RcD via email 10-14-15

Division of Health Service Regulation

PRINTED: 09/29/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060019	A. BUILDING: _____ B. WING _____	R 09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey on September 15, 2015 with an exit conference via telephone on September 16, 2015.	C 000		
C 173	10A NCAC 13G .0504 (c) Competency Validation For Licensed Health Pro 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to ensure physician certification which would approve non-licensed facility staff to be competency validated by a Licensed Health Professional to administer a subcutaneous anti-coagulant medication (Lovenox) on a temporary basis for one resident (Resident #1). The findings are:	C 173	Adm. will assure a temporary LHPS physician Certification form will be completed by the doctor on any resident requiring Nolicensed staff to conduct task on temporary basis be completed and kept on file. Admn. will also assure LHPS Nurse conduct a Ninety day on Resident depending on doctors order.	10/14/2015

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Owner / Adm

(X6) DATE: 10/14/15

STATE FORM 6899 5S5G11 If continuation sheet 1 of 39

Reviewed And Accepted
HRP 10/23/15

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C 173	Continued From page 1 Review of Resident #1's current FL-2 dated 9/15/15 revealed diagnoses included chronic bilateral lower extremity deep vein thrombi, paranoid Schizophrenia, chronic obstructive pulmonary disease, constipation, insomnia, Schizo-affective disorder, and Tardive Dyskinesia. Review of the Resident Register revealed Resident #1 was admitted to the facility on 9/28/2010. Review of Resident #1's record revealed: -A Physician's order dated 6/23/15 for Lovenox 80 mg/0.8 ml daily (A medication used to prevent and treat blood clots that is administered via injection). -A Nurse Practitioner's order dated 7/13/15 changing the Lovenox to 40 mg subcutaneously twice daily. -A Nurse Practitioner's order dated 7/20/15 to discontinue Lovenox after 3 more doses and to start Xarelto 7/22/15. Review of the Medication Administration Record (MAR) for June 2015 revealed: -An entry for Lovenox 80 mg/0.8 ml and documented as administered every evening, with no time specified, by Medication Aides (MAs) beginning on 6/22/15 through 6/31/15 (June has 30 days). Review of the MAR for July 2015 revealed: -An entry for Lovenox 80 mg/0.8 ml and documented administered once daily at 8:00 am by MAs beginning on 7/01/15 through 7/13/15. -An entry for Lovenox 40 mg/0.4 ml and documented as administered twice daily at 8:00 am and 8:00 pm by MAs beginning on 7/14/15 through 7/21/15 and discontinued per physicians	C 173		

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C 173	Continued From page 2 order. Review of Resident #1's record revealed: -There was no Temporary Licensed Health Professional Support Task Physician's Certification documentation in the resident's record. -There was no documentation of a Licensed Health Professional Support (LHPS) review 30 days after the LHPS task of subcutaneous injections by facility staff. Telephone interview with the Administrator on 9/15/15 at 3:56 pm revealed: -She was unaware that unlicensed staff were not permitted to administer anticoagulants via subcutaneous injection. -She was unaware she was to obtain physician approval to allow non-licensed facility staff to be competency validated to administer anticoagulation therapy via subcutaneous injection. -She was unaware she had to have this approval in writing and signed by the physician. -The resident had this ordered last year and the LHPS nurse checked facility staff off for subcutaneous injections last year and there was documentation of this in staff records. Interview with Resident #1 on 9/15/15 at 6:15 pm revealed: -The injection started as once a day and later was changed to twice a day. -She was taking the Lovenox "for about a month". -The MA and the administrator both administered the Lovenox. -They did inject the Lovenox in her stomach. -She did not experience any unusual bruising or bleeding. -She did have some bruising on the injection	C 173		

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C 173	Continued From page 3 sites. -She no longer took Lovenox and now she was taking Xarelto daily. _____ The facility provided a Plan of Protection on 9/15/15 as follows: - The facility will immediately review resident records for any medications or tasks requiring LHPS verification and if needed the resident's physician would be contacted for completion of an LHPS exemption form. -The form would be reviewed and signed by the physician every 30 days. -Staff will be in-serviced on the need for LHPS exemption and the tasks that required exemption. - The Administrator will be responsible for monitoring. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.	C 173		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 2 of 3 sampled residents (Residents #1 and #3) regarding ordered laboratory tests and follow-up with the physician related to an order for compression stockings.	C 246	Facility will create a system to ensure communication with doctor regarding any visits including orders and results for labs or any other special care Needs. Adm and Staff will Review to Assure All Orders from doctor ARE Followed.	10/30/15

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C 246	Continued From page 4 The findings are: A. Review of Resident #3's current FL2 dated 03/11/15 revealed: -Diagnoses included major depression with history of psychotic features, generalized anxiety disorder, alcoholism, chronic hepatitis C, chronic kidney disease, hypertension, and mild aortic stenosis. -An order for Tylenol (acetaminophen) 650mg every 8 hours as needed for arthritis. Review of the Resident Register revealed Resident #3 was admitted to the facility on 08/23/10. Review of Resident #3's record revealed: -A physician's order dated 12/04/14 for a Hepatic Function Panel A. -A physican's order dated 12/04/14 for a Lipid panel. -No documentation the Hepatic Function Panel A or the Lipid panel was completed or scheduled for completion. -A lipid panel was completed 06/10/15 in the physician's office, -A pharmacist review note dated 07/21/15 "Labs still missing from patient's chart. This must be addressed. Contact MD (physician) office to request. Patient could sustain liver damage due to medication use in conjunction with alcohol misuse and without those labs we are unable to see a problem and correct it". Interview on 09/15/15 at 6:10 pm with Staff A, Supervisor-in-Charge (SIC) revealed: -She was not aware of the orders for the Hepatic Function Panel A and the lipid panel ordered on 12/04/14. -She did not know if the tests had been	C 246		

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C 246	Continued From page 5 completed. -Sometimes the residents' families took the resident to the doctor and the facility did not get a copy of the doctor's orders. -Sometimes the doctor's office completed labwork in their office and did not send the facility a copy of the results. -She did not know if she had requested these labs to be done or if they had been done. Interview on 09/16/15 at 12:17 pm with the Administrator revealed: -The SICs were responsible for ensuring orders from physicians were completed. -She was not aware of the orders for the Hepatic Function Panel A and the lipid panel ordered on 12/04/14. -She did not know if the tests had been completed. -Sometimes the residents' families take the resident to the doctor and the facility does not get a copy of the doctor's orders. -Sometimes the doctor's office completed labwork in their office. -It was difficult to get responses or information from Resident #3's doctor's office. -She did not know if the facility had requested these labs to be done or if they had been done. -She would follow-up with the physician's office to see if the labwork had been completed. B. Review of Resident #1's current FL-2 dated 9/15/15 revealed: -Diagnoses of chronic bilateral lower extremity deep vein thrombi (DVT), paranoid Schizophrenia, chronic obstructive pulmonary disease, constipation, insomnia, Schizo-affective disorder, Tardive Dyskinesia. -A physician's order for Xarelto 20 mg 1 tablet once daily (A medication used to treat and	C 246		

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C 246	Continued From page 6 prevent blood clots). Review of the Resident Register revealed Resident #1 was admitted to the facility on 9/28/2010. Review of Resident #1's record revealed: -A physician's order dated 7/09/15 for 20-30mmhg Knee-High Compression Stockings to be worn daily. (Compression stockings prevent the occurrence of, and guard against further progression of venous disorders such as swelling and blood clots). -The resident was seen in the emergency department of a local hospital on 6/22/15 and received a diagnosis and treatment for lower extremity DVT. -A physician's order dated 6/23/15 for Lovenox 80 mg/0.8 ml daily (A medication used to prevent and treat blood clots that is administered via injection). -A Nurse Practitioner's order dated 7/13/15 changing Lovenox to 40 mg subcutaneously twice daily. -A Nurse Practitioner's order dated 7/20/15 to discontinue Lovenox after 3 more doses and to start Xarelto 7/22/15 Review of an Oncology Specialist History and Physical report with a date of service of 7/27/15 revealed: -The chronic DVT was first diagnosed in October 2010. -The resident had a DVT extending from her groin, down the thigh and into the proximal calf. -There was also thrombus (blood clots) seen in the deep femoral vein. -There was a question of possible a pulmonary embolism (blood clot in the lungs).	C 246		

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C 246	Continued From page 7 Review of the Medication Administration Record (MAR) for July 2015 revealed: -There was no entry on the MAR for Compression Stockings. Review of Resident #1's Pharmacy Review dated 07/21/15 revealed the consulting pharmacist noted an order for compression stockings and recommended a local vendor that could provide the compression stockings for the resident. Telephone interview with the Administrator on 9/15/15 at 3:56 pm revealed: -Resident #1 repeatedly refused to get the compression stockings and they never got the stockings. -The resident refused because she did not want to pay for the stockings. -She did not inform the physician that the resident refused the compression stockings. -She did not document the resident refused the compression stockings. -She did not request an order from the physician to discontinue the compression stockings or notify the physician of the refusals. Interview with Resident #1 on 9/15/15 at 4:30 pm revealed: -She did not want compression stockings. -She did not want to wear the compression stocking because they were ugly. -She did not inform the physician that she was not wearing the compression stockings. -She was unaware that they prevented blood clots. -She thought that the compression stockings helped reduce and prevent swelling. -Her physician ordered Lasix so she did not need the stockings.	C 246		

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C 246	Continued From page 8 Attempted interview on 9/15/15 at 4:29 pm with Resident #1's Vascular Physician was unsuccessful. The facility provided a Plan of Protection on 9/15/15 as follows: -The facility will immediately review resident records to identify any service or treatment of any coordination or referral to an outside agency or practice to complete the order. -Staff will be in-serviced on the importance of completing health care referrals. -The Administrator will be responsible for monitoring. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.	C 246		
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 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	C 254		

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C 254	Continued From page 9 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 and a least quarterly thereafter for 3 of 3 total sampled residents (Resident #1, #2, and #3) with the Licensed Health Professional Support (LHPS) tasks of medication through injection, application and removal of compression stockings, and fingerstick blood sugar (FSBS) monitoring. The findings are: A. Review of Resident #1's current FL-2 dated 9/15/15 revealed: -Diagnoses included chronic bilateral lower extremity deep vein thrombi (DVT), paranoid Schizophrenia, chronic obstructive pulmonary disease, constipation, insomnia, Schizo-affective disorder, and Tardive Dyskinesia. 1. Review of Resident #1's Record revealed: -A physician's order dated 7/09/15 for 20-30mmhg Knee-High Compression Stockings to be worn daily. (Compression stockings prevent the occurrence of, and guard against further progression of venous disorders such as swelling and blood clots). -The resident was seen in the emergency department of a local hospital on 6/22/15 and received a diagnosis and treatment for lower	C 254		

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C 254	Continued From page 10 extremity DVT. Review of the Resident Register revealed Resident #1 was admitted to the facility on 9/28/2010. Review of the MAR for July 2015 revealed there was no entry on the MAR for Compression Stockings. Review of Resident #1's record revealed: -There was no documentation of an Licensed Health Professional Support (LHPS) review 30 days after the LHPS task of aaplication and removal of compression stockings was acquired. -There was no documantation of Resident #1's refusal to obtain or wear compression stockings. -There was no documentation of staff contacting Resident #1's physician to report the refusal of compression stockings. Interview with a Medication Aide on 9/15/15 at 3:30 pm revealed: -Resident #1 refused to get the compression stockings because they were too expensive. -Resident #1 refused to go get the stockings when offered because she did not want to wear the "ugly socks". -She did not inform the physician that the resident refused to get the stockings. -She did not document that the Resident #1 refused the stockings on the MAR or in the resident record. Refer to telephone interview with the LHPS Nurse on 9/15/15 at 3:43 pm. Refer to telephone interview with the Administrator on 9/15/15 at 3:59 pm.	C 254	Facility will create a System to ensure proper Communications with Doctors And other Professionals. Adm. will assure LHPS Assessments be completed Completed by LHPS Professional within 30 days and every 90 days after for any Resident requiring this. Adm will work with staff to assure all orders are on MAR. Review of MAR monthly by Adm & SIC/med tech. Adm will Assure all staff (ARE LHPS Competent and have LHPS professional Complete the LHPS Clinical Checksheet.	10/30/15

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C 254	Continued From page 11 2. Review of Resident #1's record revealed: -A physician's order dated 6/23/15 for Lovenox 80 mg/0.8 ml daily (A medication used to prevent and treat blood clots that is administered via injection). -A Nurse Practitioner's order dated 7/13/15 changing Lovenox to 40 mg subcutaneously twice daily. -A Nurse Practitioner's order dated 7/20/15 to discontinue Lovenox after 3 more doses and to start Xarelto 7/22/15. Review of the Medication Administration Record (MAR) for June 2015 revealed: -An entry for Lovenox 80 mg/0.8 ml and documented as administered every evening, with no time specified, by Medication Aides (MAs) beginning on 6/22/15 through 6/31/15 (June has 30 days). Review of the MAR for July 2015 revealed: -An entry for Lovenox 80 mg/0.8 ml and documented as administered once daily at 8:00 am by Medication Aides (MAs) beginning on 7/01/15 through 7/13/15. -An entry for Lovenox 40 mg/0.4 ml and documented as administered twice daily at 8:00 am and 8:00 pm by Medication Aides (MAs) beginning on 7/14/15 through 7/21/15. Review of Resident #1's record revealed no documentation of an Licensed Health Professional Support (LHPS) review 30 days after the LHPS task of subcutaneous injections was acquired. Interview with Resident #1 on 9/15/15 at 6:15 pm revealed: -The injection started as once a day and later was changed to twice a day.	C 254		

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C 254	Continued From page 12 -She was taking the Lovenox "for about a month". -The MA and the administrator both administered the Lovenox. -They did inject the Lovenox in her stomach. -She did not experience any unusual bruising or bleeding. -She did have some bruising on the injection sites. -She no longer took Lovenox and now she was taking Xarelto daily. Refer to telephone interview with the LHPS Nurse on 9/15/15 at 3:43 pm. Refer to telephone interview with the Administrator on 9/15/15 at 3:59 pm. B. Review of Resident #3's current FL2 dated 03/11/15 revealed diagnoses included major depression with history of psychotic features, generalized anxiety disorder, alcoholism, chronic hepatitis C, chronic kidney disease, hypertension, and mild aortic stenosis. Review of the resident register revealed Resident #3 was admitted to the facility on 08/23/10. Review of Resident #3's current FL2 dated 03/11/15 revealed an order for Vivitrol 380 mg injection every month in the physician's office. Review of Resident #3's record revealed: -Resident #3 received monthly injections of Vivitrol 380 mg at the physician's office on 04/01/15, 05/01/15, 06/05/15, 07/13/15, and 08/12/15. (Vivitrol is a medication used to treat addiction to alcohol or narcotic drugs.) -LHPS reviews completed on 10/03/14, 01/16/15, and 05/29/15.	C 254		

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C 254	Continued From page 13 -No LHPS reviews were available after 05/29/15. -The LHPS Nurse documented under the physical assessment on reviews of 10/03/14, 01/16/15, and 05/29/15 Resident #3 had no complaints regarding the injections. Interview with Resident #3 on 09/15/15 at 9:50 am revealed: -The facility made his doctor's appointments and took him to the doctor. -He received monthly injections at the doctor's office. Refer to telephone interview with the LHPS Nurse on 9/15/15 at 3:43 pm. Refer to telephone interview with the Administrator on 9/15/15 at 3:59 pm. C. Review of Resident #2's current FL2 dated 12/02/14 revealed diagnoses included Parkinson's Disease, essential hypertension, and diabetes mellitus- Type II. Review of the Resident Register for Resident #2 revealed the resident was admitted to the facility 3/02/98. Review of Resident #2's current FL2 dated 12/02/14 revealed an order for fingerstick blood sugar (FSBS) checks daily. Review of Resident #2's Medication Administration Records (MARs) documented FSBS checks daily for July 2015, August 2015, and September 2015 with a range from 101 to 182. Record review revealed a hemoglobin A1C (laboratory value used to determine the average	C 254		

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C 254	Continued From page 14 blood sugar concentration for the preceding 2-3 months) value of 5.9 was documented for a laboratory test on 6/12/15. (The National Institute of Diabetes and Digestive and Kidney Diseases list the normal range for hemoglobin A1C 5.7 or lower.) Review of Resident #2's record revealed: -Licensed Health Professional Support (LHPS) reviews completed on 01/15/15, and 05/29/15. -No LHPS review was available after 05/29/15. -The LHPS Nurse documented on the assessments on 01/16/15 and 05/29/15 that Resident #2 had no complaints regarding FSBS. Interview on 9/15/15 at 3:00 pm with the Medication Aide revealed: -The LHPS Nurse came to the facility to do LHPS reviews. -The Adminstrator was responsible to assure the LHPS reviews were completed by the LHPS Nurse. Interview on 09/15/15 at 7:10 pm with Resident #2 revealed the Medication Aides checked his FSBS every day. Refer to telephone interview with the LHPS Nurse on 9/15/15 at 3:43 pm. Refer to telephone interview with the Administrator on 9/15/15 at 3:59 pm. Telephone interview with the LHPS Nurse on 9/15/15 at 3:43 pm revealed: -She had been out to the facility sometime between 5/31/15 and 9/15/15 but had not done the LHPS paperwork required. -The facility called her and requested her to complete the quarterly LHPS reviews.	C 254		

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C 254	Continued From page 15 -The facility was supposed to call her for staff competency validation if a new task was ordered or if a new staff member was hired. -The facility was supposed to call her for an on-site resident review upon admission, quarterly, or if a new task was ordered. Telephone interview with the Administrator on 9/15/15 at 3:59 pm revealed: -She was unaware that the LHPS Nurse was to perform an on-site review of the resident within 30 days of the resident was ordered a new LHPS task. -She was aware and had called the LHPS Nurse to validate competency of staff if a new LHPS task was ordered or if a new staff member was hired. -She would call and request the LHPS Nurse to do resident assessments and reviews quarterly, but sometimes the LHPS Nurse would call her.	C 254		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure a medication (Acetaminophen which is a mild pain reliever) was administered as ordered by a	C 330		

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C 330	Continued From page 16 licensed prescribing practitioner for 1 of 3 sampled residents (#3). Review of Resident #3's current FL2 dated 03/11/15 revealed: -Diagnoses included major depression with history of psychotic features, generalized anxiety disorder, alcoholism, chronic hepatitis C, chronic kidney disease, hypertension, and mild aortic stenosis. -An order for Tylenol (acetaminophen) 650mg every 8 hours as needed for arthritis. Review of the Resident Register revealed Resident #3 was admitted to the facility on 08/23/10. Continued review of Resident #3's record revealed: -A physician's visit note dated 03/11/15 documented "Patient takes Tylenol 650mg every 8 hours as needed for back. He seems forgetful at this visit and I think this needs to be monitored as overdose could cause liver injury, especially with ETOH (ethyl alcohol) use" for Resident #3. Review of a Patient Visit Summary dated 06/10/15 which included: -A list of the resident's medications, including acetaminophen (Tylenol) 325mg 2 tablets 3 times a day, which was circled in pen. -Documentation on the medication list that a prescription was sent to the resident's pharmacy for acetaminophen (Tylenol) 325mg 2 tablets 3 times a day. Record review revealed: -No copy of an order changing the Tylenol from as needed to scheduled 3 times a day. -A documented pharmacist's note faxed to the	C 330	Adm. will provide Medication Regulation training for all medication staff. Adm will Review MAR to assure All medication and special care Orders ARE Administered Per doctors orders.	10/30/15

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C 330	Continued From page 17 physician on 07/21/15 stated "Patient was previously taking Tylenol 650mg only prn (as needed). Newest order is 650mg po three times a day scheduled. Tylenol intake increased due to scheduled medication which is a concern due to chronic alcohol abuse. Would you please consider change to Tylenol 650mg po three times a day prn?" -A fax to the facility on 08/29/15 of the physician's response dated 08/02/15 with the new order for acetaminophen 325mg three times a day as needed only. Review of Resident #3's June 2015 Medication Administration Record (MAR) revealed: -A computer entry for acetaminopphen 325mg every 8 hours as needed for arthritis pain with an original order date of 03/11/15. -Documentation the resident was administered acetaminophen 325mg once on 06/03/15, 06/04/15, 06/08/15, 06/09/15, and 06/10/15. -A handwritten entry for the acetaminophen 325 mg every 8 hours as needed to "stop - changed to 3 times a day doctor's order 06/10/15". -A handwritten entry for acetaminophen 325mg two tablets three times a day beginning 06/11/15. -Documentation the resident was administered acetaminophen three times a day at 8:00 am, 2:00 pm, and 8:00 pm from 06/11/15 to 06/30/15. Review of Resident #3's July 2015 MAR revealed: -A computer entry for acetaminophen 325mg take 2 tablets three times daily for arthritis pain with an original order date of 06/10/15. -Documentation the resident was administered acetaminophen 325mg three times a day at 8:00 am, 2:00 pm, and 8:00 pm from 07/01/15 to 07/31/15. Review of Resident #3's August 2015 MAR	C 330		

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C 330	Continued From page 18 revealed: -A computer entry for acetaminophen 325mg take 2 tablets three times daily with an original order date of 06/13/15. -Documentation the resident was administered acetaminophen 325mg three times a day at 8:00 am, 2:00 pm, and 8:00 pm from 08/01/15 to 08/31/15. Interview on 09/15/15 at 3:10 pm with Resident #3 revealed: -He had pain constantly in his legs, arms, and shoulders from arthritis. -He took acetaminophen two to three times a day for the arthritis pain, "morning, lunch, and nighttime". -He could have it up to three times a day. -The facility "had a problem" with orders for his acetaminophen, but Staff A, Medication Aide/Supervisor-in-Charge (SIC) had talked to the doctor's office about it. -He had to request acetaminophen because the doctor wrote the order for it to be given when he needed it instead of three times a day. -He denied any complications with his medications recently. -He had an appointment with his physician on 10/02/15 that had been arranged by the facility. Interview on 09/15/15 at 3:00 pm with the Pharmacist revealed: -She completed pharmacy reviews for all of the residents at the facility every three months. -Resident #3 had an original order on 10/23/14 for acetaminophen 325mg take one every 8 hours as needed for arthritis pain. -She received an order on 03/11/15 for acetaminophen 325mg take two every 8 hours as needed for arthritis pain. -She received an order on 06/13/15 for	C 330		

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C 330	Continued From page 19 acetaminophen 325mg 2 tablets three times a day (not as needed). -On 07/21/15, she faxed a request to the physician requesting consideration to change the acetaminophen from scheduled three times a day to as needed due to concerns of chronic alcoholism and the effect this could have on his liver. -On 07/30/15, she received a new prescription for acetaminophen 325mg 2 tablets three times a day as needed for pain. -She sent a copy of the new order to the facility on 07/31/15 when she filled the new prescription. -The facility had problems with their fax machine often, so that was why she sent a copy of the new order when the prescription was filled. -The August 2015 MAR would have already been printed for the facility at the time the new order for acetaminophen was filled. -The facility should have administered the acetaminophen 325mg 2 tablets as needed instead of scheduled three times a day after 07/31/15. -She was not aware the resident had received acetaminophen 325 mg 2 three times a day in August. Interview with Staff A, Medication Aide/SIC on 09/15/15 at 3:15 pm revealed: -The resident requested acetaminophen "usually three times a day" and we have to give it when he asks for it. -She was aware of the pharmacist's concerns that taking too much acetaminophen could cause damage to his liver. -"I called the doctor's office last week and told them he does not need to be taking this much acetaminophen when he has a history of alcohol abuse and Hepatitis C." -Sometimes the resident would go out of the	C 330		

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C 330	Continued From page 20 facility and return with alcohol on his breath. -When she questioned the resident, he denied use of alcohol. -She did not recall receiving a new order for the acetaminophen 325 mg 2 tablets as needed instead of scheduled three times a day after 7/31/15. -The pharmacy's process was to send a copy of the new order with the medication when it was delivered. -If she had received a copy of the new order, she would have changed the order on the August 2015 MAR. Interview with the Administrator on 09/16/15 at 12:17 pm revealed: -The pharmacy sent a copy of new orders to the facility when a medication was filled. -The SIC was responsible for reviewing all new orders when they were sent to them from the pharmacy with the new prescriptions. -When the SIC received new orders, the SIC was responsible for reviewing the new order and contacted the pharmacist or physician if there was a question about the order. -She did not know if the facility received the new order for acetaminophen from the pharmacy on 07/31/15. -The SICs and she consulted the pharmacist if they had questions about Resident #3's medication orders. -She was not aware Resident #3 was administered acetaminophen 325 2 tablets a day in August 2015 when there was a new order written on 07/30/15 for it to be administered as needed. -Resident #3 requested the acetaminophen every morning when she administered medications. -Staff A or another SIC administered his medications during the day and until she arrived	C 330		

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C 330	Continued From page 21 at the facility for the night shift.	C 330		
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 observation, interviews and record review, the facility failed to assure all medications administered to residents were documented as administered immediately following administration of the medication for 1 of 4 sampled residents (Resident #3). The findings are: A. Review of Resident #3's current FL-2 dated 03/11/15 revealed: -Diagnoses included major depression with history of psychotic features, generalized anxiety disorder, alcoholism, chronic hepatitis C, chronic kidney disease, hypertension, and mild aortic stenosis. -Orders for medications including bupropion Hcl SR 200 mg 1 tablet twice daily and acetaminophen 325 mg 2 tablets three times daily as needed for pain (prn).	C 341	Adm will provide training on Medication Regulations to all medication staff/ med tech. Adm will Review MAR with staff to assure Correct documentation And no Pre charting 10/15/15	

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C 341	Continued From page 22 Observation of Staff A, Medication Aide (MA)/Supervisor-in-Charge (SIC) during medication pass on 9/15/15 at 1:30 pm revealed: -Staff A removed a tablet from a bottle of bupropion Hcl SR 200mg and placed the tablet in a plastic medication cup. The Medication Administration Record (MAR) was not in the room in which she was preparing the medication: the MAR was in a room at the back of the facility. -Staff A was provided the MAR and the MA then compared the bottle she removed the tablet from to the current MAR. -Staff A noted the times for the bupropion Hcl SR 200mg were set for 8:00 am and 8:00 pm and changed the 8:00 pm time to 2:00 pm. -Staff A poured two prn (as needed) acetaminophen tablets from the bottle and placed in the medication cup. -Staff A signed out the bupropion Hcl SR 200 mg prior to the administration of the medication. -Staff A administered the medications to Resident #3. -Staff A closed the MAR and failed to sign out the prn acetaminophen on the front and back of the MAR. Review of Resident #3's June, July and August 2015 MARs revealed that the bupropion Hcl SR 200 mg was documented as administered at 8:00 am and 2:00 pm. Review of Resident #3 September 2015 MAR revealed: - Bupropion Hcl SR 200 mg was entered for 8:00 am and 8:00 pm with a hand written "2" over the computer entry 8 for the 8:00 pm time. -Acetaminophen was signed out every day from 9/01/15 to 9/11/15 but there was no indication of what time it was signed out on the back of the	C 341		

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C 341	Continued From page 23 MAR. Interview with Staff A, MA/Supervisor-in-Charge (SIC), on 9/15/15 at 1:35 pm revealed: -She would usually take the medications out of the bottles and place in the cup and administer the medications to the resident. -Once she had completed her medication pass she would go to "the back" (back room where records were kept) and document all the medications that she had given. -She always gave the bupropion Hcl SR 200 mg at 2:00 pm and did not notice the scheduled administration time had changed on the MAR to 8:00 pm (She did not notice the pharmacy computer had changed the time to 8:00 am and 2:00 pm). -She did try to check the MAR's in the beginning of the month to ensure accuracy, but may have not gotten to this MAR or over looked this time change. -Resident #3 received his prn acetaminophen regularly in the morning, at 2:00 pm and most often in the evening. -She did try to document the administration of the prn acetaminophen, but did not always. -She did not inform the physician that Resident #3 was taking the prn acetaminophen 2-3 times a day on a regular basis. Interview with the Consulting Pharmacist on 9/15/15 at 3:15 pm revealed: - Bupropion Hcl SR 200 mg at one time was administered 8:00 am and 8:00 pm but the evening dose was keeping Resident #3 up during the night. -She discussed the administration times with Resident #3's physician and he approved the times be changed to 8:00 am and 2:00 pm but no order was received from the physician.	C 341		

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C 341	Continued From page 24 -The system that prints the MARs automatically changed the time of 8:00 am and 8:00 pm for medications that are ordered twice daily. -The system changed the time of the bupropion Hcl SR 200 mg from 8:00 am and 2:00 pm to 8:00 am and 8:00 pm. -She would typically go in and manually change the administration times to 8:00 am and 2:00 pm and did not change the time manually for the month of September 2015. -Ultimately the facility staff were responsible to review the MARs prior to the beginning of each month to assure all medications entered were correct and all administration times were correct. Interview with Resident #3 on 9/15/15 at 3:20 pm revealed: -He did take two acetaminophen and another white tablet every day at 2:00 pm. -He did take acetaminophen in the morning, afternoon and evening and sometimes it helped and sometimes it did not.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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;	C 342	Adm. will provide Medication Regulation training to all medication staff. Adm will Review MAR to ASSURE all Documentation is Accurate	10/30/15

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C 342	Continued From page 25 (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff accurately documented the administration of medications (mirtazapine and acetaminophen) on the Medication Administration Records (MAR) for 2 of 3 sampled residents (Resident #1 and #3). The findings are: A. Review of Resident #1's current FL-2 dated 9/09/15 revealed: -Diagnoses included chronic bilateral lower extremity deep vein thrombi (DVT), paranoid Schizophrenia, chronic obstructive pulmonary disease, constipation, insomnia, Schizo-affective disorder, and Tardive Dyskinesia. Review of the FL-2 dated 9/09/15 revealed medication orders on the FL-2 included: Mirtazapine 45 mg 1 tablet once daily (A medication to treat depression) Acetaminophen 650 mg twice daily as needed (A medication used to treat pain) Review of Resident #1's August 2015 Medication Administration Record (MAR) revealed: -An entry for Mirtazapine 45 mg to be taken once daily at bedtime at 8:00 pm. -Staff did not document the of administration of	C 342		

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C 342	Continued From page 26 Mirtazapine from 8/1/15 to 8/31/15. Observation on 9/15/15 at 12:45 pm of Resident #1's medications on hand revealed: -Mirtazapine 45 mg was available for administration. -According to the printed prescription label on the bottle Mirtazapine 45 mg was filled on 08/27/15 for a quantity of 30 tablets. Interview on 9/15/15 at 4:30 pm with Resident #1 revealed: -She was aware of the medications ordered for her to take. -She did receive her medication on time in the morning and in the evening -Staff did give her the Mirtazapine every evening. Interview on 9/15/15 at 3:15 pm with the Pharmacist at the contract pharmacy used to fill Resident #1's medications revealed: -Thirty tablets of Mirtazapine 45 mg was filled 5/04/15 and delivered to the family care home on 5/05/15. -Thirty tablets of Mirtazapine 45 mg was filled 6/02/15 and delivered to the family care home on 6/03/15. -Thirty tablets of Mirtazapine 45 mg was filled 6/30/15 and delivered to the family care home on 7/01/15. -Thirty tablets of Mirtazapine 45 mg was filled 7/30/15 and delivered to the family care home on 7/31/15. -Thirty tablets of Mirtazapine 45 mg was filled 8/27/15 and delivered to the family care home on 8/28/15. Interview with a Medication Aide/Supervisor-in-Charge on 9/15/15 at 4:23 pm revealed:	C 342		

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	FCL060019	A. BUILDING: _____ B. WING _____	R 09/16/2015

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C 342	Continued From page 27 -She administered the Mirtazapine 45 mg every night and Resident #1 never ran out of Mirtazapine. -MA stated, "It was an accident on my part for not signing it out." Refer to review of the facility's Medication Administration and Orders Policy. Refer to interview on 09/15/15 at 12:25 pm with the Administrator. B. Review of Resident #3's current FL2 dated 03/11/15 revealed: -Diagnoses included major depression with history of psychotic features, generalized anxiety disorder, alcoholism, chronic hepatitis C, chronic kidney disease, hypertension, and mild aortic stenosis. -An order for Tylenol (acetaminophen) 650 mg one every 8 hours as needed for arthritis. Review of the Resident Register revealed Resident #3 was admitted to the facility on 08/23/10. Review of the facility's Medication Administration and Orders Policy revealed: -"Be sure the Medication Administration Record (MAR) matches current physician orders." -"When administering medications, initial the MAR immediately after you give the medication." Review of Resident #3's July 2015 MAR revealed: -A typed entry for Acetaminophen 325mg take 2 tablets three times daily for arthritis pain with an original order date of 06/10/15. -Documentation the resident was administered Acetaminophen three times a day at 8:00 am, 2:00 pm, and 8:00 pm from 07/01/15 to 07/31/15.	C 342		

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C 342	Continued From page 28 Review of Resident #3's August 2015 MAR revealed: -A typed entry for Acetaminophen 325mg take 2 tablets three times daily with an original order date of 06/13/15. -Documentation the resident was administered acetaminophen three times a day at 8:00 am, 2:00 pm, and 8:00 pm from 08/01/15 to 08/31/15. Review of Resident #3's September 2015 MAR revealed: -An entry for acetaminophen 325 mg two tablets three times daily as needed for pain. -Documentation that acetaminophen was administered once each day by Staff A from 09/01/15 to 09/11/15. -No other documentation for administration of the acetaminophen. Observation of medications on hand revealed: -A pharmacy labeled bottle with acetaminophen 325mg tablets. -The dispense date was 08/03/15 and 180 tablets were dispensed. -Instructions were to take 2 tablets three times a day as needed. Interview on 09/15/15 at 3:00 pm with the pharmacist revealed the current order was written on 07/30/15 for acetaminophen 325mg two tablets three times daily as needed for pain. Interview on 09/15/15 at 1:05 pm with Staff A, Supervisor-in-Charge (SIC) revealed: -Resident #3 requested acetaminophen two to three times a day for pain. -She administered the acetaminophen to Resident #3 when he requested it. -"Lately it has been three times a day."	C 342		

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C 342	Continued From page 29 -The Administrator administered the acetaminophen to Resident #3 in the mornings, when he requested it. -She had documented on the MAR on the first line that the acetaminophen was given because the Administrator had not documented giving the morning dose. -Staff A had been administering the acetaminophen to the resident when she came on duty at 2:00 pm "because that is the first thing he asks for" and also at night when he requested acetaminophen for pain. -He had been receiving the acetaminophen at 2:00 pm and at night most days she worked. -She was "not thinking that I had to document the other times I gave the acetaminophen to the resident when he asked for it". -She did not know why she had not noticed that she needed to document each time she gave the acetaminophen to Resident #3. -The resident had been requesting the night dose almost every night. -"I should have initialed it every time I gave him the medicine". Interview on 09/15/15 at 3:10 pm with Resident #3 revealed: -He had pain constantly in his legs, arms, and shoulders from arthritis. -He took acetaminophen two to three times a day for the arthritis pain. -He had to request acetaminophen because the doctor wrote the order for it to be given when he needed it instead of three times a day. Interview on 09/16/15 at 12:17 pm with the Administrator revealed: -She administered acetaminophen to Resident #3 in the mornings when he requested it. -He had been requesting acetaminophen most	C 342		

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C 381	Continued From page 31 appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure action was taken as needed in response to the medication review for 1 of 3 sampled residents (Resident #3) with pharmacy recommendations. Review of Resident #3's current FL2 dated 03/11/15 revealed diagnoses included major depression with history of psychotic features, generalized anxiety disorder, alcoholism, chronic hepatitis C, chronic kidney disease, hypertension, and mild aortic stenosis. Review of the resident's record revealed: -The resident was admitted to the facility on 08/23/10. -Liver function tests were completed on 03/11/15 at the physician's office. -A lipid panel and a basic metabolic panel (BMP) were completed 06/10/15 at the physician's office. -No documentation of results of the labs completed on 03/11/15 and 6/10/15. -A physician visit note dated 06/10/15 with an order to "continue meds and avoid alcohol". Review of the quarterly pharmacist review completed on 07/21/15 revealed: -"Labs still missing from patient's chart. This must be addressed. Contact MD (physician) office to request. Patient could sustain liver damage due to medication use in conjunction with alcohol misuse and without those labs we are unable to see a problem and correct it." -A request for updated labs needed, including a complete blood count (CBC), Chem 7, lipids, and liver function tests.	C 381	Adm w.ll Assure Any Recommendations by the pharmacist on the quarterly pharmacy Reviews are followed upon a timly basic. Adm/med tech w.ll conduct Communicatio. with the Pharmacist After the Reviews if needed	10/30/15

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C 342	Continued From page 30 mornings for arthritis pain. -It was the policy of the facility that staff were to document on the MAR when administering medication to residents. -She did not realize she had not documented when administering the acetaminophen to Resident #3. -She did not know Staff A had not documented on the MAR when administering the acetaminophen to Resident #3. Refer to review of the facility's Medication Administration and Orders Policy. Refer to interview on 09/15/15 at 12:25 pm with the Administrator. Review of the facility's Medication Administration and Orders Policy revealed: -"Be sure the Medication Administration Record (MAR) matches current physician orders." -"When administering medications, initial the MAR immediately after you give the medication." Interview on 09/15/15 at 12:25 pm with the Administrator revealed: -The SICs and she were to document on the MAR when a medication was administered. -The facility did not have a formalized review process of the MARs for accuracy except when they consulted the pharmacist for questions regarding medications and orders.	C 342		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .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	C 381		

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C 381	Continued From page 32 Interview on 09/15/15 at 12:00 pm with Staff A, Supervisor-in-Charge (SIC) revealed: -The pharmacist came to the facility every three months. -The pharmacist wrote her evaluation and recommendations and "took the original paper with her to copy since we don't have a copier or fax that works sometimes." -The pharmacist faxed the recommendations to the physician and sent a copy of the notes to the facility with a note of when the information was sent to the physician. -"We have to follow-up on whatever she recommends. We have to make sure the doctor responded." Interview on 09/15/15 at 3:00 pm with the pharmacist revealed: -She completed pharmacy reviews for all of the residents at the facility every three months. -"I cannot do a complete review for Resident #3 without having lab results." -She reviewed her recommendations for Resident #3, including the request for lab results for previous lab tests and updated labs needed included a Complete Blood Count, a Chem-7, lipids, and liver function tests with the staff person on duty on 07/21/15. -She was not certain which staff person she reviewed her recommendations with on 07/21/15. -She documented her review and recommendations and took the original form with her to fax to the physician "since the facility has problems with their fax machine". -She had difficulty receiving timely responses from Resident #3's physician's office. -She sent to the facility a copy of her review and recommendations with notation of when she faxed it to the physician, "usually the day after my	C 381		

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C 381	Continued From page 33 visit". -She had told the Administrator that it was the facility's responsibility to follow-up with any recommendations she made during her visit. Interview on 09/16/15 at 9:50 am with a nurse at the physician's office revealed: -Resident #3 had a comprehensive metabolic panel (CMP) on 03/11/15. -Resident #3 had a BMP and a lipid panel on 06/10/15. -She could not access the results of the tests on the computer. -There was no documentation that the facility had requested results of the labwork. Interview on 09/15/15 at 3:10 pm with Resident #3 revealed: -"It has been a couple of months since I had labwork done." -He was not certain what labwork had been completed. -The facility scheduled an appointment today with his physician for October 2, 2015. Interview on 09/16/15 at 12:20 pm with the Administrator revealed: -She and the SICs were responsible for following up with recommendations from the pharmacist. -The pharmacist had faxed the request for labwork and results to Resident #3's physician. -She thought she had contacted Resident #3's physician to request copies of the lab results, but was not certain. -She and the SICs did not currently document in the resident's record when they contacted the physician's office with a request for records. -She did not think the lab tests requested by the pharmacist on 07/21/15 had been ordered by the physician.	C 381		

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C 381	Continued From page 34 -The facility did not have a formalized procedure for reviewing orders to ensure they were processed correctly or documenting when they followed up with the pharmacist's recommendations. -The facility would make an appointment for Resident #3 to be seen by his physician.	C 381		
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 staff competency validation for Licensed Health Professional Support tasks and health care. The findings are: A. Based on observation, interview and record review, the facility failed to ensure physician certification which would approve non-licensed facility staff to be competency validated by a Licensed Health Professional to administer a subcutaneous anti-coagulant medication (Lovenox) on a temporary basis for one resident (Resident #1). [Refer to Tag 0173, 10A NCAC 13G .0504(c) Competency Validation for Licensed	C 912	Adm will assure staff are certified thru LHPS for any Resident requiring LHPS tasks before any tasks are preformed	10/30/15

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C 912	Continued From page 35 Health Professional Support Tasks (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 2 of 3 sampled residents (Residents #1 and #3) regarding ordered laboratory tests and follow-up with the physician related to an order for compression stockings. (Refer to Tag 0246, 10A NCAC 13G .0902(b) Health Care (Type B Violation).]	C 912		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled staff (	C 934	Adm will assure Infection Control Training be conducted Annually for All staff	10/30/15

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C 934	Continued From page 36 Medication Aide/Supervisor in Charge, Staff A, and Administrator) completed the state mandatory annual infection prevention training for Medication Aides (MA). The findings are: A. Review of Medication Administration Records (MARs) revealed Staff A (Medication Aide) routinely administered medications to residents in the facility. Review of personnel files revealed: - Staff A's hire date was 4/30/11 as a Supervisor-in-Charge/Medication Aide (SIC/MA). - Staff A passed the state written Medication Aide test on 3/29/11 and completed the Medication Clinical Skills Validation on 8/03/12 and 8/30/12. - Staff A completed the annual state approved infection prevention training for adult care homes on 6/04/14. - There was no documentation in the personnel file reflecting Staff A completed the annual state approved infection prevention training after 6/04/14. Telephone interviews on 9/15/15 at 1:35 pm and 3:55 pm with the Administrator revealed: -Staff A had not completed the state approved infection prevention training for adult care home since 6/14/14. - The Administrator was aware the infection prevention training was required annually by Medication Aides in the facility. - The facility's Licensed Health Professional Support (LHPS) Nurse was responsible for providing the infection prevention training annually for facility medication aides. - The Administrator said she had spoken with the facility's LHPS Nurse about conducting the infection prevention training, but had not yet	C 934		

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C 934	Continued From page 37 scheduled a date and time for the training to be completed after 6/14/14. Interview with Staff A on 9/15/15 at 11:20 am and 4:30 pm revealed: - Staff A had been a MA at the facility since her hire date. - Staff A last took the annual state infection prevention training on 6/14/14 and had not taken the training since that date. - No one at the facility had said anything to her about taking the infection prevention course again. - Staff A administered Finger Stick Blood Sugar (FSBS) to one resident in the facility. - Staff A used gloves and a new lancet each time she obtained the resident's FSBS. Interview with the resident receiving FSBS on 9/15/15 at 4:50 pm revealed: -The resident had his FSBS checked every day by facility staff. - Facility staff used gloves when they checked his FSBS. Refer to telephone interview with the facility LHPS Nurse on 9/15/15 at 4:20 pm. B. Review of Medication Administration Records (MARs) revealed the Administrator routinely administered medications to residents in the facility. Review of personnel files revealed: - The Administrator completed the state approved infection prevention training for adult care homes on 6/04/14. - The Administrator passed the written state Medication Aide test on 7/27/00 and completed the Medication Clinical Skills Validation on	C 934		

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C 934	Continued From page 38 10/09/06 and 10/11/06. - There was no documentation in the personnel file reflecting the Administrator completed the annual state approved infection prevention training after 6/04/14. Telephone interviews with the Administrator on 9/15/15 at 1:35 pm and 3:55 pm revealed: -She had not completed the state approved infection prevention training for adult care home since 6/14/14. - The Administrator was aware the infection prevention training was required annually by Medication Aides in the facility. - The facility's Licensed Health Professional Support (LHPS) Nurse was responsible for providing the infection prevention training annually for facility Medication Aides. - The Administrator said she had spoken with the facility's LHPS Nurse about conducting the infection prevention training, but had not yet scheduled a date and time for the training to be completed after 6/14/14. Refer to telephone interview with the facility LHPS Nurse on 9/15/15 at 4:20 pm. Telephone interview on 9/15/15 at 4:20 pm with the facility's LHPS Nurse revealed: - The last time she conducted the required annual infection prevention training for the facility's Medication Aides was on 6/14/14. - The Nurse was aware the state infection prevention training was required annually. - The Nurse said that it was up to the Administrator to contact her to schedule the infection prevention training and revealed the Administrator had not contacted her to schedule the training any time after 6/14/14.	C 934		

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Richard O. Brajer
Secretary

Drexdal Pratt, Director
Division of Health Service Regulation

Certified Mail and Electronic Mail
#7011 3500 0000 0941 7336

September 30, 2015

Ms. Vernal Osborne, Owner/Administrator
Vernal Osborne, Licensee
Shady Harbour Adult Living
908 Tom Hunter Road
Charlotte, North Carolina 28213

E-mail address: vo.dotticosborne2@gmail.com

Re: Annual and Follow-up Survey completed September 16, 2015 (ASPEN Event ID: 5S5G11)
Type B Violations

Facility: **Shady Harbour Adult Living**
Licensure Number: **FCL-060-019**
County: **Mecklenburg**

Dear Ms. Osborne:

Thank you for the cooperation and courtesy extended during the survey completed September 16, 2015 by staff with the Adult Care Licensure Section and Mecklenburg County Department of Social Services. As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Adult Care Licensure Section
www.ncdhhs.gov
Tel 919-855-3765 • Fax 919-733-9379
Location: Broughton Building, 805 Biggs Drive • Raleigh, NC 27603
Mailing Address: 2708 Mail Service Center • Raleigh, NC 27699-2708
An Equal Opportunity / Affirmative Action Employer

Type B Violations

- Type B rule violations are cited for **10A NCAC 13G .0504(c) Competency Validation for Licensed Health Professional Support Tasks, 10A NCAC 13G .0902(b) Health Care** and **G.S. § 131D-21 Resident Rights.**
- Type B Violations must be corrected within 45 days from the exit date of the survey, which is **October 31, 2015.**

  As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation, the Department shall assess the facility a civil penalty in the amount of up to $400.00 for each day that the violation continues beyond the time specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form **within 15 working days** from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is **SIGNED AND DATED** or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not approved. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **October 20, 2015**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **October 20, 2015**. You must submit 5 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: Beth Bowman, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at (336) 341-8127. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

www.ncdhhs.gov
Tel 919-855-3765 • Fax 919-733-9379
Location: Broughton Building, 805 Biggs Drive • Raleigh, NC 27603
Mailing Address: 2708 Mail Service Center • Raleigh, NC 27699-2708
An Equal Opportunity / Affirmative Action Employer

Sincerely,

H. Ray Peedin, RPh

H. Ray Peedin, Registered Pharmacist
Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Ms. Nina Anderson, Supervisor/Designee, Mecklenburg County Department of Social Services
Ms. Carolyn Harrison, Team Supervisor, Home-based West 2 Region, Adult Care Licensure Section
Raleigh Facility File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
FCL060019	A. Building B. Wing	9/16/2015

Name of Facility	Street Address, City, State, Zip Code
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix C0202 Reg. # 10A NCAC 13G .0702(a) LSC	Correction Completed 09/16/2015	ID Prefix C0231 Reg. # 10A NCAC 13G .0801(b) LSC	Correction Completed 09/16/2015	ID Prefix C0249 Reg. # 10A NCAC 13G .0902(c)(3)(4) LSC	Correction Completed 09/16/2015
ID Prefix C0315 Reg. # 10A NCAC 13G .1002(a) LSC	Correction Completed 09/16/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: K Ray Hedrick, RN	Date: 9/29/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/25/2014			

Peedin, Ray

From: Osborne, VO <VO.Osborne@duke-energy.com>
Sent: Wednesday, October 14, 2015 3:08 PM
To: Peedin, Ray
Subject: Deficiencies Report
Attachments: Scanned from a Xerox multifunction device.pdf

Please acknowledge.

-----Original Message-----
From: EC21360C@duke-energy.com [mailto:EC21360C@duke-energy.com]
Sent: Wednesday, October 14, 2015 2:57 PM
To: Osborne, VO
Subject: Scanned from a Xerox multifunction device