pharmacy repackaged Resident #3's Prozac 10mg in bubble packs. -There was one pack with 42 capsules remaining from the 60 that were re-packaged on 8/31/15 -There was a second pack with 30 capsules remaining from the 30 that were re-packaged on 8/27/15. -Both packs were labeled Fluoxetine (generic Prozac) 10mg take 1 capsule every day. Telephone interview on 10/07/15 at 1:06 pm with the mail order pharmacy representative revealed: -They had shipped 90 capsules of Prozac 10mg on 8/25/15. -They shipped 90 capsules of Prozac 10mg on	D 358		

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D 358	Continued From page 23 4/28/15. -They did not have an order for Prozac 20mg one capsule once daily. Interview with a Medication Aide (MA) on 10/07/15 at 10:30 am revealed: -The family brought in bottles of medication from the mail order pharmacy and the facility sent the bottles to their contract pharmacy to be re-packaged in the bubble packs. -The family brought in the Prozac 10mg tablets and they were sent for re-packaging. -She did review the MARs for accuracy and made sure new orders and changes were present on the next months MAR. -She and another MA did this monthly. -She thought that the order for Resident #3's Prozac was for 10mg when the resident returned from the hospital in July 2015. -She did produce an unsigned hospital medication list that was provided to the facility upon Resident #3's discharge that did have Prozac 10 mg daily on the list. -She knew this list was not considered medication orders because they were unsigned. -She did not produce a signed medication list that included Prozac 10 mg. Interview on 10/07/15 at 10:45 am with Resident #3 revealed: -Resident #3 was not aware of the names of the medications. -Resident #3 took the medications provided and they came on time every day. -Resident #3 denied any symptoms of depression. Interview on 10/07/15 at 4:03 pm with the Administrator revealed: -The MAs did check the MARs month to month to	D 358		

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D 358	Continued From page 24 verify accuracy. -The Administrator allowed family members to use an outside pharmacy. Interview with Resident #3's psychiatrist on 10/07/15 at 2:13 pm revealed: -He had increased Prozac 20mg daily for Resident #3 March 26, 2015. -The decrease to Prozac 10 mg may have occurred because the primary care physician wanted her on the least amount of medication that was effective and if this was the case he would be fine with the decrease. -Since the primary care doctor did not change the dose, he was going to fax the facility an order for Prozac 20mg to clarify what dose Resident #3 should be taking. -He wanted Resident #3 to take the higher dose because she had been going through a lot and her presentation was considered to be "fair".	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367		

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D 367	Continued From page 25	D 367		

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

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure accuracy of the Medication Administration Record (MAR) according to the facility's policies and procedures for 1 of 6 sampled residents (#3).

The findings are:

Review of Resident #3's current FL2 dated 4/20/15 revealed:
-Diagnoses of depression, hip fracture, diabetes mellitus type 2, chronic obstructive pulmonary disease, primary pulmonary hypertension and hypothyroidism.
-An order for Prozac 20 mg.

Review of the Resident Register revealed the date for admission to the facility was 2/12/15.

Review of Resident #3's October 2015 MAR revealed:
-An entry for Prozac 10 mg - take one capsule once daily.
-Administration of Prozac 10mg daily was documented from 10/01/15 to 10/07/15.

Review of Resident #3's September 2015 MAR revealed:
-An entry for Prozac 10mg - take one capsule once daily.
-Administration of Prozac 10mg daily was

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D 367	Continued From page 26 documented from 9/01/15 to 9/30/15. Review of Resident #3's August 2015 MAR revealed: -An entry for Prozac 20mg - take one capsule once daily. -The "2" in the number 20 was hand written over the original, computer generated "1" in the number 10. -Administration of Prozac 20mg daily was documented from 8/01/15 to 8/31/15. Review of Resident #3's July 2015 MAR revealed: -An entry for Prozac 20 mg - take one capsule once daily. -The "2" in the number 20 was hand written over the original, computer generated "1" in the number 10. -Administration of Prozac 20mg daily was documented from 7/01/15 to 7/31/15 except for 7/06/15, 7/07/15 and 7/08/15 because resident was in the hospital on those days. Review of Resident #3's record revealed an electronically signed Discharge Summary from a local hospital dated 7/08/15 with an order for Prozac 20 mg daily. Observation of the medication on hand for administration for Resident #3 on 10/07/15 revealed: -The contract pharmacy repackaged Resident #3's Prozac 10mg in bubble packs. -There was one pack with 42 capsules remaining from the 60 that were repackaged on 8/31/15 -There was a second pack with 30 capsules remaining from the 30 that were repackaged 8/27/15. -Both packs were labeled Fluoxetine (generic Prozac) 10mg take 1 capsule every day.	D 367		

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D 367	Continued From page 27 Interview with a Medication Aide (MA) on 10/07/15 at 10:30 am revealed: -She reviewed the MARs for accuracy and made sure new orders and changes were present on the next months MAR. -She and another MA did this monthly. -She thought that the order for Resident #3's Prozac was reduced to 10mg when Resident #3 returned from the hospital in July 2015. -She produced an unsigned hospital medication list that was provided to the facility upon Resident #3's discharge that did have Prozac 10 mg daily on the list. -She knew that this list was not considered medication orders because they were unsigned. -She did not produce a signed medication list that included Prozac 10 mg. Interview on 10/07/15 at 10:45 am with Resident #3 revealed: -Resident #3 was not aware of the names of the medications. -Resident #3 took the medications provided and they came on time every day. -Resident #3 denied feeling depressed. Interview on 10/07/15 at 4:03 pm with the Administrator revealed the medication aides did check the MARs month to month to verify accuracy. Interview with Resident #3's psychiatrist on 10/07/15 at 2:13 pm revealed: -He had increased Prozac 20mg daily for Resident #3 March 26, 2015. -The decrease to Prozac 10 mg may have occurred because the primary care physician wanted her on the least amount of medication that was effective and if this was the case he	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013007	A. BUILDING: _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 28 would be fine with the decrease. -Since the primary care doctor did not change the dose, he was going to fax the facility an order for Prozac 20mg to clarify what dose Resident #3 should be taking. -He wanted Resident #3 to take the higher dose because she had been going through a lot and her presentation was considered to be "fair".	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding criminal background checks for new hires. The findings are: Based on record review and interview, the facility failed to assure a Criminal Background check was completed on 1 of 4 sampled staff (Staff A). [Refer to Tag 139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation)].	D912		