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	FCL079098	A. BUILDING: ______ B. WING ______	10/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLAM'S FAMILY CARE HOME	**109 ROANOKE STREET REIDSVILLE, NC 27323**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 8, 2015 and October 9, 2015 with an exit conference via telephone on October 12, 2015.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. 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 is not met as evidenced by: TYPE A 2 VIOLATON Based on observations and interviews, the facility failed to maintain the hot water temperature between 100-116 degrees Fahrenheit (F) in 2 of 2 bathrooms, each with 1 sink and 1 shower/tub combination, used by all of the residents. The findings are: Observation on 10/08/15 of the two bathrooms used by residents in the facility revealed: - The bathroom labeled for "Men" at 9:10 am had a hot water temperature of 142 degrees F at the the sink and 142 degrees F at the tub/shower faucets. - The bathroom labeled for "women" at 9:14 am had a hot water temperature of 138 degrees F at the sink and 138 degrees F at the tub/shower faucets.	C 105		

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C 105	Continued From page 1 Interview with the Administrator on 010/08/15 at 9:20 am revealed: -She had taken over ownership of the facility July 15, 2015. -She did not know the hot water temperature was above the required range. -There was only one hot water heater for the home. -There had not been any burns or complaints about the hot water; residents liked having hot baths. -The hot water heater element had been replaced by a local gas company in late July 2015 or early August 2015. -The gas company had not sent her a bill for the repair, so she did not have documentation for the exact date of repairs to the hot water heater. - She did not inform the gas company of a hot water temperature setting or hot water parameters. -She had not checked the hot water temperatures and had no hot water temperature log for review. -She would contact a family member that performed routine maintenance to adjust the hot water heater temperature to get water temperatures with the range of 100 to 116 degrees F as required. -She would place "Caution Hot Water" signs in the bathrooms and inform residents to request staff to assist with using the hot water in the bathrooms. Interview on 10/08/15 at 9:30 am with the family member responsible for maintenance revealed: -He only did occassional minor maintenence repairs. -He verified the gas company had replaced the heating element in the water heater a few weeks	C 105		

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C 105	Continued From page 2	C 105		

ago.
-He was not aware of the requirements for of 100 to 116 degrees F and had not been monitoring hot water tempetures.
-He thought the facility had a digital thermometer in a drawer in the kitchen that could be used for checking hot water temperature.

On 10/08/15 at 10:45 am, the surveyor and facility thermometers were calibrated in an ice water slurry with the surveyor's thermometer reading 32 degrees F and the facility's digital thermometer reading 32.5 degrees F.

Later interview on 10/08/15 at 10:15 am with the Administrator revealed:
-She had located a digital thermometer she thought could be used for testing hot water temperatures.
-She was not sure if the thermometer was the one previously used by the facility to test hot water temperatures.
-She stated she had seen a notebook in one of the kitchen drawers that had hot water temperatures listed, but that was from the previous owner and must have been removed when the owner packed up her items during the change of ownership.

Interview with three residents on 10/08/15 revealed:
-The water was hot, but each would adjust the water temperature by using the hot and cold faucets to their preference.
-The residents stated they had not been burned by the hot water, and liked the water hot like it would be at home.

Interview with a fourth resident on 10/8/15 revealed:

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C 105	Continued From page 3	C 105		

-She had no problems with the hot water and knew how to adjust it.
-Staff routinely assisted her with her bathing because she was unsteady in the shower.
-She had never been burned by the hot water.

Recheck of the hot water temperature on 10/08/15 at 1:00 pm revealed:
-The "Mens" bathroom hot water temperature was 116 degrees F at the sink and tub/shower faucets.
-The "Mens" bathroom hot water temperature was 116 degrees F at the sink and tub/shower faucets.

____

The facility provided the following Plan of Protection as follows:
-Post CAUTION HOT WATER in each bathroom making everyone aware of water being too hot.
-Inform each resident about the water temperatures and for them to let staff know if they needed to go to the bathroom.
-Maintenance man came to adjust the hot water heater thermostat downward.
-Rechecked hot water temperature several times until it was in the 100-116 degrees F range for at least two checks.
-The facility will monitor water temperature on a daily basis and record daily.
-Administrator will monitor for at least daily for 2 weeks, then every week thereafter (keeping a log).

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 11, 2015.

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C 202	Continued From page 4	C 202		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 sampled residents (#1) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #1's current FL-2 dated 09/14/15 revealed a diagnoses of schizophrenia, diabetes and hypertension. Review of Resident #1's Resident Register revealed an admission date of 08/13/15. Review of Resident #1's record revealed: - A hospital FL-2 dated 08/13/15 with no documentation for Resident #1 having a tuberculosis (TB) skin test from a hospital. - Documentation of a chest X-ray from the hospital dated 08/13/15 revealing: Finding-"...No acute infiltrate or pleural effusion. No pulmonary edema", Impressions- "No active	C 202		

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C 202	Continued From page 5 cardiopulmonary disease". - The chest X-ray dated 08/13/15 did not not indicate negative for tuberculosis. - No documentation of any other TB skin test. Interview on 10/08/15 at 2:45 pm revealed: - Resident #1 was admitted to the facility from the behavioral unit of a local hospital. - The Administrator stated she requested the hospital administer the first TB skin test prior to discharging the resident to the facility. - She was informed by the hospital that a chest X-ray should be sufficient for TB testing. - She thought Resident #1 was admitted directly to the hospital from the resident's primary residence (home) and not from another assisted living or family care home. - She had not contacted the contract facility Nurse. - Resident #1 had seen the resident's Primary Care Physician (PCP) on 2 visits since admission, but the Administrator had not requested for the PCP to administer a TB skin test to Resident #1. - She would contact the contract Nurse or PCP office to have a TB skin test.	C 202		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	C 249		

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C 249	Continued From page 6	C 249		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to assure documentation and implementation of a physician's order for for a physician's order for haloperidol decanoate for 1 of 3 sampled residents (Resident #1).

The findings are:

Review of Resident's #1 current FL-2 dated 09/14/15 revealed:
- Diagnoses included paranoid schizophrenia and diabetes.
- An order for haloperidol decanoate (used to treat mental disorders) 100 mg/ml, inject monthly.

Review of Resident #1's record revealed a previous hospital FL-2 dated 08/13/15 with an order for "Haloperidol decanoate 100 mg/ml, intramuscular once a month for psychosis. Next injection on 09/10/2015."

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 08/13/15.

Observation of medication on hand for Resident #1 on 10/09/15 revealed a manufacturer's carton (box) containing an unopened vial of haloperidol decanoate 100 mg/ml labeled for Resident #1, with a dispensing date of 08/14/15, on the second tray of the door of the facility's food refrigerator in the kitchen.

Telephone interview on 10/08/15 at 3:20 pm with the contract pharmacy revealed:
- The pharmacy had dispensed one vial of haloperidol decanoate 100 mg/ml for Resident #1 on 08/14/15.

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C 249	Continued From page 7 - The facility had not requested another vial of haloperidol decanoate 100 mg/ml for Resident #1. Review of Resident #1's record revealed: - No documentation on the resident's Medication Administration Records (MARs) for September 2015 and October 2015 for administration of the haloperidol decanoate injection. - No documentation in the resident's Progress Notes for administration of the haloperidol decanoate injection as ordered for 09/10/15. - Documentation for visits to the resident's primary care physician (PCP) on 08/27/15, and 09/09/15. - No documentation for contact with the local mental health provider. Observation of Resident #1 at various times on 10/08/15 and 10/09/15 revealed: - The resident was ambulating slowly around the facility and out on the the porch. - The resident was pleasant, but spoke loudly when engaging other residents in conversation. - The resident was not observed displaying any combative behaviors; no emotional outburst or confrontation situations were observed. Interview on 10/8/15 at 3:35 pm with the Administrator revealed: - She was aware Resident #1 had not received the haloperidol decanoate 100 mg/ml injection. - She had not been able to find a provider to administer the injection. - She had contacted the a mental health provider and arranged an appointment for Resident #1. - The appointment time was set by the provider's scheduler for 09/07/15 (a holiday) and later rescheduled by the provider for 9/17/15. - The resident was taken to the appointment on	C 249		

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C 249	Continued From page 8 09/17/15, but the provider's clinic stated they would not give the haloperidol decanoate 100mg/ml injection until the resident was seen by the psychiatrist, which routinely occurred after 2 patient visits with an appointed therapist. (The 09/17/15 clinic visit lasted 2 hours and involved a tele-visit video session.) - She had not taken Resident #1's haloperidol decanoate 100mg/ml injection to the mental health provider appointment. - She insisted that an appointment with the psychiatrist would be as soon as possible, however Resident #1 had not seen the psychiatrist as of 10/09/15. Interview on 10/09/15 at 1:00 pm with the Administrator revealed: - She had not contacted the facility Contract Nurse to administer the haloperidol decanoate 100 mg/ml injection because she was attempting to have the resident's mental health physician/provider administer the medications. - She had not taken the haloperidol injection to the resident's PCP because the PCP had refused to administer injectable psychotropic medications to other residents in the past. Interview on 10/09/15 at 12:30 pm with Resident #1 revealed: - She had been in a local behavior hospital and was discharged to the facility because family refused to let her go back home. - She received her oral medications at the facility. - She did not think she had any haloperidol tablets prescribed now; had been on it before, but she did not like taking it because she thought it made her have trouble passing urine. - She was not aware she was supposed to have any kind of injection or that the facility had not arranged for her to receive the injection.	C 249		

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C 249	Continued From page 9 - The injection made her have trouble going to the bathroom (urinating) she did not want it. Telephone interview on 10/12/15 at 11:17 am with Resident #1's PCP's office nurse revealed: - The PCP's office did not administer injectable psychotropic medications; the resident's mental health provider would be responsible for administering the medication. - The facility Administrator would be responsible for making arrangements for another provider to administer the haloperidol injection for Resident #1. Telephone interview on 10/12/15 at 10:20 am with the Administrator revealed: - Another appointment had been arranged with the local mental health provider for 10/15/15 (earliest available) for the resident to see a psychiatrist at the clinic. - The resident had informed the Administrator that she would refuse to take the medication because "Haldol (haloperidol) stopped her urine. - She had not informed the resident's physician that the resident refused to receive haloperidol injection.	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date	C 254		

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a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews, observation, and interviews, the facility failed to ensure an assessment was performed by a qualified health professional within 30 days of admission or developed the need for a task, and a least quarterly thereafter for 2 of 3 sampled residents (Resident #1, and #2) with Licensed Health Professional Support (LHPS) tasks of medication through injection, and fingerstick blood sugar (FSBS) monitoring.

The findings are:

A. Review of Resident #1's current FL-2 dated 09/14/15 revealed a diagnoses of schizophrenia, diabetes and hypertension.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/13/15.

Review of Resident #1's record revealed:
- A physician's order dated 8/27/15 and current

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C 254	Continued From page 11 FL-2 dated 09/14/15 ordering fingerstick blood sugars (FSBS) twice a day. - A physician's order dated 09/09/15 and current FL-2 dated 09/14/15 prescribing Lantus insulin (a long acting insulin analog) 20 units each evening. Review of Resident #1's August 2015, September 2015, and October 2015 Medication Administration Records (MARs) revealed: - FSBS were obtained twice a day and ranged from 91 to 156 in August 2015. - FSBS were obtained twice a day and ranged from 76 to 239 in September 2015. - FSBS were obtained twice a day and ranged from 61 to 163 in October 2015. - Lantus was administered each evening from September 9, 2015 to October 8, 2015. Continued review of the resident record revealed Resident #1 did not have a LHPS review for the task of FSBS testing or medications administered through injection. Interview on 10/09/15 at 12:00 pm with Resident #1 revealed: - The facility staff obtained FSBS checks 2 times a day. - The resident received Lantus insulin injections each evening. Refer to interview on 10/08/15 at 3:30 pm with the Administrator. B. Review of Resident #2's current FL-2 dated 06/18/15 revealed: - Diagnoses included bipolar 1 disorder mania with psychosis, and hypertension. - An order for Invega Sustenna 234mg/1.5 ml infection every month. (Invega Sustenna injection is a long acting medication used to treat mental	C 254		

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health disorders.)

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 06/18/15.

Review of Resident #2's July 2015,August 2015, September 2015, and October 2015 Medication Administration Records (MARs) revealed Resident #2 received documented Invega Sustenna injections by a mental health provider on 7/15/15, 8/12/15, 9/10/15 and 10/8/15.

Review of Resident #2's record revealed:
-Resident #2 received documented Invega Sustenna injections by a mental health provider on 7/15/15, 8/12/15, 9/10/15 and 10/8/15.
-Resident #2 did not have a LHPS review for the task of medications administered through injection.

Interview on 10/08/15 at 2:00 pm with Resident #2 revealed:
- The facility staff took him to an outside provider routinely to receive his Invega shot.
- He had not experienced any site of injection irritation from the injection.

Refer to interview on 10/08/15 at 3:30 pm with the Administrator.

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Interview on 10/08/15 at 3:30 pm with the Administrator revealed:
- She had obtained a change of ownership for the facility on 07/15/15.
- The Administrator was responsible to assure the LHPS review were completed on residents.
- She was aware LHPS reviews were required for any resident with an appropriate task.
- She was aware a LHPS review was due for at

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C 254	Continued From page 13 least one resident. - She had a contract Nurse that provided LHPS services for a sister facility, but she had not scheduled a definite time for the contract Nurse to do the LHPS reviews for this facility. - She would contact the contract Nurse to immediately do the LHPS reviews.	C 254		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on interview, and record review, the facility failed to assure the medication aide administering and observing a resident's medication was the same medication aide documenting the administration of medications immediately following the administration and observation of the resident actually taking the medications for 2 of 2 residents (#1, and #4). The findings are: A. Review of Resident #3's current FL-2 dated 07/28/15 revealed diagnoses included schizophrenia, agitation, constipation,	C 341		

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gastroesophageal reflux disease (GERD), and dyslipidemia.

Review of the current FL-2 dated 07/28/15 revealed medications ordered on the FL-2 included:
- Lorazepam 2 mg one-half tablet 2 times daily and one tablet in the pm. (used to treat anxiety).
- Chlorpromazine 200 mg one tablet 2 times a day and 4 tablets in the evening (used to treat mental disorders).
- Benztropine 0.5 mg one tablet 2 times a day (used to treat tremors).
- Risperidone 4 mg one tablet 2 times a day (used to treat mental disorders).
- Lactulose 10 gm/15 ml syrup 22.5 ml by mouth daily (used to treat constipation).
- Loratadine 10 mg one tablet daily (used to treat allergies).
- Vitamin D3 2000 international unit capsules one capsule 2 times daily (used to treat Vitamin D deficiency).
- Omeprazole 20 mg one capsule daily (use to treat gastric acid reflux).
- Linzess 145 mcg one capsule daily (used to treat constipation).

Review of Resident #3's Resident Register revealed an admission date of 09/02/14.

Interview with a Resident #3 on 10/09/15 at 1:50 pm revealed:
- Staff C, Personal Care Aide (PCA), routinely stayed with residents at the facility on Monday, Tuesday, Wednesday and Thursday night from around 8:00 pm to around 8:00 am.
- Staff C prepared breakfast for the residents.
- The resident had medications scheduled for 8:00 am, 2:00 pm, and 8:00 pm.
- The Administrator usually gave the resident's

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medications during the week.
- Staff C had occasionally given the resident's 8:00 am and/or 8:00 pm medications to take when the Administrator was not at the facility.

Review of Resident #3's August 2015, September 2015 and October 2015 Medication Administration Records (MARs) revealed:
- Current medications ordered by the providers matched the printed MARs.
- Staff C had not documented administration of any medications.

Refer to interview on 10/09/15 at 5:00 pm with the Administrator.

Refer to telephone interview on 10/12/15 at 1:30 pm with Staff C, Personal Care Aide/Supervisor in Charge.

B. Review of Resident #4's current FL-2 dated 08/13/15 revealed diagnoses included schizophrenia paranoid type, and alcohol dependence- partial remission.

Review of the current FL-2 dated 08/13/15 revealed medications ordered on the FL-2 included:
- Naltrexone 50 mg daily (used to treat alcohol dependence).
- Olanzapine 20 mg one tablet at bedtime (used to treat mental disorders).
- Acetaminophen 500 mg 2 every 4 hours as needed for pain.
- Motrin 800 mg one tablet 3 times a day as needed for pain.

Interview on 10/09/15 at 2:10 pm with Resident #4 revealed:
- Staff C, Personal Care Aide, worked nights from

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Monday to Thursday.
- Another staff member worked on weekends (Friday morning to Monday morning).
- Staff C prepared the resident's 8:00 am medication and gave the medication on a few occasions.
- The Administrator routinely administered the resident's evening medications.

Review of Resident #4's August 2015, September 2015 and October 2015 Medication Administration Records (MARs) revealed:
- Current medications ordered by the providers matched the printed MARs.
- Staff C had not documented administration of any medications.

Refer to interview on 10/09/15 at 5:00 pm with the Administrator.

Refer to telephone interview on 10/12/15 at 1:30 pm with Staff C, Personal Care Aide/Supervisor in Charge.

Interview on 10/09/15 at 5:00 pm with the Administrator revealed:
- The Administrator was working 12 hour day shifts, 4 days a week, at the facility.
- Staff C worked four nights weekly (the days the Administrator worked) as a Personal Care Aide in the facility.
- Staff C had administered medications to residents on a very few occasions when she was running late.
- Staff C did not document administration of medications on the Medication Administration record; the Administrator documented administration when she arrived at the facility.

Telephone interview on 10/12/15 at 1:30 pm with

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C 341	Continued From page 17 Staff C, Personal Care Aide, revealed: - She was not a Medication Aide. - She had not taken the Medication Aide training or Medication Aide test. - Staff C had administered medications to residents one a few occasions, mainly when the Administrator had been running very late on a few morning, or if a resident had been out of the facility and came back after the Administrator had left the facility. - Staff C had administered residents' medications at most 1 or 2 times in a week, but not every week. - Staff C did not document any medication administration on the Medication Administration Record.	C 341		
C 358	10A NCAC 13G .1006 (g) Medication Storage 10A NCAC 13G .1006 Medication Storage (g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident's (Resident #1) medication stored in a refrigerator containing non-medication and non-medication items were stored in a	C 358		

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separate container when stored with non-medication items.

Observation on 10/09/15 at 12:45 pm of the facility's kitchen area revealed:
- The kitchen was adjacent to the dining room used by residents for eating meals.
- The kitchen was accessible from the dining area and a common hallway.
- The hallway entrance to the kitchen had a lockable cafe-style door (open at the top and bottom).
- The dining area to the kitchen had a lockable door.
- The kitchen contained an upright side by side refrigerator/freezer combination.
- The refrigerator side of the combination was on the right hand side.
- The kitchen was accessible by all residents.

Review of Resident's #1 current FL-2 dated 09/14/15 revealed:
- Diagnoses included paranoid schizophrenia and diabetes.
- Medication orders included; Haloperidol decanoate (used to treat mental disorders) 100 mg, inject monthly and Lantus insulin (a long acting insulin analog used in treating diabetics) 20 units in the evening.

Observation of medication on hand for Resident #1 on 10/09/15 revealed:
- A partial 10 ml vial of Lantus insulin labeled for Resident #1 located on the second tray of the door of the facility's food refrigerator in the kitchen.
- A manufacturer's carton (box) containing an unopened vial of haloperidol decanoate 100 mg/ml labeled for Resident #1 on the second tray of the door of the facility's food refrigerator in the

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kitchen.

Interview on 10/09/15 with a Medication Aide (MA) revealed:
- The MA had worked at the facility since July 2015.
- The MA routinely worked 24 hour shifts starting Friday around 9:00 am and ending on Monday around 8:30 am.
- The kitchen refrigerator was accessible to the residents unless the doors were locked, but the residents did not retreive items from the refrigerator.
- He routinely locked the kitchen doors after he cleaned up the dining area and kitchen, during the day, and at night after residents went to bed.
- He had not observed residents unattended at the refrigerator.
- Resident #1's haloperidol decanoate injection had been stored in the refrigerator since it was delivered from the pharmacy 08/14/15.
- Resident #1's Lantus insulin was always stored in the kitchen refrigerator except when he used the Vail for administering Resident #1's insulin.
- Resident #1 was the only resident that had refrigerated medications.
- The facility had not had a separate container to store refrigerated medication items since he began working at the facility.

Interview with Administrator on 10/09/15 at 1:00 pm revealed:
- She was aware medications stored in the kitchen refrigerator should be stored in a separate container and locked if residents have access to the refrigerator.
- The kitchen door was routinely locked when staff were not in the area of the kitchen.
- The previous owner of the facility had a locked storage box in the refrigerator prior to the change

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C 358	Continued From page 20 of ownership on 07/15/15. - She had planned to obtain a lockable container for storing medications in the refrigerator but continued to forget when she was at a store. - She had a container to be used today.	C 358		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and,	C 375		

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(C) documenting the results of the medication review in the resident's record;

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews the facility failed to assure medication reviews were completed at least quarterly for 2 of 3 sampled residents (Residents #2, and #3).

The findings are:

A. Review of Resident #3's current FL-2 dated 07/28/15 revealed diagnoses included schizophrenia, agitation, constipation, gastroesophageal reflux disease (GERD), and dyslipidemia.

Review of the current FL-2 dated 07/28/15 revealed medications ordered on the FL-2 included:
- Lorazepam 2 mg one-half tablet 2 times daily and one tablet in the pm. (used to treat anxiety).
- Chlorpromazine 200 mg one tablet 2 times a day and 4 tablets in the evening (used to treat mental disorders).
- Benztropine 0.5 mg one tablet 2 times a day (used to treat tremors).
- Risperidone 4 mg one tablet 2 times a day.
- Lactulose 10 gm/15 ml syrup 22.5 ml by mouth daily (used to treat constipation).
- Loratadine 10 mg one tablet daily (used to treat allergy).
- Vitamin D3 2000 international unit capsules one capsule 2 times daily (used to treat Vitamin D deficiency).
- Omeprazole 20 mg one capsule daily (use to treat gastric acid reflux).
- Linzess 145 mcg one capsule daily (used to treat constipation).

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C 375	Continued From page 22 Review of Resident #3's Resident Register revealed an admission date of 09/02/14. Review of Resident #3's record revealed: - Documentation Quarterly Drug Regimen Reviews were completed on 02/16/15 and 05/19/15. -There were no other reviews completed in the record for 2015. Resident #3 was out of the facility on 10/09/15 and unavailable for interview. Refer to interview with the Administrator on 10/08/15 at 3:35 pm. B. Review of Resident #2's current FL-2 dated 06/18/15 revealed diagnoses included bipolar 1 disorder mania with psychosis, and hypertension. Review of Resident #2 record revealed medications ordered on current signed physician's orders dated 10/06/15 included: - Benztropine 1 mg every morning (used to treat tremors). - Clonazepam 0.5 mg one tab;et every 8 hours (used to treat anxiety). - Fish oil 1000 mg twice a day (used to treat elevated triglycerides). - Hydrochlorothiazide 25 mg daily (used to treat high blood pressure). - Invega Sustenna 234mg/1.5 ml infection every month. (a long acting injection medication used to treat mental health disorders.) - Lisinopril 20 mg daily (used to treat high blood pressure). - Lithium Carbonate 300 mg 2 capsules 2 times a day (used to treat mental disorders). - Seroquel XR 300 mg 2 tablets at bedtime (used	C 375		

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to treat bipolar disorders).
- Simvastatin 10 mg at bedtime (used to treat elevated cholesterol).
- Nicorette 2 mg gum one piece chewed as needed.

Review of Resident #2's Resident Register revealed an admission date of 06/18/2015.

Review of Resident #3's record revealed there was no documentation Quarterly Drug Regimen Reviews were completed since admission to the facility on 06/18/15.

Interview on 10/09/15 at 1:25 pm with Resident #3 revealed:
- The resident had been receiving medications daily and his injection monthly.
- He relied on the pharmacy and the Medication Aides to administer his medications as the physician ordered.
- He did not know if the facility kept up with all the correct paperwork.
- He had not experienced any problems with his medications.
- He had seen his mental health provider a few days ago.
- He had been to 3 doctors as of Thursday this week.

Refer to interview with the Administrator on 10/08/15 at 3:35 pm.

____
Interview on 10/08/15 at 3:35 pm with the Administrator revealed:
- She had obtained a change of ownership for the facility on 07/15/15.
- The Administrator was responsible to assure the Quarterly Drug Regimen Reviews were completed on residents.

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C 375	Continued From page 24 - She was aware Quarterly Drug Regimen Reviews were required for all residents. - She stated 2 residents had not been at the facility 60 days. - She had a Contract Nurse that provided Quarterly Drug Regimen Reviews for a sister facility but she had not scheduled a time for the Contract Nurse to do the Quarterly Drug Regimen Reviews reviews for this facility. - She would contact the Contract Nurse to immediately do the Quarterly Drug Regimen Reviews.	C 375		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with 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 facility hot water temperatures and Medication Aide training and competency. The findings are: A. Based on observations and interviews, the facility failed to maintain the hot water temperature between 100-116 degrees Fahrenheit (F) in 2 of 2 bathrooms, each with 1 sink and 1 shower/tub combination, used by all of	C 912		

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C 912	Continued From page 25 the residents. [Refer to Tag C 0105, 10A NCAC 13G .0317(d) Building Service Equipment (Type A2 Violation)]. B. Based on interview and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff C) who performed medication aide duties met the requirements to administer medications by documentation of successful completion of the clinical skills validation, had completed the 5 hour, 10 hour, or 15 hour state approved medication aide training course, and passed the state medication aide test. [Refer to Tag C 0935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency (Type B Violation)].	C 912		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and	C935		

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

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

Based on interview and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff C) who performed medication aide duties met the requirements to administer medications by documentation of successful completion of the clinical skills validation, had completed the 5 hour, 10 hour, or 15 hour state approved medication aide training course, and passed the state medication aide test.

The findings are:

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C935	Continued From page 27 Review of Staff C's personnel record revealed: - Staff C was hired 07/30/15 as Personal Care Aide. - Staff C completed personal care training 11/01/1991. - There was no documentation Staff C had passed the written Medication Aide (MA) test. - There was no documentation of the completion of the 5 hour, 10 hour or 15 hour MA training course. - There was no documentation Staff C had completed the Medication Clinical skills validation. Review of the residents' Medication Administration Records (MARs) for August 2015, September 2015 and October 2015 revealed no documentation that Staff C had administered medications to residents. Interview with a resident on 10/09/15 at 1:50 pm revealed: - Staff C routinely stayed with residents at the facility on Monday, Tuesday, Wednesday and Thursday night from around 8:00 pm to around 8:00 am. - Staff C prepared breakfast for the residents. - The resident had medications scheduled for 8:00 am, 2:00 pm, and 8:00 pm. - The Administrator usually gave the resident's medications during the week. - Staff C had occasionally given the resident 8:00 am and/or 8:00 pm medications to take when the Administrator was not at the facility. Interview with a second resident at 2:10 pm revealed: - Staff C worked nights from Monday to Thursday. - Another staff member worked on weekends (Friday morning to Monday morning).	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079098	A. BUILDING: ____ B. WING ____	10/12/2015

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C935	Continued From page 28	C935		

- Staff C prepared the resident's 8:00 am medication and gave the medication on a few occassions.
- The Administrator routinely administered the resident's evening medications.

Interview on 10/09/15 at 9:20 am with Staff C, Personal Care Aide, revealed:
- She had worked for several years as a personal care aide in skilled facilities.
- She had worked as a personal sitter for a home health agency.
- She was scheduled to work at the facility Monday, Tuesday, Wednesday and Thursday nights.
- She would call the Administrator, who lived across the street, to administer any medications to residents.

Telephone interview on 10/12/15 at 1:30 pm with Staff C revealed:
- She was not a Medication Aide.
- She had not taken the Medication Aide training or Medication Aide test.
- She had administered medications to residents one a few occcasions, mainly when the Administrator had been running very late on a few morning, or if a resident had been out of the facility and came back after the Administrator had left the facility.
- She had administered residents' medications at most 1 or 2 times in a week, but not every week.
- The medications were prepacked by the pharmacy with all the medications being in one bubble pak on a color coded card for the time of administration (Meds-On-Time package system).
- She had never given a resident an insulin injection.
- She did not document any medication administration on the Medication Administration

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C935	Continued From page 29 Record. Interview on 10/09/15 at 5:00 pm with the Administrator revealed: - The Administrator was responsible for reviewing and filing information in the staff personnel records. - The Administrator was working 12 hour day shifts, 4 days a week, at the facility. - Staff C worked four nights weekly (the days the Administrator worked) as a personal care aide in the facility. - Staff C had administered medications to residents on a very few occasions. - The Administrator was aware Staff C had not completed the 5 hour, 10 hour or 15 hour MA training course, had not passed the state Medication Aide test, and did not have a Medication Aide Clinical Validation checklist completed. - The Administrator was aware Staff C had administered medications at 8:00 am a very few times when she was running late. - Staff C did not document administration of medications on the Medication Administration record; the Administrator documented administration when she arrived at the facility. - Staff C would not pass medications until she had completed the 5 hour, 10 hour or the 15 hour MA training, Medication Aide Checklist, and passed the state Medication Aide test. ______________________ The Administrator submitted a Plan of Protection as follows: - The Administrator will immediately make sure medications are not passed by unlicensed staff. - Making sure that a medication aide is available at all times or within 500 feet of the facility. - The Administrator will be responsible for monitoring the Medication Aide staffing.	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C935	Continued From page 30 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 26, 2015.	C935		