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	HAL060132	A. BUILDING: _____ B. WING _____	11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted an Annual Survey and Complaint Investigation on 11/4-11/6/15 and 11/19/15 with an exit conference on 11/10/15 via telephone.	D 000		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure the Administrator was responsible for the total operations of the facility to maintain compliance in the rule areas including, Medication Administration, Resident Rights, Infection Prevention Requirements, Staffing of Personal Care Aides Supervisors, Personal Care and Supervision, Health Care, Nutrition and Food	D 176		

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D 176	Continued From page 1 Service, Medication Orders, Medication labels, Declaration of Residents Rights, Adult Care Home Infection Prevention Requirements, ACH Infection Prevention Requirements, and Medication Aide Training and Competency. The findings are: Interview on 11/6/15 at 8:30 am with the Sales Manager revealed: -She had been employed at the facility for over a year. -The facility's former ED had left the facility in September 2015, and they had not hired a new ED as of this time. -They had several acting ED from other communities "helping out". -Her chain of command for day to day operations were the ED or for nursing issues the Health and Wellness Director (HWD). -The former HWD had left the facility 2 weeks ago. -The facility had several nurses from other communities "helping out". Interview on 11/6/15 at 8:40 am with the Business Office Coordinator revealed: -She had been employed with the facility for 10 months. -The ED was responsible for the day to day operations of the facility. -The ED had left in September and they did not have a current ED. -ED from other communities came to help out until they facility hired the new ED. -If a problem or issue occurred she would go to the Sales Manager for guidance. -The HWD had left in September 2015, "He only worked two weeks". -The facility had not hired a new HWD yet.	D 176		

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D 176	Continued From page 2 Interview on 11/6/15 at 9:30 am with the Regional District Director of Operations revealed: -She or the ED were responsible for the day to day operations of the facility. -She or the ED were on call 24/7. -The former ED had left the facility September 10, 2105. -The facility had not hired a new ED as of 11/6/15. -ED from other communities were assisting in the facility at this time until a new ED was hired and trained. -On 11/9/15 an Operations Specialist will start in the facility to over see the day to day operations. A. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 8 sampled residents (#12) which included errors with administration of Novolog insulin, Lantus insulin and Metoprolol 25 mg. [Refer to Tag 0358, 10A NCAC 13F .1004(a)Medication Administration (Type A2 VIOLATION).] B. Based on observations, interviews, and record reviews the facility failed to assure the rights of all residents are maintained and may be exercised without hindrance for 2 of 5 residents (Residents #3 and #11) regarding neglect related to not administering medications as ordered, pain medications, and not responding to call bells in a timely manner for 53 of 53 residents living on the on the 2nd and 3rd floor. [Refer to Tag 0338, 10A NCAC 10 F .0909 Resident Rights (Type A2 VIOLATION).] C. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Center for	D 176		

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D 176	Continued From page 3 Disease Control Prevention guidelines on infection control regarding the use of "house" glucometers for multiple residents and sharing glucometers for 3 of 3 sampled residents (#3, #8, and #14) and storage and use of an insulin pen without any identification labeling of who the insulin pen belonged to.[(Residents #3, #8, and #14).{Refer to Tag 0931, G.S. 131D-4.4(b)(1)Infection Prevention Requirements (Type B VIOLATION).] D. Based on observations, and interviews, the facility failed to assure there was a designated supervisor on duty on third shift in the facility or within 500 feet and immediately available.[Refer to Tag 0214, 10A NCAC 10 F .0605(c)Staffing Personal Care Aide Supervisors (Type B Violation).] E. Based on observations, interviews, and record reviews, the facility failed to assure supervision for 2 of 2 sampled residents (#5 in the Memory Care Unit and #9 in the Assisted Living) with multiple falls. [Refer to Tag 027, 10A NCAC 10 F .0901(b)Personal Care and Supervision (Type B VIOLATION).] F. Based on observations, interviews, and record reviews the facility failed to assure referral and follow-up for 2 of 5 residents by not sending a resident out for medical evaluation (Resident #2) and not obtaining urine culture and sensitivity for one resident (Resident #13).[Refer to Tag 273, 10A NCAC 10 F .0902(b) Health Care(Type B VIOLATION).] G. Based on interview and record review, the facility failed to assure 3 of 6 Medication Aides (Staff G, Staff H, and Staff I) received annual in-service training for infection control, safe	D 176		

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D 176	Continued From page 4 practices for injections and glucose monitoring. [Refer to Tag 934, G.S. 131D 4.5 (B) (a) Adult Care Homes Infection Control Requirements(Type B VIOLATION).] H. Based on interview and record review, the facility failed to assure 3 of 6 sampled medication staff met requirements to administer medications, prior to administering medication, one staff (Staff F) who was not competency validated to administer medications and 2 staff who did not (Staff A and Staff E). [Refer to Tag 935, G.S. 131D 4.5 (b)Medication Administration (TYPE B VIOLATION).] I. Based on observations, interviews, and record reviews, the facility failed to assure staff assisted with showers for 3 of 5 sampled residents (Residents #9, #13 and #15) in accordance to the residents' personal care needs. [Refer to Tag 0269, 10A NCAC 10 F .0901(a) Personal Care (Type B VIOLATION).] J. Based on observations, interviews and record reviews the facility failed to assure weights and vital signs were obtained as ordered by a Licensed Health Professional for 3 of 5 sampled residents (Resident # 11, # 1, and # 2).[Refer to Tag 0276, 10A NCAC 13F. 0902 C(3)(4) Health Care.] K. Based on observation, record review, and interview, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for 1 of 5 sampled residents prescribed therapeutic diets of No added Salt Diet (Residents #3). [Refer to Tag 0309, 10A NCAC 10 F .0904(e)(3) Nutrition and Food Service.]	D 176		

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D 176	Continued From page 5 L. Based on observation, record review, and interviews, the facility failed to assure 1 of 5 sampled residents (Resident #2) with a physician's order for therapeutic diet of Texture Modified was served as ordered. [Refer to Tag 0310, 10A NCAC 10 F .0904(e)(4) Nutrition and Food Service.] M. Based on record review, observation, and interviews the facility failed to clarify orders for 1 of 4 residents (Resident #8) with orders for finger stick blood sugars (FSBS) and Novolog sliding scale. [Refer to Tag 0344, 10A NCAC 10 F .1002 (a) Medication Orders.] N. Based on observations, interviews, and record review, the facility failed to assure an insulin pen was properly labeled for 1 of 5 sampled residents (Resident #3). [Refer to Tag 0352, 10A NCAC 13F .1003(a) Medication Labels.] O. Based record reviews and interviews the facility failed to assure that action was taken in response to a pharmacist recommendation including informing the resident's physician in 1 of 5 residents. [Refer to tag 0406, 10A NCAC 13F .1009(b) Pharmaceutical Care.] _____ A plan of protection was provided by the facility on 11/06/15: -Effective immediately, a community manager will be present on all shifts to ensure resident, staff and community needs are met. -The District Director of Operations will assume immediate responsibility of the community operations to ensure that all duties are carried out according to rules and regulations. -Prior to their scheduled shift, staff will be in-serviced as to who is responsible for	D 176		

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D 176	Continued From page 6 community operations, reportable events and should be contacted. DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 11, 2015.	D 176		
D 215	10A NCAC 13F .0605 (d) Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (d) On third shift in facilities with a capacity or census of 61 to 90 residents, the supervisor shall be on duty in the facility for at least four hours and within 500 feet and immediately available, as defined in Rule .0601 of this Subchapter, for the remaining four hours. In facilities sprinklered for fire suppression with a capacity or census of 61 to 90 residents, the supervisor's time on duty in the facility on third shift may be counted as required aide duty. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, and interviews, the facility failed to assure there was a designated supervisor on duty on third shift in the facility or within 500 feet and immediately available. The findings are: Inteview on 11/4/15 at 10:00 am with the interim Executive Director revealed: -The current total census was 71. -53 residents lived in the Assisted Living Unit.	D 215		

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D 215	Continued From page 7 Observation of the building lay-out on 11/4/15 at 10:00 am revealed the facility Assisted Living Unit (ALU) consisted of two floors (2nd and 3rd) and the Memory Care Unit (MCU) was on the bottom level (1st floor). Interview on 11/6/15 at 4:50 am with a ALU Medication Aide (MA) revealed: -She worked third shift all the time. -On third shift only 2 staff a Personal Care Aide (PCA), and a MA worked the ALU. -The MCU had two staff a MA and a PCA who worked on third shift. -The staff from MCU had never worked on the ALU. -She was responsible for administration of medication on the ALU the second and the third floor. -She was unaware who the supervisor on duty was nor had she had a supervisor on duty on third shift. -She had never called anyone in regards to supervision issues or concerns with residents or staff. Inteview on 11/6/15 at 5:00 am with a ALU PCA revealed: -She worked the ALU only. -She never worked on the MCU. -She was unaware who the supervisor on duty was for third shift. -She assumed it was the MAs. -There had never been a supervisor on duty on third shift. Observation and review on 11/6/15 of staff compared to resident census revealed: -Four staff members were present in the facility on 11/6/15 for third shift for a census total of 71 residents.	D 215		

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-Two staff members on the ALU a MA and a PCA for 53 residents.
-Two staff members on the MCU a MA and a PCA for 18 residents.
-The staff worked 8 hour shifts.
-Total staffing hours for third shift were 32 hours for 71 residents.

Observation on 11/6/15 at 5:15 am revealed:
-An on-site Emergency Medical Service (EMS) had a call from the MCU MA to transfer a resident to the emergency room.
-The MA in the MCU did call the Nurse on-call and left a message but was unable to immediately contact the Nurse on-call.

Interview on 11/6/15 at 5:04 am with a MA in the MCU revealed:
-She had worked as a MA in this facility for over 5 years.
-They only had one MA and one PCA in the MCU on 11/6/15.
-She did not have a Supervisor or Lead Care Staff.
-If there was an extreme emergency they sent the resident to the emergency room.
-They would call the Nurse when they had an emergency, but they would wait until the end of the shift.
-They could call the Regional Nurse if there was a necessity because she was in charge.
-She had never known a supervisor or someone considered "in charge" to come out to the facility in the case of an emergency.

Interview on 11/6/15 at 8:40 am with the Business Office Coordinator revealed:
-The MAs were supervisors on second and third shift.
-A management staff stayed in the facility until

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8:00 pm daily.
-Staff should know who the supervisors were on second and third.

Interview on 11/6/15 at 9:30 am with the Regional Nurse revealed:
-She was on call 24/7.
-On first shift a manger was in the facility at all times.
-One manager was in the facility till 8:00 pm.
-MAs were in charge on second shift and third shift.
-She was unaware if the MAs on second or third knew they were the supervisor on duty.

Observation on 11/6/15 between 4:15 am and 4:22 am upon multiple attempts to enter the facility front door secured entrance revealed:
-Between 4:15 am and 4:22 am the surveyors used the telephone call system to announce their arrival at the facility with no response from the staff in the building.
-Looking through the glass window at the front entrance, surveyor saw a staff person slumped over in a chair in the common room area.
-The staff member's head was leaned back over the back of the chair and the staff member's legs were extended outward on the floor.
-The staff member had a hoodie coat on backward with the hoodie pulled over the neck and around head.
-After multiple knocks loudly on the glass pane the staff member stood up slowly and appeared groggy.
-She proceed down the hall toward the front entrance in an unsteady manor.
-She held her head in a downward position until halfway down the hall and then attempted to stand-up straight.
-She adjusted the hoodie jacket she was wearing

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backwards and turned it around so the zipper opening was in the front.
-As she proceeded to the front door, a second staff member, later identified as the Medication Aide started to walk toward the front door.
-The Medication Aide unlocked the front door for surveyors to enter the building, the time was 4:22 am.

Interview on 11/06/15 at 4:20 am with a ALU third shift MA revealed:
-She worked at the facility for 2 years.
-She did checks on residents every 2 hours.
-She answered call bells as soon as residents pushed the button, unless in the room with another resident.
-She worked the second floor and the PCA worked the third floor.
-She was the Medication Aide for the second and third floors.
-She was not the supervisor.
-She was unaware if there was a supervisor on duty.

Interview on 11/06/15 at 4:28 am with a ALU third shift PCA revealed:
-She worked at the facility for 2 months, and had not observed any management come in on the third shift to ensure staff were completing their duties.
-She did rounds at 4:30 am checking on residents on the third floor.
-She was not sleeping, because staff were not allowed to sleep when on duty.
-She did not respond to open the door when the surveyors rang the bell because she did not have the key to the door.
-Only the MA had the key to unlock the front door.
-When there was an Executive Director worked at the facility there were three people working

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D 215	Continued From page 11 between the 2nd and 3rd floors. -She did not know who management was at the facility. _____ The facility provided a Plan of Protection on 11/06/15: -Effective immediately, a Community Manager will be present on all shifts to ensure resident, staff and community needs are met. -The District Director of Operations will assume immediate responsibility of the community operations to ensure all duties are carried out according to rules and regulations. -Prior to their scheduled shift, staff will be in-serviced to the responsibilities and expectations of a supervisor. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 26, 2015.	D 215		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 269		

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reviews, the facility failed to assure staff assisted with showers for 3 of 5 sampled residents (Residents #9, #13 and #15) in accordance to the residents' personal care needs.

The findings are:

A. Review of Resident #15's current FL2 dated 6/18/15 revealed:
-Diagnoses included Parkinson disease (a progressive disease of the nervous system which causes stiffness and slowing of movement) and hypertension.
-Personal care needs were documented as bathing and dressing.
-Ambulatory status was documented as with walker.

Review on 11/5/15 at 10:00 am of Resident #15's facility Care Profile dated 2/28/15 revealed:
-Documentation Resident #15's preferred shower times on Wednesday and Saturday between the hours of 7:00 pm and 8:00 pm.
-Documentation Resident #15 could perform washing lower body with verbal prompts.

Review of Resident #15's Care Plan dated 10/5/15 revealed:
-Documentation Resident #15 required supervision with bathing.
-Documention Resident #15 needed "stand by assist" with showers.

Inteview on 11/5/15 at 3:00 pm and 11/6/15 at 7:30 am with Resident #15 revealed:
-She had lived in the facility one year.
-She used a walker for ambulation.
-She had Parkinson's disease, and was unsteadiness with her standing, and walking.
-She relied on facility staff to assist her with

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D 269	Continued From page 13 showers due to her "fear of falling." -She had not fallen, but had a fear of falling due to Parkinson's disease. -She was scheduled for showers in the evening (2nd shift), on Wednesday and Saturday. -She had missed several showers because the second shift Medication Aide (MA) told her she would not be able to assist her with a shower due to not enough staff on the floor. -She took "sponge baths" by herself at the sink in her room, but was still uncomfortable, due to her fear of falling. -The recent dates she was able recall asking for a shower were 11/4/15 and 11/5/15 around 8:30 pm, and she was told by staff there was no staff available to assist with her shower. -On 11/5/15 she took a sponge bath around 8:30 pm by herself. -She went to bed at 9:30 pm on 11/5/15, staff came to her room asked if she was ready for a shower, she declined because she was already asleep in bed. Interview on 11/6/15 at 5:00 am with a Personal Care Aide (PCA) revealed: -She worked third shift as a PCA on the Assisted Living Unit. -She never had given showers on third shift. -The second shift and first shift PCAs assisted residents with showers. -It was not reported to her Resident #15 needed a shower. Review of the facility staff scheduled for 11/4/15 and 11/5/15 revealed: -Two staff members worked on the Assisted Living Unit (ALU) second shift on 11/04/15, a MA and a PCA. -Two staff members worked on the ALU second shift on 11/05/15, a MA and a PCA.	D 269		

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D 269	Continued From page 14 Interview on 11/6/15 at 7:35 am with the Maintenance Director revealed: -He was the manager on duty. -He was not aware Resident #15 had ask for a shower the past 2 nights and was denied. -It was not acceptable for residents to be told there were not enough staff to perform personal care to residents. -He would immediately get a PCA to assist Resident #15 with her shower. Interview on 11/6/15 at 9:30 am with Resident #15 revealed staff assisted her with personal care and shower on 11/6/15. Review of the Skin Integrity Monitoring Form for Resident #15 on 11/06/15 at 11:00 am revealed: -Documentation of shower completed on 10/14/15 and no other documentation on form until 11/6/15 "shower completed on 1st shift, no skin breakdown." Interview on 11/6/15 at 10:45 am with the Regional Nurse revealed: -She was not aware Resident #15 had requested a shower on 11/4/15 and 11/5/15. -She was not aware staff had declined to assist Resident #15 with her personal care and shower on both days. -She was not aware staff had told Resident #15 there was not enough staff to assist her with her shower. -It was not acceptable for staff to tell any resident there was not enough staff in the facility. B. Review of Resident #13's current FL2 dated 10/10/15 revealed: -Diagnoses included Alzheimer's Disease -Personal care needs were documented as	D 269		

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bathing and dressing.
-Resident #13 was ambulatory and incontinent of bladder and bowel.
-The current recommended level of care was domiciliary.

Review of Resident #13's Care Plan dated 10/07/2014 revealed the resident required supervision with showers and the showers were to be given daily.

Review of Staff Assignment schedule dated 11/02/15 revealed:
-Resident #13 was scheduled to have showers every Sunday and Thursday on first shift.
-Resident #13's laundry was scheduled to be washed and linens were to be changed on Sundays and Thursdays.
-Resident #13 was to be assisted to the bathroom every two hours and as needed.
-Resident #13 required assistance with dressing and grooming.

Observation of Resident #13's room on 11/05/15 at 3:32 pm revealed:
-There was clothing draped on the back of a recliner.
-There was a strong odor of dirty clothes in the room.
-Resident #13's hair was greasy and smelled dirty.
-The bathroom had a strong odor and the toilet was soiled and not flushed with fecal material present in the bowl.
-Dirty clothes were stacked on the back of the toilet.
-There was a 420 ml bottle of dandruff shampoo that was filled by the pharmacy on 9/28/15. The bottle was almost completely full of shampoo.

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D 269	Continued From page 16 Interview with Resident #13's Responsible Party on 11/05/15 at 3:32 pm revealed: -Resident #13 rarely if ever got a shower. -The Responsible Party (RP) has had to come in and shower the resident without assist from staff. -The staff let her go without washing her hair for so long, at times Resident 13's hair was so greasy it looked wet. -The RP had to request a physician's order so staff would help the resident wash the resident's hair because staff would not wash the resident's hair. -The physician ordered a special dandruff shampoo that the staff were to use every day and they did not. -The staff did not wash Resident #13's clothes and the room smelled of body odor all the time. -They let Resident #13's clothes pile up on the recliner chair and floor. -The RP was going to take Resident #13's bag of dirty clothes home and wash them and staff assured the RP that they would clean the clothes. -The RP returned a week later and the bag of dirty clothes was never washed and it was thrown in the bottom of the closet. -The RP had several pictures on his phone of her un-shampooed, unkempt, greasy hair. -The RP had pictures of clothes on the floor, a trash bag full of dirty clothes thrown in the shower. -The RP had pictures of feces in the commode and no toilet paper was used by Resident #13. -The RP had a picture of a urine cup that had been in the bathroom for at least a month. -The pictures are dated from 12/28/14 though 10/28/15. -He had approached management about these issues on several occasions and nothing had ever improved. -The most recent concern the RP submitted was	D 269		

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on 9/27/15 had not heard any follow up from the facility.
-The RP told them he was not going to pay for services that were not rendered and one of the Regional Directors gave him a $1500 refund because she understood his frustration and his not wanting to pay for services that were not rendered.
-The RP was moving Resident #13 to a different facility this month because Resident #13 did not get any of the care she needed and deserved.
-He had never been informed by the facility that Resident #13 refused a shower.

Interview with Personal Care Aide (PCA) on 11/05/15 at 3:51 pm revealed:
-Resident #13 routinely refused her showers.
-The PCA was trying to get Resident #13 to get in the shower and Resident #13 refused.
-The PCA attempted at this time of day because it was harder to get her to take a shower after dinner.
-Resident #13 liked to visit other residents in their rooms after dinner and commonly refused showers at that time of day.
-The PCA did not know why Resident #13 was on the shower list for first shift because they had always tried to give her showers on second shift.
-She was not aware of the special shampoo that Resident #13 was supposed to use.
-When a resident refused a shower they document the refusal and call the family members to inform them of the refusal.

Observation of the Personal Care Log for Resident #13 on 11/06/15 at 9:35 am revealed:
-There were no documented refusals of showers in the Personal Care Records provided.

Based on record review, observation and

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D 269	Continued From page 18 interview, it was determined Resident #13 was not interviewable. C. Review of Resident #9's current FL2 not dated revealed: -Diagnoses included dementia, depression, glaucoma, Atrial fibrillation, hypothyroidism, and acute renal failure. -The resident was disoriented intermittently, was ambulatory with a walker, and needed personal care assistance with bathing. Review of Resident #9's Personal Care physician authorization and Care Plan signed by the physician on 04/29/15 revealed: -Resident #9 required supervision with toileting, and grooming/personal hygiene. -The resident required limited assistance with bathing and dressing. Review of Resident #9's service notes revealed: -05/08/15 at 4:45 pm the resident complained about "vertigo" with inability to walk unassisted. -06/26/15 at 4:45 pm Resident #9 lost her balance in her room and fell to the floor. -08/23/15 at 9:00 am Resident #9 lost balance in the bathroom and fell. -08/24/15 (no time) Resident #9 fell this morning. -09/18/15 (no time) Resident #9 found on the floor. -10/26/15 (no time) Resident #9 fell. Review of the facility's printed call bell log report revealed: -On 08/23/15 at 6:23 am Resident #9 pushed her call bell button, it took 21 minutes for staff to respond. -On 08/23/15 at 9:21 am Resident #9 pushed her call bell button, it took 1 hour and 23 minutes for staff to respond (The resident fell at 9:00 am).	D 269		

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D 269	Continued From page 19 -On 08/23/15 at 3:00 pm Resident #9 pushed her call bell button, it took 46 minutes for staff to respond. -On 08/23/15 at 9:23 am, Resident #9 pushed her call bell button, it took 17 minutes for staff to respond. -On 08/24/15 at 8:38 am Resident #9 pushed her call bell button, it took 1 hour and 46 minutes for staff to respond (the resident fell). -On 08/24/15 at 5:29 pm Resident #9 pushed her call bell button, it took 55 minutes for staff to respond. On 08/25/15 at 8:03 am Resident #9 pushed her call bell button, it took 1 hour and 54 minutes for staff to respond. -On 09/18/15 at 11:53 am Resident #9 pushed her call bell button, it took 2 hours and 55 minutes for staff to respond (the resident had a fall on this date). -On 09/18/15 at 5:22 pm Resident #9 pushed her call bell button, it took 4 hours and 57 minutes for staff to respond. Interview on 11/05/15 at 8:34 pm with Resident #9 revealed: -She was often dizzy and afraid of falling. -She fell the day before yesterday. -She had a pendent and pushed the button, but staff did not come. -She really should be smart and call for staff to help in the middle of the night, but "they hate that." -Currently, her family was seeking to move her because facility staff did not give her the supervision she needed. -When she pushed her call bell staff was supposed to come and assist her, but most time they do not come. -When staff responded they were upset. -Sometimes they took so long she forgot why she	D 269		

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called them.
-Usually, she tried to do things for herself because staff did not respond.
-There were times she wanted staff to help her to the bathroom, but they took so long to come, she usually ended going without their assistance.
-Once she fell going to the bathroom, and staff took so long to come and help after she pushed her button, she had to yell for help while on the floor (she usually left her room open in case she had to yell for help).

Interview on 11/06/15 at 7:40 pm with Resident #9's family member revealed:
-Resident #9 had several falls, at least 2-3 in the last month.
-Resident #9 needed a higher level of care more than the facility was able to provide.
-Resident #9's falls were discussed with the Regional Nurse, and the nurse told her that for staff to provide more care to Resident #9 it would cost more money.
-Some times Resident #9 fell in the middle of the night.
-The resident told her that staff did not respond when the resident pushed her call bell.
-She was unsure if staff did not respond because they were sleeping or with another resident.
-This was not discussed with facility staff because currently there was no Executive Director in charge at the facility.
-When meeting the Regional Nurse she did not discuss because they were talking about more money to provide additional care to the resident.

_____
The facility provided a plan of protection on 11/06/15:

-Effective immediately, a community manager will be present on all shifts to ensure resident rights

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D 269	Continued From page 21 are protected. -The District Director of Operations will assume immediate responsibility of the community operations to assure all duties are carried out according to rules and regulations. -Prior to their scheduled shift, staff will be in-serviced to the responsibilities and expectations related to Resident Rights. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 26, 2015.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure supervision for 2 of 2 sampled residents (#5 in the Memory Care Unit and #9 in the Assisted Living) with multiple falls. The findings are: A. Review of Resident #5's current FL2 dated 05/21/15 revealed: -Diagnoses included altered mental status, memory loss, atrial fibrillation, congestive heart	D 270		

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failure.
-Mental status was constantly disoriented; extensive assistance was needed to ambulate, transfer, and dressing; limited assistance was needed for toileting, eating, and bathing; the resident was continent of both bladder and bowel.
-Additional need was "Fall Risk."

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 5/22/15.

Review of Resident #5's Personal Service Plan signed by the physician on 09/15/15 revealed:
-The resident was not always oriented to place, person, and time. Staff was to gently redirect the resident by engaging in appropriate activities.
-The resident had a history of muscle weakness, lack of coordination.
-Extensive assistance was needed with grooming/personal hygiene, dressing and bathing.
-Staff was to assist with going to the dining room and activities.

Review of the Licensed Health Professional Support (LHPS) evaluation dated 09/09/15 revealed:
-The nurse documented the task of transferring semi-ambulatory or non-ambulatory residents.
-The nurse documented Resident #5 required one to two-person assistance with transferring.
-The nurse documented no changes are recommended this date.

Review of Resident #5's record revealed:
-A hospital encounter report 06/01/15, Resident #5 was treated for forehead contusion a result of a fall.
-06/01/15 at 1:00 pm progress note: Resident #5

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D 270	Continued From page 23 fell out of wheel chair (does not say where fall occurred). -08/12/15 at 12:20 pm progress note: Resident #5 fell in the dining room, injuring her head, sent to hospital. -08/15/15 Staff documented "resident need to be monitored for fall since resident persist to move around and transfer." -09/09/15 at 7:30 pm progress note: Resident #5 fell out of her wheelchair and hit her head (does not say where fall occurred). The resident sent to hospital. -09/18/15 at 4:30 pm progress note: Resident #5 was observed by falling backwards on the ground (does not say where fall occurred). The resident hit her head on the floor. -10/16/15 at 10:00 am progress note: Resident #5 was observed on the floor in the common sitting area, TV room. The resident complained of pain. -10/31/15 5:00 pm progress note: The Medication Aide was on her break, the Personal Care Aide came around the corner and observed Resident #5 fall trying to get up from a sitting position. The resident was in the common sitting area, TV room. Based on observation, and record review, it was determined that Resident #5 was not interviewable. Interview on 11/04/15 at 9:45 am with a first shift Personal Care Aide (PCA) revealed: -Resident #5 had frequent falls. -The resident averaged two falls a month. -There was no system in place for monitoring or supervision of Resident #5. -Staff had decided on their own to keep the resident in the common sitting area all day to ensure staff "eyed" the resident in hopes of preventing falls.	D 270		

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D 270	Continued From page 24 Interview on 11/06/15 at 6:10 am with a first shift medication aide (MA) revealed: -Resident #5 tended to get up by herself, and her legs gave out. -The resident usually got up if she saw an open chair and wanted to move. -Residents were supervised/monitored every 4 to 6 hours. -Resident #5 was kept in the common sitting area, TV room so staff could monitor the resident when walking by. -They made sure the resident was sitting by another resident to talk with in hopes of distracting the resident. -They monitored Resident #5 more often by taking her to bed and to the bathroom. -Two months back they used to put Resident #5 in her room after the lunch meal. -They noticed the resident fell getting out of the bed, so they put down mats on the floor. -The mats caused the resident to fall more, so they decided to keep the resident in the common sitting room to be monitored by staff. -Resident #5 still falls, but not as much as before the mats, and there were less injuries. Interview on 11/06/15 at 6:20 am with a second first shift Personal Care Aide (PCA) revealed: -When she got to work Resident #5 was usually in bed. -The facility staff were required to check on all residents every 4-6 hours. -She checked on Resident #5 every 2 to 2½ hours. -Resident #5 falls because she tried to walk and her legs gave out causing the resident to fall. -Resident #5 was forgetful and sometimes fell, because she thought she could walk, and wanted to go somewhere.	D 270		

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D 270	Continued From page 25 -They started putting the resident in the common sitting room so staff could observe the resident when walking back and forth. -Resident #5 still fell, but it was when staff were not around. -If staff told Resident #5 to sit down the resident would sit down, although she would try again later to get up. Interview on 11/06/15 at 1:41 pm with a second MA on third shift revealed: -Resident #5 had not fallen on her shift. -The resident went out to the hospital for falls on another shift and returned on her shift. -She heard from other staff that Resident #5 had falls. -She observed sometimes the resident would try to get up, sometimes she came into the resident's room and the resident would be in the bathroom. B. Review of Resident #9's current FL2 not dated revealed: -Diagnoses included dementia, depression, glaucoma, Atrial fibrillation, hypothyroidism, and acute renal failure. -The resident was disoriented intermittently, was ambulatory with a walker, and needed personal care assistance with bathing. Review of Resident #9's Personal Care physician authorization and Care Plan signed by the physician on 04/29/15 revealed: -Resident #9 required supervision with toileting, and grooming/personal hygiene. -The resident required limited assistance with bathing and dressing. Review of Resident #9's service notes revealed: -05/08/15 at 4:45 pm the resident complained about "vertigo" with inability to walk unassisted.	D 270		

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D 270	Continued From page 26 -06/26/15 at 4:45 pm Resident #9 lost her balance in her room and fell to the floor. -08/23/15 at 9:00 am Resident #9 lost balance in the bathroom and fell. -08/24/15 (no time) Resident #9 fell this morning. -09/18/15 (no time) Resident #9 found on the floor. -10/26/15 (no time) Resident #9 fell. Review of the facility's printed call bell log report revealed: -On 08/23/15 at 6:23 am Resident #9 pushed her call bell button, it took 21 minutes for staff to respond. -On 08/23/15 at 9:21 am Resident #9 pushed her call bell button, it took 1 hour and 23 minutes for staff to respond (The resident fell at 9:00 am). -On 08/23/15 at 3:00 pm Resident #9 pushed her call bell button, it took 46 minutes for staff to respond. -On 08/23/15 at 9:23 am, Resident #9 pushed her call bell button, it took 17 minutes for staff to respond. -On 08/24/15 at 8:38 am Resident #9 pushed her call bell button, it took 1 hour and 46 minutes for staff to respond (the resident fell). -On 08/24/15 at 5:29 pm Resident #9 pushed her call bell button, it took 55 minutes for staff to respond. On 08/25/15 at 8:03 am Resident #9 pushed her call bell button, it took 1 hour and 54 minutes for staff to respond. -On 09/18/15 at 11:53 am Resident #9 pushed her call bell button, it took 2 hours and 55 minutes for staff to respond (the resident had a fall on this date). -On 09/18/15 at 5:22 pm Resident #9 pushed her call bell button, it took 4 hours and 57 minutes for staff to respond.	D 270		

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D 270	Continued From page 27 Based on the call bell system log the facility failed to provide supervision, even when Resident #9 asked for assistance to prevent falls. Interview on 11/05/15 at 8:34 pm with Resident #9 revealed: -She was often dizzy and afraid of falling. -She fell the day before yesterday. -She had a pendent and pushed the button, but staff did not come. -She really should be smart and call for staff to help in the middle of the night, but "they hate that." -Currently, her family was seeking to move her because facility staff did not give her the supervision she needed. -When she pushed her call bell staff was supposed to come and assist her, but most time they do not come. -When staff responded they were upset. -Sometimes they took so long she forgot why she called them. -Usually, she tried to do things for herself because staff did not respond. -There were times she wanted staff to help her to the bathroom, but they took so long to come, she usually ended going without their assistance. -Once she fell going to the bathroom, and staff took so long to come and help after she pushed her button, she had to yell for help while on the floor (she usually left her room open in case she had to yell for help). Interview on 11/06/15 at 7:40 pm with Resident #9's family member revealed: -Resident #9 had several falls, at least 2-3 in the last month. -Resident #9 needed a higher level of care more than the facility was able to provide. -Resident #9's falls were discussed with the	D 270		

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D 270	Continued From page 28 Regional Nurse, and the nurse told her that for staff to provide more care to Resident #9 it would cost more money. -Some times Resident #9 fell in the middle of the night. -The resident told her that staff did not respond when the resident pushed her call bell. -She was unsure if staff did not respond because they were sleeping or with another resident. -This was not discussed with facility staff because currently there was no Executive Director in charge at the facility. -When meeting the Regional Nurse she did not discuss because they were talking about more money to provide additional care to the resident. _____ The facility provided the following Plan of Protection on 11/06/15: -Immediately, a community manager will be present on all shifts to ensure oversight and supervision of residents, staff and community needs are met. -The District Director of Operations will assume immediate responsibility of the community operations to ensure all duties are carried out according to rules and regulations. -The Director of Operations, Clinical Services, Health and Wellness Director Designee, Executive Director Designee and/or Manager on Duty will conduct daily site visits to ensure resident needs are being met for one month. Then weekly thereafter. These will continue on an as needed basis here after. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 26, 2015.	D 270		

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D 273	Continued From page 29	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to assure referral and follow-up for 2 of 5 residents by not sending a resident out for medical evaluation (Resident #2) and not obtaining urine culture and sensitivity for one resident (Resident #13). The findings are: A. Review of Resident #2's current FL2 dated 6/22/15 revealed diagnoses included pulmonary hypertension, peripheral edema, and anemia. Interview on 11/4/15 at 10:45 am with Resident #2's family member revealed: -He visited Resident #2 daily. -He was Resident #2's Health Care Power Of Attorney (HPOA). -He was concerned the facility did not have enough staff and the staff was not competent. -He visited Resident #2 on 10/27/15 and 10/28/15. -Resident #2 complained to family member on 10/28/15 she was nauseated and had abdominal pain. -He could not find staff to inform them of Resident #2's condition. -He visited on 10/29/15 and could not find staff to	D 273		

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inform them Resident #2 was still not well and needed to be sent to the emergency room.
-He left the facility, went home and called Resident #2's physican office and was told the facility would need to call the physican.
-He called the facility and spoke to a Medication Aide and was told they needed an order to call Emergency Medicial Service (EMS) for Resident #2 to be sent out for evaluation.
-He called 911 and had EMS go to the facility and transport Resident #2 to the Emergency room.
-He met EMS and Resident #2 at the emergency room.

Review on 11/4/15 at 1:30 pm of Resident #2's record revealed:
-A Emergency Room (ER) discharge summary dated 10/29/15.
-Rocephin (an antibiotic) 1 gram was administered in the ER via intravenously.
-Laboratory studies were performed as well as chest xray.
-A diagnosis of Urinary Tract Infection.
-A prescription for Cipro (an antibiotic) 250mg tablets take 1 tablet 2 times a day for 10 days sent back to the facility with Resident #2.

Further review of Resident #2's progress notes revealed:
-Documentation on 10/29/15 at 4:30 pm, Resident #2 had complained of stomach pain and nausea.
-Documented on 10/29/15 at 4:30 pm Resident #2 was given ginger ale to drink.
-Documented on 10/29/15 at 4:30 pm staff ask Resident #2 if she wanted to be sent to hospital and she had refused to go.
-Documented on 10/29/15 at 4:30 pm EMS arrived at the facility to transport Resident #2 to the ER, and the family member had contacted

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D 273	Continued From page 31	D 273		

EMS.
-No documentation noted prior to 10/29/15 of Resident #2's nausea or abdominal pain.

Based on record review, observation and interview, it was determined Resident #2 was not interviewable.

Interview on 11/9/15 at 2:30 pm with the Regional Nurse revealed:
-She recalled Resident #2 had gone to the ER in October 2015.
-She was not aware the MA told Resident #2's family member they needed an order to transports Resident #2 to the ER.
-The facility staff did not need an order to send a resident who was hurting or trauma out to get evaluated in the ER.
-She worked in the facility on 10/29/15 the MA had not spoken to her with concerns the family member had for Resdient #2's abdominal pain.
-If she had known she would have assessed Resident #2's symptoms.
B. Review of Resident #13's current FL2 dated 11/10/15 revealed diagnoses included Alzheimer's Disease.

Review of Resident #13's record revealed:
-A physician's order dated 10/06/15 to re-check a urinalysis with culture and sensitivity 2 days after the last dose of Cipro.
-A physician's order dated 10/01/15 for Cipro 250mg 1 tab twice daily for ten days.
-There was no documentation of laboratory results documented on of after 10/06/15.
-The most recent result for a urinalysis in the laboratory section of the record was dated 9/30/15.

Observation of Resident #13's bathroom on

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D 273	Continued From page 32 11/05/15 at 3:32 pm revealed: -A urine cup inside a specimen bag with a laboratory requisite form for a urinalysis with culture and sensitivity. Attempted interview with Resident #13's Physician on 11/06/15 at 10:02 am and was unsuccessful. Interview with Resident #13's Responsible Party on 11/05/15 at 3:32 pm revealed: -He did not know when the lab work was ordered, but the specimen cup had been on the back of the toilet for at least a month. -Resident #13 was treated with an antibiotic for a urinary tract infection in early October 2015. Interview with a Medication Aide (MA) on 11/07/15 at 9:40 am revealed: -The nurse would fill out a lab form and ask either a MA or a Personal Care Aide(PCA) to catch urine samples and give them the cups in the specimen bag. -It was sometimes hard to catch urine samples because a resident might not remember to urinate in the cup or to tell staff when they had to urinate. -It was also hard to catch urine samples if the resident was incontinent and could not tell staff when they had to urinate. -Staff did not tell the nurse if they did not obtain the sample but they would tell the next shift to obtain the sample. -She was not aware Resident #13 had an order for a urinalysis. Interview with a second MA on 11/07/15 at 2:55 pm revealed: -Staff did obtain urine specimens and would assist residents in obtaining samples.	D 273		

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D 273	Continued From page 33 -Once a sample was obtained it was given to the Nurse and he would send it to the lab. -She never had an occasion whereby she was unable to obtain a specimen. -It had never been requested by the staff on the off-going shift that she obtain a specimen because they were unable. -She was unaware the Resident #13 had an order for a urinalysis. The facility provided a Plan of Protection on 11/09/15: -Effective immediately, residents will receive care and services in accordance their individualized care plans. -The community will assure referral and follow-up to meet residents routine and acute care needs. -Documentation of care and services will be available in the residents record. A minimum of two nurses will be present in the facility 5 days a week to provide oversight and monitoring of the community's healthcare needs. -A nurse will also be available by phone daily, after hours and on weekends to triage care and service needs with community staff and managers as needed. -Staff will be retrained on who to contact regarding questions related to care, services and follow up when nurses are not present. -This will occur prior to their next shift. -All contact information will be clearly posted in the community. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 26, 2015.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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D 276	Continued From page 34 10A NCAC 13F .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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure weights and vital signs were obtained as ordered by a Licensed Health Professional for 3 of 5 sampled residents (Resident #1, # 2 and # 11). The findings are: A. Review of Resident #11's current FL2 dated 4/30/15 revealed: -Diagnoses of migraine headaches, chronic obstructive pulmonary disease, hyperlipidemia, hyperparathyroidism and osteoporosis. Review of Resident #11's subsequent physician orders dated 8/20/15 revealed physicians orders for weights and vital signs (to include blood pressure, temperature, pulse and respirations) be obtained every month. Review of Resident #11's MAR's for September, October and November 2015 revealed entries for weights and vital signs to be obtained once a month and there was no data entered. Review of facility weight and vital sign book revealed:	D 276		

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D 276	Continued From page 35 -No documentation of vital sign or weight for Resident #11. Interview with Resident #11 on 11/06/15 at 3:30 pm revealed: -She had not recently lost any weight and knew this because she was weighed at her doctor's office. -She has lost weight in previous months and she took dietary supplements to prevent further loss. -She had not been weighed in the facility in months and never on a regular basis. Refer to interview on 11/4/15 at 2:30 pm with the facility nurse. B. Review of Resident #1's current FL2 dated 7/10/15 revealed: -Diagnoses included coumadin therapy, hypertension, and cerebral vascular accident history. -An order for vital signs and weights monthly. Review on 11/4/15 of Resident #1's Medication Administration Record (MAR) for September, October, and November, 2015 revealed. -An entry for weights and vital signs to be obtained once a month and there was no data entered. -No documented entries weights or vital signs were obtained September, October, or November 2015 on the MAR. Review of facility weight and vital sign book revealed: -No documentation of vital signs or weights for Resident #1 for the months of September, October, or November 2015. Interview on 11/4/15 at 4:00 pm with a second	D 276		

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shift MA revealed:
-She thought resident's weights and vital signs were obtained on first shift.
-She was unaware Resident #1 had no weights or vital signs completed for 3 months.
-She never transferred the resident's weight or vital signs to the facility weight log book.

Interview on 11/5/15 at 10:30 am with a first shift PCA revealed:
-She relied on the MA to tell her when a resident weight needed to be obtained.
-She had not obtained the resident's vital signs, "MA do that".
-She was unaware Resident #1 needed vital signs or weight's monthly.

Interview on 11/6/15 at 9:30 am with Resident #1 revealed:
-She cannot recall the last time staff took her vital signs or obtained her weight.
-She had gone to her physician last month and had vital signs and weights obtained.
-The staff were mostly new, "I am not sure they know how to weigh me".
-"The physician wanted my vital signs taken due to my high blood pressure."

Attempted telephone interview on 11/4/15, 11/5/15 and 11/9/15 with Resident #1's physician office was unsuccessful.

Refer to interview on 11/4/15 at 2:30 pm with the facility nurse.

C. Review of Resident #2's current FL2 dated 6/22/15 revealed:
-Diagnoses included pulmonary hypertension, peripheral edema, and anemia.
-An order to check weight weekly on Saturdays.

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D 276	Continued From page 37 -An order to encourage fluids to avoid dehydration. Review of Resident #2's Medication Administration Record (MAR) for September 2015 revealed: -An entry for vital signs to be obtained once a month. -Vital signs were documented on September 1st as follows: -Blood pressure 168/82, pulse 83, and respirations 18. -An entry for weights to be obtained weekly on Saturday, there was no data entered on MAR. Review of Resident #2's MAR for October and November 2015 revealed: -An entry for vital signs to be obtained once a month and there was no data entered. -An entry for weights to be obtained weekly on Saturday and there was no data entered. Interview on 11/4/15 at 10:45 am with Resident #2's family member revealed: -He visited Resident #2 daily. -He was Resident #2's Health Care Power Of Attorney (HPOA). -He found it hard to locate facility staff when he had visited Resident #2 and needed assistance on October 29, 2015. -He was concerned the facility did not have enough staff and the staff was not competent. Based on record review, observation and interview, it was determined Resident #2 was not interviewable. Observation on 11/6/15 of the facility weight book log revealed no weight entries for October or November 2015 documented for Resident #2.	D 276		

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D 276	Continued From page 38 Attempted telephone interview on 11/9/15 at 10:30 am with the facility LPN was unsuccessful. Attempted telephone interview on 11/9/15 at 11:00 am with Resident #2's physician office was unsuccessful. Interview on 11/9/15 at 9:40 am with a Medication Aide revealed: -The resident's weight and vital signs were completed by the MA and the Personal Care Aides (PCA). -All residents had their weight obtained monthly using the stand-up scale or the chair scale. -Resident #2 gets weighed weekly. -The MA charted the vital signs and weights on the MAR and the facility Licensed Practical Nurse (LPN) transferred the entries into the weight log book. -The LPN was retired, but she worked 2 days a week in the facility. -The weight log book was kept in the medication room. Observation on 11/6/15 of the facility weight book log revealed no weight entries for October or November 2015 documented for Resident #2. Attempted telephone interview on 11/9/15 at 10:30 am with the facility LPN was unsuccessful. Refer to interview on 11/4/15 at 2:30 pm with the facility nurse. Interview on 11/4/15 at 2:30 pm with the Nurse revealed: -She had worked in the facility for a week. -The facility was not her permanent facility.	D 276		

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D 276	Continued From page 39 -The Personal Care Aides (PCA) and the Medication Aides (MA) were to obtain residents' weights and vital signs as ordered by the physician. -The MAs were to document the weights and vital signs on the MAR and then transfer the weights and vital signs over to the facility log book every month. -She was unaware the staff had not obtained weights or vital signs for the residents in the last three months. -The facility does not have a current Health and Wellness Director to oversee the nursing staff. -The facility had a big turn-over in MAs and PCAs in the last few months. -The facility did not have a system in place to assure the weights and the vital sign for the residents were bring completed as ordered by the physician.	D 276		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for 1 of 5 sampled residents prescribed therapeutic diets of No added Salt Diet (Residents #3). The findings are:	D 309		

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D 309	Continued From page 40 Review of Resident #3's current FL2 dated 3/27/15 revealed: -Diagnoses of diabetes mellitus with hyperosmolarity, history of urinary tract infection, pain in shoulder joint and history of fracture, difficulty walking, pre-senile dementia, constipation, history of falls, history of pulmonary embolism. -An order for No Added Salt and Carbohydrate Controlled diet. Review of posted therapeutic diet list in the kitchen on 11/05/15 at 11:20 am revealed: -A posted therapeutic diet list that included residents who must have therapeutic diets included Controlled Carbohydrate Diet, No added Salt. -Resident #3 was listed to be served a controlled carbohydrate diet. Review of Resident #3's record revealed a diet order dated 8/21/15 for "Continue only No Added Salt Diet discontinue Low Cholesterol, Fortified Foods Diet". Review of the therapeutic diet breakfast menu for 11/05/15 for a prescribed Controlled Carbohydrate Diet per the Resident Therapeutic Diet List revealed: -4 ounces of Potato, bacon and eggs scramble with 1/2 cup hot cereal. -Cheerios Observation of the breakfast meal served to Resident #3 on 11/05/15 from 8:20 am to 9:35 am revealed: -The resident was served one 6 ounce glass of water, one 6 ounce glass of cranberry juice and one 6 ounce cup of coffee and she added one	D 309		

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packet of regular sugar to the coffee.
-The resident was served Raisin Bran cereal with 2% milk and one banana.
-She was offered eggs and bacon but what was served was all that she requested.

Review of the therapeutic diet breakfast menu for 11/05/15 for a prescribed Controlled Carbohydrate Diet revealed:
-Turkey Sandwich (omit bread and potato selection), 1/2 cup broccoli and reduced sugar pineapple upside down cake or reduced sugar strawberry banana pudding.

Observation of the lunch meal served to Resident #3 in her room on 11/05/15 from 12:36 pm to 1:05 pm revealed:
-The resident requested and received a turkey sandwich one wheat bread with no lettuce or tomato.
-The resident was also served reduced sugar key lime pie, 6 ounces of sweet tea.
-Resident #3 said it was sweet tea and could tell by tasting the tea.
-Resident #3 ate 100% of her sandwich, all of her pie except the crust and 25% of her tea.
-She asked the MA for water but did not receive water.

Interview with Resident #3 on 11/06/15 at 12:58 pm revealed:
-She did not like to restrict her diet.
-Resident #3 liked to eat and knew she should be on "some type of diabetic diet " because she had diabetes.
-She took insulin and the staff regularly checked her blood sugar in the morning and evening.
-She was usually served diabetic desserts.
-They gave her diabetic cake, but she did not eat it because she did not like it.

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-They also gave her canned peaches, jello or pudding and she did not like these either.
-She did put one packet of sugar in her coffee per her preference, but did not like sugar in tea.
-The tea she was served at lunch today was far too sweet.

Interview with a Medication Aide who served lunch on 11/05/15 at 1:03 pm revealed:
-Resident #3 had an order for a controlled carbohydrate diet.
-She did not know what kind of tea she served Resident #3.
-She usually would pour the tea from the unsweetened tea pitcher, but someone else had poured this glass and she just delivered it to Resident #3.
-She did not know of a diet order that said " NAS only " .
-If she received a doctor's order she would would give a copy to the DM or whoever was working in the kitchen.

Interview with the Dietary Manager (DM) serving dinner on 11/06/15 at 4:15 pm revealed:
-He knew what to serve each resident, because he looked at the menu to prepare the meal.
-He knew how many of each therapeutic diets to prepare based on the therapeutic diet list.
-The nursing staff were responsible for updating the kitchen staff about new resident's and their diets or any diet changes.
-The nursing staff would give him a copy of the new diet order and he would keep them in a notebook.
-Anytime there was a diet change he was responsible for changing the therapeutic diet list.
-He knew that Resident #3 had a controlled carbohydrate diet and was unaware of any diet order that was written and received by the facility

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on 8/21/15 that changed Resident #3's diet order.
-He updated his diet notebook and the therapeutic diet list anytime nursing gave him a written order.

Interview with the Director of Clinical Services on 11/06/15 at 1:30 pm revealed:
-The Nurse was to inform the dietary staff when there was a new resident admitted and their diet order.
-The Resident Care Coordinator was to enter the diets into the nutrition tracker which listed the resident's diet, food allergies, preferences, nutritional supplements and if they required feeding assistance.
-Resident #3's diet was listed as carbohydrate controlled on the nutrition tracker.
-The nursing staff informed dietary staff verbally and in writing by giving them a copy of the diet order.
-She was not aware the diet orders were not accurately reflected by the therapeutic diet list.
-She was not aware that Resident #3 had a diet order updated on 8/21/15.

Interview with Resident #3's physician's nurse on 11/06/15 at 4:16 pm revealed:
-She was not sure why the diet order did not include the controlled carbohydrate diet.
-She verified the last diet order in the resident's record was to continue no added salt diet only and to discontinue the low cholesterol diet.
-She did not have any calls from the facility to verify the diet order should include consistent carbohydrate or sugar restriction.
-She was going to clarify the diet order with the physician and call back.

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D 310	Continued From page 44	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to assure 1 of 5 sampled residents (Resident #2) with a physician's order for therapeutic diet of Texture Modified was served as ordered. The findings are: Review of Resident #2's current FL2 dated 6/22/15 revealed: -Diagnoses included osteoporosis, history of compression fracture, hypertension, anemia, pulmonary hypertension, history of falls, weakness and peripheral edema. -An order for a texture modified diet. Review of the textured modified diet was defined as the one that offers food that is moist and soft-solid. All meats and poultry are ground with the exception being small tender pieces of meat allowed in soups. Review of the posted diet list posted in the kitchen revealed the diet for Resident #2 was listed as "Texture Modified/Cut meat". Review of the therapeutic diet breakfast menu to be served for the texture modified diet on	D 310		

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D 310	Continued From page 45 11/05/15 revealed: -Resident was to be served 4 ounces of a potato egg bake, a ground sausage patty with gravy in lieu of bacon, 1 piece of wheat bread and 1/2 cup chilled applesauce in lieu of fresh fruit. Observation of the breakfast meal served to Resident #2 on 11/05/15 from 8:20 am to 9:35 am revealed: -The resident was served 8 ounces of water, 6 ounces glass of orange juice, 6 ounces of coffee and the resident brought in an 8 ounce bottle of Ginger Ale. -The resident was served 1 piece of wheat toast with a pack of grape jelly on the side, 1 whole banana, scrambled eggs and two full pieces of bacon. -The resident did not have difficulty swallowing. -The resident consumed 100% of the egg. -The resident consumed 100% of the toast, 100% of the bacon and 50% of her banana and took the remaining portion with her. Review of the therapeutic diet menu for the lunch meal for the texture modified diet on 11/05/15 revealed: -The resident was to be served roasted chicken and the chicken was to be de-boned with skin removed. The chicken was to be ground and served with gravy, ½ cup of beets, 1/2 cup of roasted red skin potatoes and potatoes were to be peeled and served with gravy, one roll served with butter and peach slices. Observation of the lunch meal served to Resident #2 on 11/05/15 from 12:05 pm to 1:05 pm revealed: -The resident was served 6 ounces of tea and 6 ounces of water and the resident brought in an 8 ounce bottle of Ginger Ale.	D 310		

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-The resident was served a ½ cup of pickled beets, ½ cup of red skin potatoes and they were diced but the skin was still present, 1 chicken drum stick with skin on and one roll.
-Resident #2 pulled the chicken off the bone and did have some difficulty managing both the drum stick and the fork and she consumed 50% of the chicken.
-Resident #2 consumed 25% of the potatoes and ate 100% of her roll.
-Resident #2 did not have any difficulty chewing or swallowing.

Interview with Resident #2 on 11/05/15 at 3:15 pm revealed:
-Resident #2 did not know what type of diet she was prescribed.
-Resident #2 liked her meat to be cut because it was easier to eat.
-Resident #2 did not know if she was usually served cut meats but did not think she was.
-Resident #2 did not ask for her meat to be cut up because she did not think to ask.
-She did not recall having difficulty swallowing but she also eats very slow.

Interview with the Dietary Aide on 11/05/15 at 1:08 pm revealed:
-If there was a diet change the nursing staff would give her a copy of the new diet order.
-She would hang it next to the therapeutic diet list and put a copy in the Dietary Manager's folder.
-The last time the therapeutic diet list was updated was 10/12/15

Interview with the Dietary Manager (DM) serving dinner on 11/06/15 at 4:15 pm revealed:
-He knew what to serve each resident.
-He looked at the menu to prepare the meal, and knew how many of each therapeutic diets to

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D 310	Continued From page 47 prepare based on the therapeutic diet list. -The nursing staff were responsible for updating the kitchen staff. -The nursing staff would give him a copy of the new diet order and he would keep them in a notebook. -Anytime there was a diet change he was responsible for changing the therapeutic diet list. -He knew he served Resident #2 bacon as well as chicken on the bone and did so because that was her preference. -He did not know the skin should have been off the potatoes, but did make sure they were soft and cut into small pieces. -Her preferences were not documented anywhere. Interview with the Director of Clinical Services on 11/06/15 at 1:30 pm revealed: -The Nurse was to inform the dietary staff when there was a new resident admitted and their diet order. -The Resident Care Coordinator was to enter the diets into the nutrition tracker which listed the resident's diet, food allergies, preferences, nutritional supplements and if they required assistance. -Resident #2's preference for meat on the bone or full pieces of bacon was not noted on the nutrition tracker. -The nursing staff informed dietary staff verbally and in writing by giving them a copy of the diet order. -She was not aware the meat for Resident #2 was not cut or prepared as ordered.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 48 An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure the rights of all residents are maintained and may be exercised without hindrance for 2 of 5 residents (Residents #3 and #11) regarding neglect related to not administering medications as ordered, pain medications, and not responding to call bells in a timely manner for 53 of 53 residents living on the on the 2nd and 3rd floor. The findings are: A. Confidential interviews with 9 residents during the initial tour of the facility on 11/04/15 from 9:45 am to 11:30 am revealed: -9 residents said the facility staff never responded when they called for assistance. -6 residents believed the facility was short of staff. -The residents said they had "call buttons" around their neck to call for staff assistance. -9 residents said when they pushed the call button for assistance staff took a long time to come, and sometimes staff never came to their room to inquire what the resident wanted. -4 residents said they needed staff assistance with toileting. -1 residents need help changing their brief. -3 residents physically needed help on and off the toilet. -1 residents said she tried to go herself and sometimes fell.	D 338		

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D 338	Continued From page 49 -3 residents said they needed assistance with showering/bathing, but had been refused the shower due to not enough staff. -1 resident needed assistance with as needed medications. -7 residents said they needed staff for various reasons. -3 residents needed assistance getting in and out of bed. -2 residents needed assistance with getting from bed to wheelchairs. -1 resident said she pushed the pendant's red button several times today (11/4/15) without response from staff. -The resident said "It takes a long time before the staff comes in to check on me, sometimes they do not come at all." -If assistance was needed to the bathroom, shower, or for any reason, sometimes you did not get the help. -9 residents said how the call button worked was: they pushed the red button on the pendent; they don't hear the alarm, but it's supposed to alert the aides (Medication Aide and Personal Care Aide). -Aides were supposed to respond with so many minutes (how long, unknown). -The residents were unaware if the system continually alarmed, when staff did not respond. -The resident were also unaware how staff stopped the alarm. -Some residents thought staff had to use their walkie/talkie near their pendent. -2 residents said,the facility did not have enough staff. -Some staff never responded when residents pushed their call bell. -Some staff responded, but it took anywhere from 30 minutes to 2 hours. -1 resident said there was usually only two staff on the first and second shifts, unsure if any staff	D 338		

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were on the third shift.
-1 resident said between the hours of 3:30 pm and 5:00 pm staff on the second shift were never around because they were in the dining room setting up for the meal.

Observation on 11/05/15 at 4:28 pm on the third floor revealed:
-A resident yelling "help me."
-The resident yelled to the surveyor walking in the hallway to come to her room and help her.
-The resident stated she needed to be changed.
-She had been in the bed for more than 3 hours.
-The resident was unaware who the staff were at the facility, and asked the surveyor to change her.
-The surveyor asked the resident did she push her button.
-The resident responded "yes," and pushed the button again.
-The surveyor searched the entire third floor looking for staff and could not find any staff.
-A family member approached the surveyor stating she was looking for staff.
-No staff was identified on the third floor.
-A resident waiting for the elevator said, no staff was upstairs, because they were in the dining room setting up for the dinner meal.
-The resident said it was the same every day.
-The resident stated they (residents) always had to wait a long time for staff to come, and between the hours of 4:00 pm and 5:15 pm no staff was to be found.
-No staff was to be found because they were all downstairs setting up for the meal.
-At 5:15 pm the surveyor observed the PCA coming up the stairs.
-The surveyor informed the PCA the resident needed help.

Observation on 11/4/15 between 10:15 am and

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D 338	Continued From page 51 10:55 am of response by staff when the call bell system was pushed revealed, no staff entered the resident room located on the third floor. Observation on 11/04/15 at 10:00 am of the facility's call bell system revealed: -The facility's call bell system consisted of a pendent worn around the residents' neck. -The pendent was a 1"x 1" manilla square with a round red button in the middle. -To call for staff a resident had to push the red button. -If the call was effectively transmitted a red light quickly flashed twice. -The call was sent to the hand held "walkie/talkie" that was carried by all Personal Care Aides (PCAs) and Medication Aides (MA). -In each resident bathroom was a long white string attached to the call system. -To call for staff a resident had to pull the string. -If the call was effectively transmitted a red light quickly flashed twice. Observation on 11/5/15 at 11:05 am of the facility's protocal for residents pendant call bell button pushed and staff response revealed: -A PCA and surveyor went into a resident's room on the third floor. -The resident pushed the call bell button pendant in front of PCA and surveyor. -The resident's pendant red light quickly flashed twice. -A PCA had the walkie talkie on her right hip and was standing 3 feet from the resident. -The walkie talkie beeped and displayed the resident's room number and pendant alarm within 45 seconds. -The PCA reset the pendant by re-pushing the pendant while holding the walkie talkie up to the	D 338		

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pendant.
-That was the only way to stop the beeping and to reset the resident's pendant.
-"You can only reset the pendant if you have the walkie talkie near the pendant".

Review on 11/4/15 at 12:00 pm of the facility call bell system activity report calls for assistance by various residents revealed:
-The report was computerized with room numbers, events, dates, and response time.
-Examples of data entries for 11/4/15 were as follows:
-Room 207, event "Bath Call", response time 1 hour 38 minutes.
-Room 212, event "Pendant alarm", response time 2 hours 30 minutes.
-Room 219, event "Bath Call", response time 3 hours 4 minutes.
-Room 302, event "Bath Call", response time 1 hour 20 minutes.
-Room 305, event "Pendant alarm", response time 1 hour 31 minutes
-Room 325, event "Pendant alarm", response time 1 hour 18 minutes.
-Examples of data entries from 10/31/15 to 11/3/15 are as follows:
-Room 214, event "Pendant alarm", 10/31/5, response time 3 hours 24 minutes.
-Room 228, event "Pendant alarm", 11/1/15, response time 8 hours 33 minutes.
-Room 302, event "Pendant alarm", 11/2/15-11/4/15 response time 51 hours 30 minutes.
-Room 312, event "Pendant alarm", 10/30/15, response time 6 hours 22 minutes.

Interview on 11/4/15 at 11:15 with a Medication Aide (MA) revealed:
-She was a MA assigned to the second floor on

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D 338	Continued From page 53 11/4/15. -The flu clinic was today in the activity room. -She and the other floor staff were responsible for taking the residents down to the second floor for flu shots on 11/4/15. Interview on 11/5/15 at 11:00 am with a Personal Care Aide (PCA) revealed: -The residents pushed the button on the pendant call bell when they need assistance. -All PCA's and MA carry the hand held "walkie/talkie." -The walkie talkie beeps when a resident needs assistance and the room number and the event is displayed. -The event displayed is either pendant alarm, bathroom call, or batteries replaced. -"We have 5 minutes to get to the resident's room." -"Sometimes we are busy in another resident's room." Interview on 11/4/15 at 10:45 am with a family member on the third floor revealed: -He visted the facility daily. -He was concerned the facility did not have enough staff and the staff was not competent, he found it hard to located staff for assistance for his family member. Interview on 11/5/15 at 12:50 pm with the Maintenance Director revealed: -He had been employed at the facility for 3 years. -He was in charge of the call bell system. -The call bell system was an outside computerized system. -The call bell system consisted of a pendant for each resident and a walkie talkie for each the floor staff. -The resident's bathroom call bell was	D 338		

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incorporated into the call bell system.
-The call bell system was new to him.
-He had taken the call bell system over from nursing management.
-He checked the call bell system monthly.
-He changed the batteries in the resident's pendant when the walkie talkie alerted the staff to "Replace Battery".
-If a walkie talkie was full of data entries it would not work.
-He placed the walkie talkie on the base to download and clear the data.
-The walkie talkie stayed charged by placing them on the base located at the nurses station.
-He was unsure who reviewed the call bell activity log or the data entries.
-The facility had a big turnover in staff, most of the PCA's and MA are new to the facility.
-Residents told him staff took a long time to answer the call bells when they needed assistance.

Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision.

Refer to confidential interview with a staff member.

Refer to Interview on 11/06/15 at 4:20 am with a third shift Medication Aide.

Refer to interview on 11/06/15 at 4:28 am with a third shift Personal Care Aide.

B. Review of Resident #11's current FL2 dated 4/30/15 revealed:
-Diagnoses of migraine headaches, chronic obstructive pulmonary disease, hyperlipidemia, hyperparathyroidism and osteoporosis.
-Physician orders for Axert 12.5 mg tab once daily

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D 338	Continued From page 55 as needed (A medication used to treat migraine headaches). Interview with Resident #11 on 11/05/15 at 10:33 am revealed: -On 10/24/15 she rang her call bell because she needed her migraine medication -After two hours an PCA finally came in her room and Resident #11 requested her migraine medication. -She never received her migraine medication. -On 10/25/15 she was very upset because she never received her medication and she began to get another migraine headache. -She wrote down that she rang the call bell for her migraine medication at 1:50 pm and [staff member's name] finally answered the call bell at 5:10 pm. -The MA did bring her migraine medication in after 5:10 pm, but it did not work and Resident #11 ended up having "the worst" migraine headache the rest of the night. -She had complained about her call bells going unanswered and not getting her medication to the last Nurse, the last Administrator and the Memory Care Unit Coordinator. -Every time she complained to the Nurse and the Adminstrator she requested they follow up with her to let her know the outcome. -They never followed up with her and nothing ever improved. Review of Resident #11's October and November 2015 MARs revealed: -An entry for Axert 12.5 mg once daily as needed, -No documented administrations from 10/1/15 to 10/31/15. -No documented administrations from 11/1/15 to 11/5/15.	D 338		

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D 338	Continued From page 56 C. Review of Resident #3's current FL2 dated 3/27/15 revealed: -Diagnoses of Diabetes Mellitus with hyperosmolarity, history of urinary tract infection, pain in shoulder joint and history of fracture, difficulty walking, pre-senile dementia, constipation, history of falls, history of pulmonary embolism. -Resident #3 required assistance with bathing, dressing and set up assistance for feeding. 1. Review of Resident #3's Medication list dated 9/16/15 revealed: -A physician's order for Tramadol HCL 50 mg 1 tablet every 4 hours as needed for pain. -A physician order for Tramadol 50 mg 2 tablets (=100mg) every 4 hours as needed for moderate pain. -A physician order for Hydrocodone 5/325 mg 1 tablet by mouth every 4 hours as needed. (used for severe pain) Interview of Resident #3 in her room on 11/05/15 at 9:38 am revealed: -Her shoulder was causing her pain. -She rang the call bell at 9:41 am to request pain medication. -She rang the call bell again at 9:49 am because there was no response. -At 9:50 am a Personal Care Aide (PCA) came in and she requested pain medication. The PCA told Resident #3 she would get the Medication Aide (MA) for her. -At 10:08 am a second PCA entered the room and turned off her call bell and told Resident #3 that she would get the MA. -At 10:13 am the MA entered the room and Resident #3 requested the MA get her pain medication because her shoulder was causing her pain.	D 338		

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D 338	Continued From page 57 -The MA said she would go and get her some pain medicine and left the room. -At 10:25 am the MA returned with Resident #3's pain medication which was Hydrocodone 5/325 mg. -Resident #3 asked the MA if she had anything that was not as strong as hydrocodone and the MA said, "No. Hydrocodone is all you have". -Resident #3 took the medication and swallowed it and then stated, "God, I do not need something this strong. I thought my doctor prescribed something else instead of that because that [the hydrocodone] is too strong." Interview with a MA on 11/05/15 at 10:05 am revealed: -She was to check the Medication Administration Record to check the last time an as needed (PRN) medication was administered. -She administered the hydrocodone because that was what Resident #3 had prescribed for her for pain. -She did not know Resident #3 had Tramadol prescribed. -She did not know the last time Resident #3 was given any pain medication. Interview with Resident #3 on 11/05/15 at 12:27 pm revealed: -Resident #3 rang her call bell because she was "shaky and wobbly". -Resident #3 was told by the MA she could not go to the dining room, and that she would be served lunch in her room. -Resident #3 was served lunch in her room and she was "Ok", but after she ate she was going to sleep Interview with Resident #3's physician's Nurse on 11/06/15 at 4:16 pm revealed:	D 338		

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D 338	Continued From page 58 -The facility did not inform the physician's office Resident #3 was dizzy and weak from the hydrocodone. Attempted interview with Resident #3's responsible party on 11/06/15 at 10:35 am and 3:59 pm and on 11/09/15 at 11:59 pm was unsuccessful. 2. Review of Resident #3's record on 11/05/15 revealed: -Physician's orders dated 10/22/15 for Zithromax 250 mg 2 tabs x 1 dose and 1 tablet by mouth daily for 4 days. (A medication used to treat respiratory infections). -An order for loratadine 10 mg 1 tablet everyday. (A medication used to treat allergy symptoms) Review of Resident #3's subsequent physician orders dated 9/16/15 revealed: -A physican's order for patanol eye drops - 2 drops in both eyes twice daily as needed for allergies. (A medication used to treat itchy, red eyes caused by allergies). -A physician's order for fluticasone nasal spray - 2 sprays into each nostril every day as needed for allergies. (A medication used to treat runny nose caused by allergies). Review of Resident #3's Medication Administration Record (MAR) for October 2015 revealed: -An entry for Zithromax 250 mg 2 tabs x 1 day that was documented as administered at 9:00 am on 10/23/15. -An entry for Zithromax 250 mg 1 tab daily x 4 days that was documented as administered at 9:00 am from 10/24/15 - 10/28/15. -An entry for Robitussin 1 teaspoon every four hours as needed and was documented as	D 338		

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D 338	Continued From page 59 administered on 10/28/15 and 10/31/15. -An entry for loratadine 10 mg 1 tab at 8:00 am daily, to start on 10/22/15, that was documented as administered from 10/28/15 - 10/31/15. -An entry for patanol eye drops - 2 drops in both eyes twice daily as needed for allergies with no documented administrations. -An entry for fluticasone nasal spray - 2 sprays into each nostril every day as needed for allergies with no documented administrations. Review of Resident #3's Medication Administration Record (MAR) for November 2015 revealed: -An entry for Robitussin 1 teaspoon every four hours as needed and was documented as administered on 11/01/15. -An entry for patanol eye drops - 2 drops in both eyes twice daily as needed for allergies with no documented administrations. -An entry for fluticasone nasal spray - 2 sprays into each nostril every day as needed for allergies with no documented administrations. Interview with Resident #3 on 11/05/15 at 9:38 am revealed: -She went to the nurses station to find staff when she needed assistance or medication because "nothing happens when you ring the call bell". -Resdient #3 did have a cough and a runny nose. -She went to her doctor on 10/22/15 for a cold that she had not been able to get rid of and was prescribed an antibiotic and some cough syrup. -The physician told her to take her eye drops and nose spray that she already had on her medication list. -She knew the medications were in the building because she and her family member picked the medications up at the pharmacy and brought them to the facility.	D 338		

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D 338	Continued From page 60 -She requested the cough syrup, the nose drops and the eye drops at least daily but never received anything except the cough syrup "maybe two or three times". -On one occasion the Medication Aide (MA) brought some cough syrup a few nights ago and Resident #3 accidentally spilled it. -The MA left and never brought her more cough syrup. -Resident #3 requested pain medication on 11/04/15 and she never received her pain medication. Attempted interview with Resident #3's responsible party on 11/06/15 at 10:35 am and 3:59 pm and on 11/09/15 at 11:59 am was unsuccessful. Refer to confidential interview with a staff member. Refer to Interview on 11/06/15 at 4:20 am with a third shift Medication Aide. Refer to interview on 11/06/15 at 4:28 am with a third shift Personal Care Aide. _____ Confidential interview with a staff person revealed: -They worked in the dining room every morning. -Residents complained daily about facility staff not responding to their call bells or taking more than 30 minutes to respond to a call for help. Interview on 11/06/15 at 4:20 am with a third shift Medication Aide (MA) revealed: -She worked at the facility for 2 years. -She did not administer a lot of medications. -She usually gave residents as needed	D 338		

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medications (PRNs).
-She signed off on the MAR if the medications were effective.
-She usually arrived to work around 10:00 pm and did rounds with the second shift staff.
-She had to set-up the dining room for breakfast and it took anywhere from 1 to 2 hours.
-She did laundry - wash and fold residents' clothes.
-She did checks on residents every 2 hours.
-She answered call bells as soon as residents pushed the button, unless in the room with another resident.
-She filed paperwork in the residents' records.
-She did not do medication cart audits.
-She worked the second floor and the Personal Care Aide (PCA)worked the third floor.

Interview on 11/06/15 at 4:28 am with a third shift PCA revealed:
-Around 1:30 am she set-up the dining room for breakfast and it took about 2 hours.
-She went downstairs to do the laundry, but did not stay.
-After putting the clothes in the machine she came back to the third floor.
-The time off the floor to put clothes in the washing machine was 15-20 minutes.
-When she was downstairs there was no staff on the third floor.
-She went down to transfer clothes from the washer to the dryer, which did not long.
-She went down a third time to retrieve clothes from the dryer, which took at the most 20 minutes.
-She folded residents' clothes, putting them in a basket outside the residents' doors.
-She did rounds at 4:30 am checking on residents on the third floor.
-She usually did not open the doors because she

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D 338	Continued From page 62 did not want to wake the residents. -If a room door was open she observed the resident through the open door. -She answered call bells as soon as she was available. -Around 5:00 am she started showers for residents scheduled for the day. -When there was an Executive Director working at the facility there were three people working between the 2nd and 3rd floors. -She was not sleeping, because staff were not allowed to sleep when on duty. -It appeared she was sleeping because her head was covered with the hood from her jacket. -She did not move or respond to open the door when the surveyors rang the bell because she did not have the key to the door. -Only the MA had the key to unlock the front door. -She worked at the facility for 2 months, and had not observed any management come in on the third shift to ensure staff were completing their duties. -She did not know who management was at the facility. _____ The facility provided a plan of protection on 11/06/15: -Effective immediately, a community manager will be present on all shifts to ensure resident rights are protected. -The District Director of Operations will assume immediate responsibility of the community operations to assure all duties are carried out according to rules and regulations. -Prior to their scheduled shift, staff will be in-serviced to the responsibilities and expectations related to Resident Rights. DATE OF CORRECTION FOR THE TYPE A2	D 338		

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D 338	Continued From page 63 VIOLATION SHALL NOT EXCEED DECEMBER 11, 2015.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record review, observation, and interviews the facility failed to clarify orders for 1 of 4 residents (Resident #8) with orders for finger stick blood sugars (FSBS) and Novolog sliding scale. The findings are: Review of Resident #8's current FL2 dated 03/18/15 revealed: -Diagnoses included dementia and diabetes mellitus type II. -Medications and treatments to control blood sugars included Finger Stick Blood Sugars (FSBS) before meals and at bedtime (four times daily); Detemir/Levemir (control and lower blood	D 344		

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D 344	Continued From page 64 sugars) 5 units subsequently at bedtime; and 25 units subsequently in the morning; and Novolog (quickly lower blood sugar) sliding scale (200-250= 0 units; 251-300=4 units; 301-350= 6 units; 351-400= 8 units; 401-451= 10 units; 451-500= 12 units; If meter reads high give 14 units, recheck in 2 hours, if FSBS less than 100 or greater than 400 call physician). Review of Resident #8's record revealed: -A request from facility staff dated 3/25/15, was faxed to the Resident #8's physician asking how often to obtain the resident's accuchecks. -The request did not address the Novolog sliding scale ranges. -The response was not the physician's signature. -The nurse wrote "Q am," and signed her name with credentials "RN" after her signature. -Staff changed the resident's FSBS to once daily without clarifying the order to ensure the physician wanted to decrease the number of times FSBS were obtained, and to ensure the physician wanted the Novolog sliding scale stopped. Review of the Licensed Health Professional Support (LHPS) evaluation dated 09/09/15 revealed: -The Registered Nurse (RN) doing the evaluation documented the resident had the task of collection and testing of finger stick blood samples. -The resident was receiving FSBS daily in the am, blood sugar ranges was 100-230. -The RN recommended changes in plan of care were to obtain FSBS as ordered and document; and administer Levemir as ordered. In October 2015 Resident #8's blood sugar ranges were between 127-343.	D 344		

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D 344	Continued From page 65 -FSBS in range for Novolog SSI and no insulin was administered: -10/02/15 FSBS, 263 required 4 units; -10/04/15 no FSBS documented; -10/08/15 FSBS, 268 required 4 units; -10/14/15 FSBS, 291 required 4 units; -10/17/15 FSBS, 256 required 4 units; -10/22/15 FSBS, 266 required 4 units; -10/26/15 FSBS, 343 required 6 units; -10/28/15 FSBS, 292 required 4 units. In November 2015 Resident #8's blood sugar ranges were between 160-390. -FSBS in range for Novolog SSI and no insulin was administered: -11/01/15 FSBS, 284 required 4 units; -11/02/15 FSBS, 270 required 4 units; -11/05/15 FSBS, 390 required 8 units; -11/06/15 FSBS, 292 required 4 units; -11/08/15 FSBS, 288 required 4 units; -11/09/15 FSBS, 324 required 6 units; -11/10/15 FSBS, 337 required 6 units; Attempted interview with Resident #8's physician on 11/06/15 and 11/09/15 was unsuccessful. The Regional Nurse faxed a request to Resident #8's physician on 11/09/15 clarifying FSBS with sliding scale order revealed: -The physician responded back he wanted FSBS before meals and at bedtime (four times daily). -The physician also ordered Humalog sliding scale. Interview on 11/05/15 at 5:53 pm with Resident #8 revealed: -He was a diabetic. -Staff checked his FSBS, but not every day. -He received insulin injections before bed, but was unable to recall any other insulin injections	D 344		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 66 administered.	D 344		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure an insulin pen was properly labeled for 1 of 5 sampled residents (Resident #3). The findings are: Review of Resident #3's record revealed a current FL2 dated 3/27/15 included diagnoses of Diabetes Mellitus with hyperosmolarity, history of	D 352		

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D 352	Continued From page 67 urinary tract infection, pain in shoulder joint and history of fracture, difficulty walking, pre-senile dementia, constipation, history of falls, history of pulmonary embolism. Review of Resident #3's physician orders dated 9/16/15 revealed an order for Lantus Solostar 100units/ml Insulin Pen - Inject 22 units subcutaneously at bedtime (Lantus is a slow acting insulin used to control high blood sugars). Observation of the medication cart on 11/04/15 at 4:00 pm revealed: -A 3 ml Lantus Insulin Pen without a container or bag. -There were 140 units left in the insulin pen. -The Lantus Pen had no label. -A second Lantus Pen in a plastic bag that labeled by the pharmacy for a different resident. Interview with a Medication Aide on 11/04/15 at 4:02 pm revealed: -She could not be sure the Lantus Insulin Pen belonged to Resident #3 but the only other Lantus pen was labeled for [resident's name] so they used the unlabeled pen for Resident #3. -The MA was not aware the insulin pens had to be labeled or in a labeled container. -She did not know what information should be on a prescription medication label. Interview with a second MA on 11/04/15 at 4:05 pm revealed: -There was a box in the medication room refrigerator that contained Lantus Insulin Pens for Resident #3. -The box was labeled with Resident #3's name and they would remove a pen from the labeled box and put it on the medication cart for Resident #3.	D 352		

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D 352	Continued From page 68 -She was aware she could not put the whole box on the med cart because the unopened insulin needed to be refrigerated. -She was not aware the pen should have a label prior to it being on the med cart. Interview with the Regional Nurse on 11/04/15 at 4:07 pm revealed: -She was unaware the insulin pen was on the medication cart without a label. -The pharmacy should package the pens individually or provide labels and bags for each pen.	D 352		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 8 sampled residents (#12) which included errors with administration of Novolog insulin, Lantus insulin and Metoprolol 25 mg. The finding are:	D 358		

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D 358	Continued From page 69 Review of Resident #12's current FL2 dated 5/18/15 revealed diagnoses included diabetes mellitus II, sleep apnea, hypertension and sarcoidosis. Review of the Resident Register revealed Resident #12 was admitted to the facility on 11/05/13. 1. The 5/18/15 FL2 medication orders included: -An order for Lantus insulin 10units subcutaneously every evening (Lantus is a long acting insulin to control high blood sugar). -An order for Novolog sliding scale insulin (SSI) to be given before meals per the following sliding scale: <100 = 4 units, 101-125 = 5 units, 126 - 150 = 6 units, 151-175 = 7 units, "0 175 = 7 units", Notify doctor if blood sugar is greater than 250 for two consecutive readings (Novolog is a fast acting insulin that quickly lowers blood sugars). Review of Resident #12's record revealed: -Subsequent physician orders dated 5/18/15 as follows: -An order for Lantus insulin 6 units subcutaneously at bedtime. -An order to check blood sugars three times daily before meals and administer Novolog SSI as needed per the sliding scale as follows: <100 = 4 units, 101-125 = 5 units, 126 - 150 = 6 units, 151-175 = 7 units, >175 = 7 units, Notify doctor if blood sugar is greater than 250 for two consecutive days. Hand written addition, "If blood sugar is less than 100 give insulin with meal". -An order to check blood sugar before meals and at bedtime. Review of Resident #12's Medication	D 358		

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D 358	Continued From page 70 Administration Record for August 2015 revealed: -An entry for blood sugar to be taken before meals and at bedtime and handwritten below this an entry was Novolog SSI 100 unit/1ml as needed per the sliding scale as follows: <100 = 4 units, 101-125 = 5 units, 126 - 150 = 6 units, 151-175 = 7 units, >175 = 7 units, Notify doctor if blood sugar is greater than 250 for two consecutive days. Administration times were scheduled as 7:30 am, 11:30 am, 4:30 pm and 9:00 pm. -An entry for Lantus 6 units subcutaneously at bedtime scheduled at 9:00 pm. -The Novolog was documented as administered per sliding scale with meals and bedtime from August 1, 2105 to August 21, 2015. -The bedtime blood sugars were documented and Novolog SSI was documented as 6 units being administered every evening. -The Lantus insulin was documented as administered 13 out of 21 opportunities from August 1, 2105 to August 21, 2015. -Resident #12's blood sugar was taken four times a day from 8/01/15 to 8/21/15 and ranged from 64-184 with 12 readings below 100. -The Novolog was documented administered according to the sliding scale before meals incorrectly 7 times out of 63 opportunities in that the blood sugar was documented and there was no documentation that the insulin was given (no site, no initials). Review of Resident #12's MAR for September 2015 revealed: -Novolog was documented as administered per sliding scale before meals. -Lantus was documented as administered at bedtime and blood sugar taken at bedtime. Review of Resident #12's October 2015 MAR	D 358		

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D 358	Continued From page 71 revealed: -Novolog was documented as administered per sliding scale before meals from 10/01/15 - 10/08/15. -Lantus was documented as administered at bedtime and blood sugar taken at bedtime 10/01/15 - 10/08/15. -On 10/09/15 the Novolog was "re-written" and documented as administered before meals and at bedtime from 10/09/15 - 10/31/15. -The evening dose of Novolog was documented as 5 units administered every night with the exception of 10/24/15/ and 10/25/15 and 8 units of Novolog was documented as administered. -Lantus insulin was documented as administered every night in a separate entry with omissions on 10/07/15, 10/08/15 and 10/11/15 and 10/12/15. Review of the nurses notes in Resident #12's record revealed: -It was documented that on 8/22/15 Resident #12 was sent to the local hospital emergency department with signs of a stroke. -There was no documentation the physician was notified. -The facility was unable to provide an incident report this occurred. Interview with a resident during initial tour on 11/04/15 at 10:33 am revealed: -She was very concerned about the medication administration because she is routinely given the wrong medications and her friend, Resident #12, was sent to the hospital because Resident #12 told her the staff administered the wrong insulin. Interview with Resident #12's Responsible Party (RP) on 11/05/15 at 7:31 pm revealed: -This hospitalization really bothered him. -The RP got a call in the evening that reported to	D 358		

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the RP that Resident #12 was lethargic and weak and minimally responsive and instead of calling 911 they called the RP.
-Staff did not check Resdient #12's blood sugar prior to calling him despite her symptoms and that she was a known diabetic.
-The RP knew they did not check the resident's blood sugar as he knew the symptoms of low blood sugar, asked and they could not report the results.
-Resident #12 had regular blood sugars and was not a "brittle" diabetic.
-The RP had concerns prior to this hospitalization because the staff was administering Resident #12's Novolog insulin an hour before the resident's meals and he had to go in and instruct the medication staff on fast acting insulin and when to give it.
-The responsible party said, "They have no idea about the the types of insulin and on-set of action."
-Resident #12 had to refuse the insulin on several occasions because the staff brought it too early and this was after his instruction.
-The family always made sure Resident #12 had snacks because they were afraid her blood sugar might drop due to the timing of fast acting insulin administration.
-The RP said, "If they gave [Resident #12] the appropriate insulin that should never had happened. [Resident #12] eats a snack every night."
-He did not know if Resident #12 ate a snack snack but said that staff reported the resident ate 100% of dinner.
-He did report his concern to the Resident Care Coordinator (at the time) that there was a potential mix up with the insulin that resulted in Resident #12's hospitalization without any result.
-He reported his concern to the "next RN

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D 358	Continued From page 73 [Registered Nurse] in charge" and she said that she knew it was a concern and aggressively seeking training and having the RNs observe the medication passes. -Two weeks after this hospitalization his mother reported two different occasions she had to stop the MA because they were going to give her the wrong insulin. The Resident Care Coordinator was no longer employed by this facility and unavailable for interview. Review of Resident #12's History and Physical from the emergency department dated 8/22/15 revealed: -Resident #12 had a blood sugar of 31 and was effectively treated in the ambulance en route to the local emergency department. -The patient was awake, alert and appropriately conversant. -The etiology of the hypoglycemia was unclear as the patient reported normal intake and no change in diabetic regimen. -Hemoglobin A1c was 6.8% (a test that reflects how well blood sugars are being controlled and less than 7% is the therapeutic goal). Interview with Resident #12 on 11/09/15 at 8:17 am revealed: -The evening Resident #12 went to the hospital for low blood sugar the resident ate most of the evening meal which was Swedish meatballs. Resident #12 had a dose of insulin prior to supper, but did not know what type of insulin was administered. -Resident #12 got back to the room after 7:00 pm and ate a snack which was a whole ham and cheese sandwich and staff administered the oral medications and her insulin.	D 358		

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D 358	Continued From page 74 -Resident #12 was receiving assistance in the shower and started to feel lethargic. -Resident #12 was on a stretcher and knew it was an ambulance attendant because of the blue outfit. -Resident #12 heard the ambulance attendant say, "This baby needs some sugar, her blood sugar is 31!". -On two occasions after this hospitalization MAs attempted to administer the wrong insulin and the resident had to stop them and have them get the correct pen. -Resident #12 knew that it was the wrong kind of insulin, because the "Novolog is a dark blue pen with some orange on the label and the Lantus is a grayish pen"]. -The MAs had been administering Novolog too early before mealtime and they would "load me" up with cranberry juice so the resident's blood sugar would not drop and this upset the resident's "overall sugar balance". -The RP came in and instructed the MAs on the difference between the insulins and the on-set of action. -This helped but some of the MAs still act like they are irritated, because the resident needed to have it administered right before a meal. -Resident #12 stated, "The med techs need more education on Diabetes." -Resident #12 often worried about the medication that was administered and had on several occasions refused oral medications and insulin because they were incorrect. Attempted interview with the MA who administered medication the evening of 8/21/15 on 11/07/15 at 11:49 am was unsuccessful. Interview with a MA on 11/07/15 at 3:25 pm revealed:	D 358		

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D 358	Continued From page 75 -She gave the Lantus at night before bed and did not administer the Novolog. -She did not know why she documented the Lantus under the Novolog entry and the Lantus entry and it was confusing. -She did not receive training on the different types of insulin and did not receive training on the symptoms of low and high blood sugar. Interview with a MA on 11/06/15 at 5:04 am revealed: -She was not able to describe what the symptoms of high or low blood sugar were. -She could not remember when the last inservice was and did not recall having any inservices on diabetes or insulin. Interview with the Regional Nurse on 11/07/15 at 2:55 pm revealed: -The MAs were documenting they were giving 6 units of Lantus in the Novolog entry where they documented the evening blood sugar and they were also documenting the Lantus was being administered in the the Lantus entry. -She did not know why they were documenting the administration of Lantus in the Novolog entry and the Lantus entry. -She did not think the MA were administering Novolog every evening and they were only giving the Novolog with meals. Interview with Resident #12's Primary Care Physician on 11/06/15 at 8:47 am revealed: -He was aware of the hypoglycemic episode on 8/22/14, because he had seen Resident #12 since and he had access to the hospital records. -When a facility called his office there was documentation of this communication and his office was never notified by the facility about this episode.	D 358		

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D 358	Continued From page 76 -He did not know what attributed to her low blood sugar. 2. Review of Resident #12's current FL2 dated 5/18/15 revealed: -A physician's order for Rythmol 225 mg SR 1 tab daily (A medication used to treat heart rhythm problems) -A physician's order for Cardizem 120mg CD 1 tab twice daily (A medication used to treat high blood pressure and heart rhythm problems) Review of Resident #12's previous FL2 dated 11/29/13 revealed she also had diagnoses of atrial fibrillation, congestive heart failure and hypertension. Review of Resident #12's physician's orders revealed: -An order dated 8/19/15 that Rythmol SR and Cardizem CD were both discontinued. -An order dated 8/19/15 Coreg 6.25 mg was started (Coreg is a medication used to treat high blood pressures and heart rhythm problems). -An order dated 9/09/15 to obtain heart rate with the automated machine. Resident #12's family member was providing. -An order dated 9/16/15 to increase Coreg to 12.5 mg 1 tab twice daily. The Physician's Assistant (PA) wrote the order so that staff could utilize Coreg 6.25 mg - 2 tabs = 12.5 mg until this supply was exhausted.. -An order dated 9/28/15 to increase Coreg to 25 mg 1 tab twice daily. The PA wrote the order so staff could utilize Coreg on hand and give 6.25 mg - 4 tabs = 25 mg until the supply was exhausted. -An order dated 10/28/15 to discontinue Coreg 25 mg and to start Metoprolol 25 mg 1 tab three times daily.	D 358		

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D 358	Continued From page 77 A review of Resident #12's September 2015 MAR revealed: -Physician's orders dated 9/16/15 to increase Coreg were implemented 9/16/15. -Physician's orders dated 9/28/15 were transcribed on to the MAR as Coreg 6.25 mg take 4 tabs twice daily and was documented as administered 8:00 am 9/28/15. -The was no documentation of Coreg 25 mg (6.25 mg = 25 mg) having been administered the evening of 9/28/15 or at all on 9/29/15 and 9/30/15. -There was no documentation as to why the Coreg 25 mg (6.25 mg = 25 mg) was not administered the evening of 9/28/15 or at all on 9/29/15 and 9/30/15. A review of Resident #12's October 2015 MAR revealed: -An entry for Coreg 6.25 mg - take 4 tabs (=25mg) twice daily and documented as administered twice daily from 10/01/15 to 9:00 am 10/06/15. -An entry for Coreg 25 mg 1 tablet twice daily documented as administered 10/02/15 - 10/06/15 at 9:00am only and then entry was rewritten. -An entry for Coreg 25 mg 1 tab twice daily to start 10/06/15 at 9:00 pm and documented as administered 9:00 am and 9:00 pm on 10/07-10/08/15 and 9:00 am on 10/09/15 and then entry was rewritten. -An entry for Coreg 25 mg 1 tab twice daily documented as administered twice daily starting 10/09/15 at 9:00 pm through 10/28/15 at 9:00 pm with omission of administration at 9:00 pm on 10/12/15 and 10/15/15. -An entry for Metoprolol 25 mg was documented as administered 10/29/15 at 8:00 am and refused at 2:00 pm because "Resident wanted to talk to	D 358		

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daughter-in-law before taking the medication".
-Metoprolol 25 mg was not documented as administered at 8:00 pm 10/30 or 10/31/15.
-Resident #12 was not administered 4 out of 9 scheduled metoprolol tablets from 10/29/15 through 10/31/15.

Review of the facility's incident reports for Resident #12's dated 10/31/15 at 1:15 am revealed Resident #12 was sent to the local emergency room via ambulance because Resident #12 was having difficulty breathing with a blood pressure of 150/100, Pulse of 92 and Respirations of 22.

Observation of Resident #12's medication on hand on 11/06/15 at 7:15 am revealed:
-Three medication cards, 30 tablets each, of Metoprolol 25 mg dispensed 10/28/15.
-There were 7 tablets were missing or punched out and 83 tablets remaining.

Interview with Resident #12's primary care physician on 11/06/15 at 8:47 am revealed:
-Resident #12 had persistent tachycardia and they were trying to titrate her cardiac medication to resolve or reduce the tachycardia.
-He ordered that they document blood pressures, apical and radial pulse and oxygen saturation and report results to his office.
-The facility did report blood pressures and radial pulses but not apical pulses until redirected to do so.
-The facility did not report oxygen saturations because they do not have a bed side pulse oximeter which "is standard equipment when caring for these residents."
-The physician was trying to titrate her cardiac medications to treat her uncontrolled atrial fibrillation based on the information that the

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D 358	Continued From page 79 facility supplied. -He was not informed that there were medication errors related to the Coreg and the metoprolol. -It was possible that the medication errors could have lent themselves to Resident #12's heart failure but there is room for leeway given her age and this diagnosis. -"The real problem is the missing information and following our orders." _____ The facility provided a Plan of Protection on 11/06/15: Effective immediately, residents will receive medications as ordered. -Prior to their next shift, staff will be retrained on the expectations of medication administration by the director of Clinical Services. -An audit of all resident records will be conducted to ensure accuracy of medication administration. -An audit of all the medication cart will be conducted to ensure that all medications are available for administration. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 11, 2015.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based record reviews and interviews, the facility failed to assure that action was taken in response	D 406		

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D 406	Continued From page 80	D 406		

to a pharmacist recommendation including informing the resident's physician in 1 of 5 residents (Resident #3).

The findings are:

Review of Resident #3's record revealed a current FL2 dated 3/27/15 included diagnoses of:
-Diabetes Mellitus with hyperosmolarity
-History of urinary tract infection
-Pain in shoulder joint and h/o fracture
-Difficulty walking, pre-senile dementia
-Constipation
-History of falls
-History of pulmonary embolism.
-An order for aspirin 325 mg 1 tab daily.

Review of Resident #3's subsequent physician orders dated 9/16/15 revealed:
-A physician's order for aspirin 325mg 1 tablet daily.

Review of the Pharmacy Review in Resident #3's record revealed:
- A pharmacy consultant reviewed Resident #3's record on 9/04/15 but the findings were illegible.
-There was no consultation report or recommendation letter to physician in the record.

Review of Resident #3's October and November 2015 MAR's revealed an entry for aspirin 325 mg 1 tablet daily documented as administered every day at 8:00 am.

Interview with Regional Nurse on 11/05/15 at 1:25 pm revealed:
-She did not know where the pharmacy recommendations were after looking for them.
-She requested the consultant pharmacist email them to her and then she printed them.

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D 406	Continued From page 81 -She did not know why they had not been addressed. -The Resident Care Coordinator (RCC) was responsible for getting the pharmacy recommendations to the physicians but they did not have a RCC in place at that time. Review of Pharmacy Review dated 9/01/15 through 11/05/15 revealed a pharmacist recommendation for Resident #3 to reduce aspirin 325mg daily to aspirin 81 mg daily due to the risk of gastrointestinal and other bleeding. Interview with Resident #3's physician's Nurse on 11/06/15 at 4:16 pm revealed: -There was no record of Resident #3's Consultant Pharmacist recommendation having been faxed to their office. -The current dose of Aspirin was 325 mg daily.	D 406		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration, Staffing Personal Care Aide	D912		

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D912	Continued From page 82 Supervision, ACH Infection Prevention Requirements, ACH Medication Aides; Training and Competency, and management of facilities. The findings are: A. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 8 sampled residents (#12) which included errors with administration of Novolog insulin, Lantus insulin and Metoprolol 25 mg. [Refer to Tag 0358, 10A NCAC 13F .1004(a)Medication Administration (Type A2 Violation).] B. Based on observations, record reviews, and interviews the facility failed to ensure the Administrator was responsible for the total operations of the facility to maintain compliance in the rule areas including, Medication Administration, Resident Rights, Infection Prevention Requirements, Staffing of Personal Care Aides Supervisors, Personal Care and Supervision, Health Care, Nutrition and Food Service, Medication Orders, Medication labels, Declaration of Residents Rights, Adult Care Home Infection Prevention Requirements, ACH Infection Prevention Requirements, and Medication Aide Training and Competency. [Refer to Tag 0176. 10A NCAC 13F .0601(a) Management of Facilities (Type A2 Violation)]. C. Based on observations, and interviews, the facility failed to assure there was a designated supervisor on duty on third shift in the facility or within 500 feet and immediately available. [Refer to Tag 0215, 10A NCAC 13F .0605(c) Staffing Personal Care Aide Supervisors (Type B Violation).]	D912		

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D912	Continued From page 83 D. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Center for Disease Control Prevention guidelines on infection control regarding the use of "house" glucometers for multiple residents and sharing glucometers for 3 of 3 sampled residents (#3, #8, and #14) and storage and use of an insulin pen without any identification labeling of who the insulin pen belonged to. [Refer to Tag 0932, G.S. 131D-4.4(b)(1)Infection Prevention Requirements (Type B Violation).] E. Based on interview and record review, the facility failed to assure 3 of 6 sampled Medication Aides (Staff G, Staff H, and Staff I) received annual in-service training for infection control, safe practices for injections and glucose monitoring. [Refer to Tag 934, G.S. 131D 4.5B(a) ACH Infection Prevention Requirements (Type B Violation).] F. Based on interview and record review, the facility failed to assure 3 of 6 sampled medication staff met requirements to administer medications, prior to administering medication, one staff (Staff F) who was not competency validated to administer medications and 2 staff who did not (Staff A and Staff E). [Refer to Tag 935, G.S. 131D 4.5(b) ACH Medication Aides; Training and Competency (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 84 This Rule is not met as evidenced by: Based on observations, records reviews and interviews, the facility failed to assure all residents were free from verbal and physical abuse and neglect related to residents' rights and health care related to Resident Rights, Health Care Referral, and Personal Care and Supervision. The Findings are: A. Based on observations, interviews, and record reviews the facility failed to assure the rights of all residents are maintained and may be exercised without hindrance for 2 of 5 residents (Residents #3 and #11) regarding neglect related to not administering medications as ordered, pain medications, and not responding to call bells in a timely manner for 53 of 53 residents on the on the 2nd and 3rd floor. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).] B. Based on observations, interviews, and record reviews, the facility failed to assure staff assisted with showers for 3 of 5 sampled residents (Residents #9, #13 and #15) in accordance to the residents' personal care needs. [Tag to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to assure supervision for 2 of 2 sampled residents (#5 in the Memory Care Unit and #9 in the Assisted Living) with multiple falls. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).] D. Based on observations, interviews, and record reviews the facility failed to assure referral and	D914		

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D914	Continued From page 85 follow-up for 2 of 5 residents by not sending a resident out for medical evaluation (Resident #2) and not obtaining urine culture and sensitivity for one resident (Resident #13). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the	D932		

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D932	Continued From page 86 potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Center for Disease Control Prevention guidelines on infection control regarding the use of "house" glucometers for multiple residents and sharing glucometers for 3 of 3 sampled residents (#3, #8, and #14) and storage and use of an insulin pen without any identification labeling of who the insulin pen belonged to. The findings are: Observation on 11/4/15 at 10:00 pm of glucometers on the medication carts revealed: -Brand A glucometers. -Brand B glucometer "house" unlabeled case and unlabeled glucometer. -Brand C glucometers. -Brand D glucometer was unopened in the original box. -The glucometer cases were labeled with each resident's name. -The glucometers inside the case were labeled with the resident's name.	D932		

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D932	Continued From page 87 A. Review of Resident #3's current FL2 dated 3/27/15 revealed: -A diagnosis of diabetes. -A physican's order for finger stick blood sugar (FSBS) checks 4 times daily. Review on 11/4/15 of Resident #3's record revealed a subsequent signed physican order dated 9/16/15 for FSBS two times daily before breakfast and two hours after supper. Review on 11/4/15 at 9:00 pm of Resident #3's glucometer (Brand A) memory revealed: -On 10/25/15 eight FSBS were obtained between 5:10 am and 7:08 pm. -At 5:19 am FSBS 122 -At 5:35 am FSBS 166 -At 10:19 am FSBS 256 -At 1:44 pm FSBS 270 -At 4:09 pm FSBS 206 -At 6:52 pm FSBS 398 -At 7:00 pm FSBS 328 -At 7:08 pm FSBS 114 -On 10/26/15 five FSBS were obtained between 5:37 am and 8:24 pm. -At 5:37 am FSBS 201 -At 5:54 am FSBS 173 -At 10:54 am FSBS 282 -At 7:51 pm FSBS 252 -At 8:24 pm FSBS 214 -No additional FSBS readings were in Resident #3's glucometer (Brand A) memory until 11/4/15 at 6:51 am FSBS 257. Review on 11/4/15 at 9:15 pm of Resident #3's October 2015 Medication Administration Record (MAR) revealed: -FSBS was documented on the MAR two times daily at 7:00 am and at 8:00 pm.	D932		

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D932	Continued From page 88 -On 10/25/15 two FSBS documented on the MAR matched the readings from Resident #3's glucometer (Brand A) at 7:00 am FSBS 166 and at 8:00 pm FSBS 398. -On 10/26/15 two FSBS documented on the MAR matched the reading from Resident #3's glucometer (Brand A) at 7:00 am FSBS 173 and at 8:00 pm FSBS 244. -From 10/28/15 through 10/31/15 FSBS were documented on the MAR two times daily at 7:00 am and 8:00 pm, no additional readings were in Resident #3's glucometer (Brand A) history for October 29, 30, or 31, 2105. Review on 11/4/15 at 9:15 pm of Resident #3's November 2015 MAR revealed: -FSBS were documented two times daily at 7:00 am and at 8:00 pm. -On 11/4/15 one FSBS 257 documented on MAR at 7:00 am matched the reading from Resident #3's glucometer (Brand A) history on 11/4/15 at 6:51 am FSBS 257. -All other FSBS documented on the November MAR did not match the readings from Resident #3's (Brand A) glucometer. -Examples of FSBS documented on the November 2015 MAR are as follows: -On 11/1/15 at 8:00 pm FSBS 324, on 11/2/15 at 7:00 am FSBS 274, on 11/3/15 at 7:00 am FSBS 265 and on 11/4/15 at 8:00 pm FSBS 319, none of these FSBS matched entry in Resident #3's glucometer Brand A history for the same date and time. Review on 11/4/15 at 9:50 pm of the Brand B "house" glucometer memory revealed: -The meter was set to the current date and time. -There were multiple readings in the House glucometer's Brand B memory occurring at various times throughout the day. Examples	D932		

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D932	Continued From page 89 included: -10/29/15 at 8:01 am, 8:13 am, 12:05 pm, 5:26 pm, 7:31 pm. -10/31/15 at 6:45 am and 8:04 pm. -The following FSBS readings found in the unlabeled glucometer matched FSBS readings documented for the same date and time on Resident #3's MARs as follows: -10/31 at 8:04 pm FSBS 457 matched the FSBS documented on the resident's MAR for 8 pm on 10/31/15. -10/31 at 6:45 am FSBS 244 matched the FSBS documented on the resident's MAR for 7 am on 10/31/15 -10/29 at 7:31 pm FSBS 287 matched the FSBS documented on the resident's MAR for 8 pm on 10/29/15 -10/29 at 8:01 am FSBS 421 matched the FSBS documented on the resident's MAR for 7 am on 10/31/15 Interview on 11/6/15 at 10:15 am with Resident #3 revealed: -Her FSBS were obtained 2 times daily. -The staff brought a glucometer in her room and obtained her FSBS. -Sometimes the glucometer did not work and they used another glucometer. -The staff on second shift staff had trouble obtaining her FSBS. -She did not recall her name on the glucometer and never had seen the case the glucometer came in. -She relied on the Medication Aides to obtain her FSBS. Observation of the medication cart on 11/04/15 at 4:00 pm revealed: -A 3 ml Lantus Insulin Pen without a container or bag.	D932		

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D932	Continued From page 90 -The Lantus Pen had no label. -A second Lantus Pen in a plastic bag that labeled by the pharmacy for a different resident. Interview with a Medication Aide on 11/04/15 at 4:02 pm revealed: -She could not be sure the Lantus Insulin Pen belonged to Resident #3 but the only other Lantus pen was labeled for [resident's name] so they used the unlabeled pen for Resident #3. -The MA was not aware the insulin pens had to be labeled or in a labeled container. Refer to observation on 11/05/15 at 9:00 am of the medication cart for disinfecting products. Refer to review of the manufacturer's warnings for Brand A glucometer. Refer to review of the manufacturer's warnings for Brand B glucometer. Refer to review of the manufacturer's warnings for Brand C glucometer. Refer to review of the unopened Brand D glucometer manufacturer instructions. Refer to review of the facility policy, How to Clean and Maintain a Blood Glucose Meter. Refer to interview on 11/04/15 at 10:25 pm with a third shift medication aide MA. Refer to interview on 11/4/15 at 10:45 pm with another third shift Medication Aide (MA). Refer to interview on 11/5/15 at 8:15 am with a first shift MA.	D932		

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D932	Continued From page 91 Refer to interview on 11/5/15 at 9:30 am with the acting Executive Director. B. Review of Resident #14's current FL2 dated 9/14/14 revealed: -A diagnosis of diabetes type 2. -No physican's order for Fingerstick Blood Sugars (FSBS). Review of Resident #14's record revealed: -A subsequent signed physican's order for FSBS 2 times daily. -A recommendation sent to the physican on 10/18/15 documented Resident #14's FSBS was 406, "please advise". -A signed physican order dated 10/19/15 for FSBS 2 hours after lunch daily repeat for 2 days. -A signed physican order dated 10/28/15 for FSBS checks before meals and at night use sliding scale coverage Novolog Flexpen (A fast acting insulin to lower glucose in the blood) only before meals no coverage at night. Review on 11/4/15 at 10:00 pm of Resident #14's glucometer Brand A memory entries revealed: -On 10/24/15 at 2:44 pm an entry FSBS 320, no matched documented on Resident #14's MAR October 24, 2015 MAR. -From 10/25/15 through 10/29/15 no FSBS entry history in Resident # 14's (Brand A) glucometer memory.. -On 10/30/15 a entry reading from Resdient #14's Brand A glucometer for FSBS at 5:15 pm FSBS 369 and at 9:18 pm FSBS 304, both matched the entry on Resident #14's October 30, 2015 MAR. -On 11/3/15 a entry reading from Resident #14's Brand A glucometer memory at 12:37 pm FSBS 253 matched the entry documented on Resident #14's November 3, 2015 MAR.	D932		

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D932	Continued From page 92 Review on 11/4/15 at 9:40 pm of the House (Brand B) glucometer entries memory revealed: -The meter was set to the current date and time. -There were multiple entries in the glucometer's memory occurring at various times throughout the day examples follow: -10/29/15 at 8:01 am, 8:13 am, 12:05 pm, 5:26 pm, 7:31 pm. -10/31/15 at 6:45 am and 8:04 pm. Review of the House (Brand B) glucometer and Resident #14's MAR's for October 29, 2015 to November 4, 2015 revealed: -There were 4 FSBS entries recorded in the house glucometer Brand B memory that matched Resident #14 FSBS documented on the October 2015 and November 2015 MAR. -On 10/29/15 at 12:05 pm FSBS 305 entry in the house glucometer Brand B memory (matched Resident #14's FSBS documented on the MAR at 11:30 am on 10/29/15). -On 10/29/15 at 5:26 pm FSBS 454 entry in the house glucometer Brand B memory (matched Resident #14's FSBS documented on the MAR at 5:30 pm on 10/29/15). -On 11/4/15 at 8:47 am FSBS 215 entry in the house Brand B glucometer memory (matched Resident #14's FSBS documented on the MAR at 7:30 am on 11/4/15). -On 11/4/15 at 6:05 pm FSBS 215 entry in the house Brand B glucometer memory (matched Resident #14's FSBS documented on the MAR at 4:40 pm 11/4/15). Review on 11/4/15 at 10:15 pm of Resident #14's October 2015 MAR revealed: -FSBS were documented four times daily. -From 10/22/15 to 10/31/15 eighteen FSBS were documented on the MAR. -10 FSBS readings matched Resident #14	D932		

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D932	Continued From page 93 glucometer (Brand A) history entires. Review on 11/4/15 at 10:15 pm of Resident #14's November 2015 MAR revealed: -FSBS were documented four times daily. -12 matched Resident #14's Brand A glucometer history entries. -FSBS documented 11/3/15 at 7:30 am FSBS 287, no entry in Resident #14's Brand A glucometer memory on 11/3/15 at 7:30 am. -FSBS documented 11/4/15 at 7:30 am FSBS 215, no entry in Resident #14's Brand A glucometer memory on 11/4/15 at 7:30 am. -FSBS documented 11/4/15 at 11:30 am FSBS 337, no entry in Resident #14's Brand B house glucometer memory on 11/4/15 at 11:30 am. -On 11/2/15 at 8:00 pm FSBS 342 documented entry on MAR, no entry in Resident #14's glucometer (Brand A) history matched FSBS 342. Based on observation, record review and attempt interview on 11/03/15 it was determined that Resident #14 was not interviewable. Refer to observation on 11/05/15 at 9:00 am of the medication cart for disinfecting products. Refer to review of the manufacturer's warnings for Brand A glucometer. Refer to review of the manufacturer's warnings for Brand B glucometer. Refer to review of the manufacturer's warnings for Brand C glucometer. Refer to review of the unopened Brand D glucometer manufacturer instructions. Refer to review of the facility policy, How to Clean and Maintain a Blood Glucose Meter.	D932		

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D932	Continued From page 94 Refer to interview on 11/04/15 at 10:25 pm with a third shift medication aide MA. Refer to interview on 11/4/15 at 10:45 pm with another third shift Medication Aide (MA). Refer to interview on 11/5/15 at 8:15 am with a first shift MA. Refer to interview on 11/5/15 at 9:30 am with the acting Executive Director. C. Review of Resident #8's current FL2 dated 03/18/15 revealed: -Diagnoses included dementia and diabetes mellitus type II. -Medications and treatments to control blood sugars included Finger Stick Blood Sugars (FSBS) before meals and at bedtime (four times daily); and Novolog sliding scale. Review of Resident #8's record revealed no orders signed by the physician for FSBS once daily. Review of Resident #8's October 2015 Medication Administration Record (MAR) revealed: -Staff hand wrote FSBS once daily on the MAR. -FSBS was documented on the MAR once daily at 7:30 am. -Documentation FSBS were checked 30 times from October 1-31, 2015. Review of the Resident #8's November 2015 MAR revealed: -Staff hand wrote FSBS once daily on the MAR. -Documentation FSBS was checked 5 times from November 1-5, 2015.	D932		

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D932	Continued From page 95 Observation on 11/04/15 at 8:34 pm of Resident #8's glucometer revealed: -A Brand C glucometer. -The pouch and glucometer were labeled with Resident #8's name. -The glucometer was not set to the current date and time, but was off by 7 months and 5 hours. -21 FSBS results were in Resident #8's glucometer history. -8 of the FSBS results matched FSBS documented on Resident #8's MARs. -The remaining 13 FSBS results in Resident #8's glucometer did not match FSBS documented on the October or November 2015 MAR. -It could not be determined who the other FSBS readings were obtained for. Interview on 11/04/15 at 10:25 pm with a third shift medication aide (MA) revealed: -Resident #8's FSBS were not checked by her, because the resident's FSBS were checked on the first shift. -The glucometer with the resident's name on it was the glucometer that should be used to check the resident's FSBS. -The facility did not have a system in place that compared FSBS documented on the MARs with those in the glucometer to ensure FSBS glucometers were not shared. Interview on 11/05/15 at 5:30 pm with Resident #8 revealed: -He was a diabetic, his blood sugar was checked, but not daily. -He was unaware of the FSBS results, staff did not share results and he did not ask. -The glucometer used to check his FSBS was not labeled with his name. -He does not recall if a name was on the	D932		

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D932	Continued From page 96 glucometer. Refer to observation on 11/05/15 at 9:00 am of the medication cart for disinfecting products. Refer to review of the manufacturer's warnings for Brand A glucometer. Refer to review of the manufacturer's warnings for Brand B glucometer. Refer to review of the manufacturer's warnings for Brand C glucometer. Refer to review of the unopened Brand D glucometer manufacturer instructions. Refer to review of the facility policy, How to Clean and Maintain a Blood Glucose Meter. Refer to interview on 11/04/15 at 10:25 pm with a third shift medication aide MA. Refer to interview on 11/4/15 at 10:45 pm with another third shift Medication Aide (MA). Refer to interview on 11/5/15 at 8:15 am with a first shift MA. Refer to interview on 11/5/15 at 9:30 am with the acting Executive Director. D. Observation on 11/04/15 at 9:50 pm of the medication cart revealed: -An unlabeled black pouch with an unlabeled Brand B glucometer inside the pouch (house glucometer). -The meter was set to the current date and time. -The following FSBS readings found in the unlabeled glucometer matched readings on	D932		

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D932	Continued From page 97 Residents #3's, and #14's MARs as follows: 11/04 at 10:15 pm FSBS 419 11/04 at 6:05 pm FSBS 237 11/04 at 8:47 am FSBS 215 11/03 at 8:38 am FSBS 265 11/02 at 8:37 pm FSBS 560 11/02 at 9:00 am FSBS 274 11/01 at 9:58 pm FSBS 352 11/01 at 8:54 am FSBS 351 10/31 at 8:04 pm FSBS 457, on Resident #3's MAR 10/31 at 6:45 am FSBS 244, on Resident #3's MAR 10/30 at 7:53 am FSBS 274 10/29 at 7:31 pm FSBS 287, on Resident #3's MAR 10/29 at 5:26 pm FSBS 454 10/29 at 12:05 pm FSBS 305, on Resident #14's MAR 10/29 at 8:13 am FSBS 322 10/29 at 8:01 am FSBS 421, on Resident #3's MAR Refer to observation on 11/05/15 at 9:00 am of the medication cart for disinfecting products. Refer to review of the manufacturer's warnings for Brand A glucometer. Refer to review of the manufacturer's warnings for Brand B glucometer. Refer to review of the manufacturer's warnings for Brand C glucometer. Refer to review of the unopened Brand D glucometer manufacturer instructions. Refer to review of the facility policy, How to Clean and Maintain a Blood Glucose Meter.	D932		

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D932	Continued From page 98 Refer to interview on 11/04/15 at 10:25 pm with a third shift medication aide MA. Refer to interview on 11/4/15 at 10:45 pm with another third shift Medication Aide (MA). Refer to interview on 11/5/15 at 8:15 am with a first shift MA. Refer to interview on 11/5/15 at 9:30 am with the acting Executive Director. _____ Observation on 11/5/15 at 9:00 am of medication carts and nurse station revealed no PDI Super Sani-Clothes products in the facility. Review of the facility policy and procedure, How to Clean and Maintain a Blood Glucose Meter revealed: -The purpose of the policy was to provide associates on guidelines on how to clean/disinfect and maintain glucometer equipment. -Residents should have their own glucometer and it was to be intended for individual use only. -Use PDI Super Sani-Clothes products on the equipment waiting 2 minutes afterward to be effective. Review of the manufacturer's warnings for Brand A glucometer revealed the system is for one person use only, do not share the meter with anyone. Review of the manufacturer's warning for Brand B glucometer revealed the glucometer was designed for one person use, and not intended to be shared with multiple individuals. The	D932		

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D932	Continued From page 99 disinfecting instructions was to use approved PDI germicidal product. Review of the manufacturer's warnings for Brand C glucometer revealed the glucometer was for one person use only, do not share the meter with anyone. The disinfecting instructions were to use approved PDI germicidal product. Review of the unopened Brand D glucometer manufacturer instructions revealed the glucometer was for single use only and not intended to be shared with multiple individuals. Interview on 11/4/15 at 10:45 pm with a third shift Medication Aide (MA) revealed: -She was unaware of the unlabeled Brand B "house" glucometer. -She never obtained a FSBS on third shift, first shift obtained the FSBS. Interview on 11/04/15 at 10:25 pm with a second third shift medication aide (MA) revealed: -She was unaware where the unlabeled glucometer came from. -FSBS were not done on her shift (third shift), but obtained by the first shift medication aide. -Medication cart audits were supposed to be done on the medication cart for each shift. -Staff were to document items found on the medication cart that were removed or needed to be removed. -If medication cart audits were done as required, the unlabeled glucometer should have been identified. -The facility did not have a system in place that compared FSBS documented on the MARs with those found in glucometers to ensure staff did not use the same glucometer for more than one resident.	D932		

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D932	Continued From page 100 Interview on 11/5/15 at 8:15 am with a first shift MA revealed: -She was not aware where the unlabeled Brand B "house" glucometer came from. -She always used the resident's labeled glucometer for obtaining FSBS for the residents. -That was the facility policy and how she was trained to obtain the FSBS for the residents. -She cleaned the resident's individual glucometer before and after using with an "alcohol swab". -She had disinfected resident's individual glucometer the same way by using an alcohol swabs. Interview on 11/5/15 at 9:30 am with the acting Executive Director revealed: -She was unaware of the "house" glucometer or the sharing of glucometers between residents. -She thought it might had been the previous company policy to share glucometer, but was not the policy of the current owners. -She was not sure when the MAs had their diabetic training class. -The facility policy was every resident had their own glucometer and it was used only on that individual resident. -They would immediately buy new glucometers for all diabetic residents and label the glucometer and the case with residents' names. -They would immediately hold an in-service and discuss the safety and policy of not sharing glucometers. _____ The facility provided the following Plan of Protection on 11/06/15: -The District Director of Clinical Services will verify that all glucometers are replaced with new ones effective 11/05/15.	D932		

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D932	Continued From page 101 -Monitoring of glucometer usage will occur every shift by the MAs daily effective 11/05/15. -The interim Health and Wellness Director and/or District Director of Clinical Services will monitor the glucometers weekly for one month then quarterly thereafter. -A glucometer monitoring form will be utilized to document and verify monitoring. -The interim Health and Wellness Director, the District Director of Clinical Services and/or the nurse's designee will conduct staff in-services on glucometer usage, applicable policies and the use of the glucometer monitoring form. -Applicable staff will be retrained in the areas of infection control and diabetes. -A mandatory diabetic training will be conducted by the contracted pharmacy on 11/16/15. -Infection control training will also be held 11/16/15 and again on 11/17/15 and will be hosted by the interim Health and Wellness Director and/or the District Director of Clinical Services. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 26, 2015.	D932		
D934	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	D934		

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D934	Continued From page 102 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: TYPE B VIOLATION Based on interview and record review, the facility failed to assure 3 of 6 sampled Medication Aides (Staff G, Staff H, and Staff I) received annual in-service training for infection control, safe practices for injections and glucose monitoring. The findings are: A. Review of Staff G's personnel record revealed: -Staff G had passed her Medication Exam on 7/20/00. -Staff G was validated on 2/10/00 using the Medication Clinical Skills Checklist. -There was no documentation that Staff G had ever received the mandated Infection Control Course. Refer to Interview with the District Director of Operations on 11/9/15 at 10:30 am. Refer to Interview with the Business of Manager on 11/9/15 at 10:45 am.	D934		

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D934	Continued From page 103 B. Review of Staff H's personnel file revealed the following: -Staff H was hired on 5/1/12 as a Medication Aide. -Staff H had passed her Medication Exam on 12/11/12. -Staff H was validated on 5/20/12 using the Medication Clinical Skills Checklist. -There was no documentation that Staff G had ever received the mandated Infection Control Course. Refer to interview with the District Director of Operations on 11/9/15 at 10:30 am. Refer to interview with the Business of Manager on 11/9/15 at 10:45 am. C. Review of Staff I's personnel file revealed the following: -Staff I was hired on 6/7/13 as a Medication Aide. -Staff I had passed her Medication Exam on 2/25/13. -Staff I was validated on 6/14/13 using the Medication Clinical Skills Checklist. -There was no documentation that Staff G had ever received the mandated Infection Control Course. Refer to interview with the District Director of Operations on 11/9/15 at 10:30 am. Refer to interview with the Business of Manager on 11/9/15 at 10:45 am. _____ Interview with the District Director of Operations on 11/9/15 at 10:30 am revealed: -The facility has an approved infection control	D934		

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D934	Continued From page 104 program that incorporates the State approved course and company standards. -She was aware that some staff were missing documents and training requirements to assigned job duties. -She was pulling staff and Regional Directors into the community to complete an audit of all personnel files. -Interview with the Business of Manager on 11/9/15 at 10:45 am revealed: -She files the information in the personnel file or a designated notebook once the information is received. -She stated she had never completed an audit of the personnel files. -She reported receiving training on her current position, but was told by the previous administrator not to set-up personnel files in the manner she was trained. The facility provided a Plan of Protection on 11/09/15: -Effective immediately, the interim Executive Director, Health and Wellness Director, or Manager Designee will monitor Infection Control practices and expectations prior to their next shift. -A mandatory Infection Control Class will be conducted on Monday, 11/16/15 and on 11/17/15. Infection Control Trainings will be hosted by the interim Health and Wellness Director and/or District Director of Clinical Services. Infection Control Classes will be offered annually thereafter. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 26, 2015	D934		

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D935	Continued From page 105	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (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	D935		

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BROOKDALE COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(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
D935	Continued From page 106 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 review, the facility failed to assure 3 of 6 sampled medication staff met requirements to administer medications, prior to administering medication, one staff (Staff F) who was not competency validated to administer medications and 2 staff who did not (Staff A and Staff E). The findings are: A. Review of Staff F personnel record revealed: -Staff F was hired as a Resident Care Aide on 4/14/15. -Staff F was promoted to a Medication Aide on 5/7/15. -Staff F passed her Medication Exam on 3/26/15. -Staff F completed the State Mandated Medication Training on 8/26/14 and 8/27/14. -There was no documentation in the personnel file where the medication administration clinical skills checklist had been completed. Interview with the District Director of Operations on 11/9/15 at 10:30 am revealed: -The facility Nurse was responsible for completing the medication clinical skill checklist. -She was not aware Staff F did not meet all the requirements of being a MA.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 107 Interview with the Business of Manager on 11/9/15 at 10:45 am revealed: -The facility Nurse was responsible for completing the medication clinical skill checklist. -Staff F was not validated using the medication clinical skills checklist prior to exiting the facility. -Staff F was not available for interview. Refer to Interview with the District Director of Operations on 11/9/15 at 10:30 am. Refer to Interview with the Business of Manager on 11/9/15 at 10:45 am. B. Review of staff A's personnel file revealed: -Staff A was hired on 2/24/14 as a Resident Care Aide and promoted to a Medication Aide on 10/15/15. -Staff A had passed her Medication Exam on 8/18/00. -Staff A was validated on 3/21/14 using the Medication Clinical Skills Checklist. -There was no documentation of completion of the 5-hour training program and the 10-hour training program developed by DHHS. Interview with the District Director of Operations on 11/9/15 at 10:30 am revealed the facility has a policy that staff cannot be checked off on Medication Clinical Skills Checklist unless the employee has completed the 5-hour and 10-hour training programs. Refer to Interview with the District Director of Operations on 11/9/15 at 10:30 am. Refer to Interview with the Business of Manager on 11/9/15 at 10:45 am.	D935		

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D935	Continued From page 108 C. Review of Staff E personnel file revealed: -Staff E was hired on 8/24/15 as a Medication Aide. -Staff E had passed her Medication Exam on 5/26/15. -Staff E was validated on 9/11/15 using the Medication Clinical Skills Checklist. -There was no documentation of completion of the 5-hour training program and the 10--hour training program developed by DHHS. Interview with the District Director of Operations on 11/9/15 at 10:30 am revealed: -The facility has a policy that staff cannot be checked off on Medication Clinical Skills Checklist unless the employee has completed the 5-hour and 10-hour training programs. -She was not aware that Staff E had not completed the 5-hour and 10-hour course developed by DHHS. -There was no documentation presented that Staff E completed the 5-hour and 10-hour training program developed by DHHS prior to exiting the facility. -Staff E was not available for interview. Refer to Interview with the District Director of Operations on 11/9/15 at 10:30 am. Refer to Interview with the Business of Manager on 11/9/15 at 10:45 am. _____ Interview with the District Director of Operations on 11/9/15 at 10:30 am revealed: -The facility has a policy that staff cannot be checked off on Medication Clinical Skills Checklist unless the employee has completed the 5-hour and 10-hour training programs.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 109 -She was aware that some staff were missing documents and training requirements to perform assigned job duties. -She was pulling staff and regional directors into the community to complete an audit of all personnel files. Interview with the Business of Manager on 11/9/15 at 10:45 am revealed: -She files the information in the personnel file or a designated notebook once the information is received. -She stated she had never completed an audit of the personnel files. -She reported receiving training on her current position, but was told by the previous administrator not to set-up personnel files in the manner she was trained. The Facility provided a Plan of Protection on 11/09/15: -An audit of associate files will be conducted by the interim Executive Director, Business Office Manager and/or designee to identify associates without proper LHPS, training, and competency. -Those currently known to be out of compliance will receive competency by an RN prior to their next shift. Verification of Med Aide certification and documentation of competency will be available in the associate's file. -Each associate will receive Skills Competency Evaluation and/or Medication Skills Competency Evaluation by an RN prior to working an independent assignment. -Audits of associate files will continue quarterly past hire to assure compliance. -Verification of Med Aide certification and documentation of competency will be available in the associate's file.	D935		

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D935	Continued From page 110 THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 26, 2015.	D935		