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	HAL092143	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZEBULON HOUSE	551 PONY ROAD ZEBULON, NC 27597

(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 conducted an annual survey on 10/22/15 - 10/23/15 and 10/26/15.	D 000		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interview the facility failed to assure the dining room chairs, the dining room table legs, the shared bathroom, and the lounge areas were free of stains, scratches, and holes. The findings are: Observation of the dining room chairs in the Special Care Unit dining room on 10/22/15 at 2:07 PM revealed: -There were 19/25 chairs with black wet stains on the seat cushions of the chairs. -There were 25/25 chairs with scratches and dried up food particles around the wood areas of the chair. - There were 25/25 chairs with cloth cushions in them. Observation of the Special Care Unit dining room on 10/22/15 at 2:09 PM revealed the bottoms of the tables had brown food and dirt particles built up on and around them.	D 076		

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D 076	Continued From page 1 Observation of the lounge area located in the Special Care Unit on 10/23/15 at 5:05 p.m. revealed: -The light blue vinyl loveseat had a large area of missing vinyl on the left arm. -The front two wooden legs of a light blue chair with arms were scratched up and down the length of the legs. -One chair without arms had dark brown stains on the tan seat area. -A dark green chair with dark green padding on the arms had dark brown stains on the seat area. Observation of the resident common bathroom in the Special Care Unit on 10/23/15 at 5:15 p.m. revealed: -One chair without arms had several large dark brown stains on the seat area. -One large wooden chair with a padded high back and black seat had several worn and stained areas on the back and seat of chair. -Two large tan padded, vinyl covered chairs had dark brown stains on the seat areas. Observation of the dining room chairs in the Assisted Living dining room on 10/26/15 at 9:33 AM revealed: -There were 27/27 chairs with a black wet looking stains on the seat cushions of the chairs. -There were 27/27 chairs with scratches around the wooded areas of the chairs. Interview with the Special Care Unit Coordinator on 10/23/15 at 12:08 PM revealed: -Staff does not clean the chairs due to the cloth cushions. The cushion would be wet if you cleaned it. -The facility is in the process of getting new furniture.	D 076		

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D 076	Continued From page 2	D 076		

Interview with a housekeeping person on 10/26/15 at 9:50 AM revealed;
-The upholstery in the chairs gets cleaned once a month.
-The upholstery was cleaned with a sanitizer spray.
-If there was a spill then it would be cleaned at that time.
-She did not clean the chairs in the dining room.
-The other housekeeping person was responsible for cleaning the chairs in the dining room.

Interview with the Resident Care Coordinator on 10/26/15 at 10:34 AM revealed:
-She was unsure who was responsible for cleaning the chairs in the dining rooms or if they got cleaned.
-She thought housekeeping was responsible for cleaning the chairs.
-She felt the dining room chairs should only be cleaned when they got spots on them.
-She was not sure how often the chairs were cleaned.
-None of the residents have complained about the chairs being dirty.

Interview with the Administration on 10/26/15 at 10:37 AM revealed:
-During the day the housekeeping and the kitchen staff cleaned the dining room in the assisted living.
-The 3rd shift Personal Care Aides were responsible for cleaning the chairs.
-The Personal Care Aides were to spray the chairs with a cleaning solution and scrub them.
-Not all of the chairs got cleaned every night because there were so many chairs.
-The Personal Care Aides should clean the cloth in the chairs and wash the legs of the chairs.
-Some of the residents have complained to her

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D 076	Continued From page 3 about the condition of the chairs. -She had already talked to corporate about getting some new chairs. -Staff would need to keep cleaning the chairs until the facility got new chairs. -Staff used a fabric protector for the chairs when they first got them, but over time the chairs have just gotten dirty. - The Administrator said there was a log book for the Personal Care Aides to sign where they have cleaned the chairs each night. Interview with the Administrator on 10/26/15 at 4:08 PM revealed: -The last time she requested new furniture was some time around March or April of 2015. -The request was sent via e-mail, but currently she did not have the e-mails. -She checked the cleaning logs every morning to see if the aides had cleaned the chairs.	D 076		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure the walk-in coolers shelves and floors, the food storage bins, the ice machine, the reach-in cooler, and the floors in both dining rooms the assisted living and the special care unit dining rooms were cleaned and free of contamination.	D 282		

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D 282	Continued From page 4 The findings are: Observation of the dining room on the assisted living on10/22/15 at 10:19 AM revealed: -Three out of four walls had dried brown stains. -The wallpaper on 3 out of 4 the walls was noted to be coming off. Observation of the dining room in the assisted living on 10/22/15 from 10:22 AM to 10:25 am revealed: -Two out of four walls had a black stain noted about ¾ of the way down the wall. -The wall closest to the entry of the dining room had a brown stain running horizontal near the bottom of the wall. -The wall closest to the entry of the kitchen had a brown stain running horizontal near the bottom of the wall. -The door way entry to the kitchen had caked up brown and orange food stains on the frame. -The door frame had brown rusted spots and peeled paint. Observation of the kitchen area on 10/22/15 at 10:35 AM revealed: -There were three large white storage bins, which were located under a table in the kitchen. -One storage bin labeled sugar had white dried particles on top of the lid. -The storage bin labeled flour had some brown particles on top of the lid which appeared to be coffee grounds. Observation of the handwashing sink in the kitchen on 10/22/15 at 10:37 AM revealed brown stains were around the handles and the spout of the sink.	D 282		

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D 282	Continued From page 5 Observation of the ice maker in the kitchen on 10/22/15 at 10:44 revealed: -The top of the ice maker was wet and had brown rust spots. -Black grime had built up around the inside of the lid. -Ice was not touching the inside of the lid. -There was a leak around the top portion where the filtration system was located. -There was black dirt and grime built up around the outside of the lid. Observation of the walk-in cooler on 10/22/15 at 4:50 PM revealed: -There was dried up sticky yellow grime on the floor under the racks. The racks had food on them. -There was a black sticky substance under the rack which contained the milk. Observation of the dry food storage on 10/22/15 at 4:56 PM revealed: -There was small particles of brown food and dirt on the floor. -There was small white food particles on top of the sweet and low container. -There was small white food particles on top of the brown sugar and sugar packet containers. Interview with a Cook on 10/22/15 at 10:46 AM revealed: -The ice machine was cleaned twice per month. -The kitchen was cleaned after every meal. -The dietary staff swept and spot mopped the dining room after every meal. -The Personal Care Aide's wiped the tables down after each meal. Observation of the Special Care Unit dining room floor on 10/22/15 at 2:02 PM revealed the floors	D 282		

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D 282	Continued From page 6 were sticky and had hard dried white, brown, and orange food particles. Interview with the Special Care Unit Coordinator on 10/22/15 at 4:30 PM revealed: -The first and second shift personal care aides swept the special care unit dining room. -The third shift personal care aides mopped the special care dining room at night. -The floor is mopped at night so the resident's did not fall. Interview with a second Cook on 10/22/15 at 4:57 PM revealed: -The dietary staff cleaned each container lid after each use and after each meal. -The dietary staff swept and spot mopped the dining room floor after each meal. Interview with a third Cook on 10/23/15 at 1:10 PM revealed: -She was the prior dietary supervisor. -The Personal Care Aides cleaned the dining room tables after every meal. -The dietary staff clean the floor. -Dietray staff swept and spot mopped the floor after each meal. -Dietary had a log for big cleaning jobs such as the walk-in cooler or the ice machine. -Food storage areas and food container bins are cleaned once a day usually on 1st shift. -Dietary staff attempted to scrub underneath the racks in the walk in cooler using a mop and bleach. -Staff was unable to clean all the built up grime and black substance on the walk-in cooler floor because they could not move the racks around. -The current log book did not have any documentation of cleaning. -She had not been working at the facility for 3	D 282		

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D 282	Continued From page 7 weeks and was unsure of when the last time the walk-in cooler and the ice maker were cleaned. Interview with a fourth Cook on 10/23/15 at 4:46 PM revealed: -The kitchen staff cleaned the dining room after each meal. -They swept and spot mopped the kitchen after each meal. -She said housekeeping swept and mopped the whole floor every morning. Interview with a Housekeeping staff member on 10/23/15 at 4:48 PM revealed: -He does some maintenance and housekeeping. -He usually covered the special care unit on the days when there was 2 housekeepers working. -He cleaned both the special care unit and the assisted living on days he worked by himself. -He swept and mopped the special care unit dining room after every meal. -He swept and mopped the assisted living dining room on the days he cleaned the assisted living and the special care unit. -The Personal Care Aides cleaned all the tables and table legs in the dining room. Interview with a Personal Care Aide on 10/23/15 at 5:03 PM revealed the aides clean the tables after each meal. Interview with the Resident Care Coordinator on 10/26/15 at 10:34 AM revealed housekeeping and the dietary staff were responsible for sweeping and mopping the dining room floors. Interview with the Administration on 10/26/15 at 10:37 AM revealed: -During the day the housekeeping staff and the dietary staff cleaned the dining room in the	D 282		

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D 282	Continued From page 8 assisted living. -The dietary staff was responsible for mopping the floor after dinner. -The 3rd shift Personal Care Aides swept and mopped the dining room in the special care unit. Interview with the Administrator on 10/26/15 at 4:08 PM revealed: -The dietary staff should clean each container after each use. -The dietary staff should clean the floor and wipe down the counters after each meal. -She walked through the kitchen several times a day to make sure it was cleaned. -The ice maker was wiped down each day and it got a thorough cleaning each month. -The ice machine was thawed out monthly. -The dietary staff should clean the walk-in cooler every day.	D 282		
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: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 14	D 358		

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residents (#8, #9, #10) observed during the medication pass which included errors with the administration of insulin, an inhaler, a calcium supplement, and a cranberry supplement. The findings are:

The medication error rate was 13% as evidenced by the observation of 4 errors out of 29 opportunities during the 2:00 p.m. and 4:00 p.m. medication passes on 10/22/15 and the 8:00 a.m. and 12:00 noon medication passes on 10/23/15.

1. Review of Resident #10's current FL-2 dated 06/26/15 revealed diagnoses included diabetes mellitus, stroke, hypertension, hyperlipidemia, history of gout, duodenal resection status post cancer, anemia, urinary tract infection, and gastroesophageal reflux disease.

Review of a physician's order dated 10/05/15 revealed an order for Humalog 14 units 3 times daily with meals. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before eating a meal.)

Review of the October 2015 medication administration record (MAR) revealed:
- There was an entry for Humalog inject 14 units 3 times a day with meals.
- Humalog was scheduled to be administered at 7:45 a.m., 11:45 a.m., and 4:45 p.m.

Observation during the medication pass on 10/23/15 revealed:
- The medication aide checked Resident #10's blood sugar at 11:40 a.m. and it was 130.
- The medication aide administered 14 units of Humalog insulin to the resident at 11:43 a.m.
- The medication aide stated lunch was served at

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D 358	Continued From page 10 12:00 noon. Interview with Resident #10 on 10/23/15 at 12:10 p.m. revealed: - The resident was in the dining room waiting for lunch. - She usually got her meal about 10 to 15 minutes after she received her insulin. - They were sometimes late serving meals. - Her blood sugar had dropped once a long time ago when she first came because she had to wait a while before getting her meal. - She denied any current symptoms of low blood sugar. Observation on 10/23/15 revealed Resident #10 was not served lunch until 12:18 p.m., 35 minutes after receiving Humalog, a rapid-acting insulin, instead of with the meal as ordered. Interview with the medication aide on 10/23/15 at 1:14 p.m. revealed: - The facility's policy was to give insulin ordered with meals 15 minutes before the resident eats. - The Humalog is fast-acting and should not be given no more than 15 minutes before the meal. - She did not realize lunch was served late today. - Lunch was usually on the table at 12:00 noon. Interview with the Resident Care Coordinator (RCC) on 10/23/15 at 1:20 p.m. revealed: - The facility's policy was to give insulin ordered with meals right before the meal or at least within 20 minutes of the meal. - She thought lunch was usually served at 11:30 a.m. - The diabetic residents were supposed to be served first. - She would contact the physician to get a specific time frame so it would be clear to staff	D 358		

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D 358	Continued From page 11 when the insulin should be administered. Review of a new prescription dated 10/23/15 revealed a new order to administer Humalog insulin no more than 30 minutes prior to each meal. Review of the October 2015 medication administration record revealed Resident #10's blood sugar ranged from 73 - 324. 2. Review of Resident #9's current FL-2 dated 09/16/15 revealed diagnoses included asthma, Alzheimer's dementia, memory loss, essential tremor, abnormal involuntary movements, hypertension, hyperlipidemia, and weight loss. A. Review of Resident #9's record revealed: - Order on the current FL-2 dated 09/16/15 for Flovent HFA 110mcg inhaler 1 puff twice daily. (Flovent is used to treat asthma.) - Subsequent physician's order dated 10/16/15 for Flovent HFA 110mcg 2 puffs daily in the morning, rinse mouth after each use. (The manufacturer recommends rinsing mouth after use of Flovent to reduce the risk of getting a fungal infection of the mouth.) Review of a list of medications signed by a family nurse practitioner (FNP) for Resident #9 revealed: - The list was not dated. - FNP noted to schedule the resident's medications as listed. - The list included Flovent 2 puffs in the morning (no strength was specified). - The list included BreatheRite MDI Spacer (inhalational spacing device) as needed. (A spacer is a plastic cylinder device that an inhaler can be attached to so when pressed the vapors	D 358		

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D 358	Continued From page 12 go into a holding chamber to allow the user to breathe in the vapors slowly and deeply so the medication can reach the lungs easier.) Review of the October 2015 medication administration record (MAR) revealed: - An entry for Flovent HFA 110mcg inhale 2 puffs every morning, rinse mouth after each use. - Flovent was scheduled to be administered at 8:00 a.m. - There was no documentation regarding a BreatheRite spacer device included on the MAR. Observation of the medication pass on 10/23/15 revealed: - The medication aide administered 1 puff of Flovent 44mcg to Resident #9 at 8:54 a.m. - The medication aide did not instruct the resident to inhale the medication when the inhaler was pressed down nor to hold breath in for approximately 10 seconds to allow the medication to reach the lungs. - Some of the medication vapors came back out of the resident's mouth. - The medication aide did not offer a second puff to the resident. - The medication aide did not ask the resident to rinse her mouth. - A spacer device was not used. Interview with the medication aide on 10/23/15 at 10:20 a.m. revealed: - She did not notice the inhaler on hand was Flovent 44mcg and the MAR listed Flovent 110mcg. - The Flovent 44mcg was the only Flovent inhaler on hand for this resident. - She did not notice the instructions on the MAR was for 2 puffs instead of 1 puff. - She usually gave 1 puff to the resident.	D 358		

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- She usually gave the inhaler after breakfast and had the resident to rinse her mouth.
- She did not ask the resident to rinse her mouth today because she was in the dining room.
- She was not aware of a spacer device for this resident and had not used one for the resident.
- The resident's family provided her medications.

Review of the medications on hand for Resident #9 on 10/23/15 revealed:
- One Flovent 44mcg inhaler with instructions for 2 puffs twice daily.
- There was no spacer device on hand for this resident.

Interview with Resident #9 on 10/23/15 at 10:15 a.m. revealed:
- She usually gets 1 puff of the inhaler.
- She did not usually rinse her mouth.

Interview with Resident #9's family member on 10/23/15 at 10:17 a.m. revealed:
- She usually got the resident's medications from a mail order pharmacy.
- The resident's medications had not changed.
- The Flovent on hand is what the resident was supposed to receive.
- The resident was supposed to rinse her mouth after using the inhaler.
- She brought a spacer device (clear with blue ends) to the facility when the resident was admitted and it was supposed to be used when the resident received her inhaler.
- The resident has not had any recent flare ups with her asthma.

Interview with the Special Care Coordinator (SCC) on 10/23/15 at 10:30 a.m. revealed:
- The facility received the list of medication orders from the FNP after the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092143	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZEBULON HOUSE	551 PONY ROAD ZEBULON, NC 27597

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14	D 358		

admitted on 09/21/15.
- She did not notice the order for the Flovent was incomplete so the physician had not been contacted to clarify the order.
- Medication aides were supposed to stop if the medications on hand do not match the MARs.
- She thought Resident #9 had a spacer device but she was not sure because the family brought the resident's medications.
- The resident's mouth should be rinsed after using the inhaler.
- She would contact the physician to clarify the order.

Review of clarification order dated 10/23/15 revealed the physician wrote an order to discontinue Flovent 110mcg and start Flovent 44mcg 2 puffs at 8:00 a.m.

B. Review of a list of medications signed by a family nurse practitioner (FNP) for Resident #9 revealed:
- The list was not dated.
- FNP noted to schedule the resident's medications as listed.
- The list included Cranberry pill OTC (over-the-counter) should be given in the morning.
- The strength of the Cranberry tablet and the number of tablets to be administered was not included.

Review of the October 2015 medication administration record (MAR) revealed there was no entry for Cranberry tablets on the MAR.

Observation of the medication pass on 10/23/15 revealed no Cranberry tablets were administered to Resident #9 when she received her other morning medications at 8:52 a.m.

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D 358	Continued From page 15 Interview with the medication aide on 10/23/15 at 10:20 a.m. revealed: - There was a bottle of Cranberry tablets provided by the resident's family. - She did not administer the Cranberry tablets because it did not come up on the electronic MAR. Review of the medications on hand for Resident #9 on 10/23/15 revealed an OTC bottle of Cranberry 4200mg tablets. Interview with the Special Care Coordinator (SCC) on 10/23/15 at 10:30 a.m. revealed: - The facility received the list of medication orders from the FNP after the resident was admitted on 09/21/15. - She did not notice the order for the Cranberry tablets was incomplete so the physician had not been contacted to clarify the order. - She would contact the physician for clarification. - The resident had not had any urinary tract infections to her knowledge. Review of clarification order dated 10/23/15 revealed the physician noted the resident should be receiving Cranberry 4200mg 1 tablet once daily at 8:00 a.m. 3. Review of Resident #8's current FL-2 dated 07/17/15 revealed: - Diagnoses included dementia, coronary artery disease, hypertension, peptic ulcer disease, anemia, and history of prostate cancer status post prostatectomy. - Order for Calcium 600mg with Vitamin D 400 IU take 1 tablet twice daily. (Calcium with Vitamin D is a supplement.)	D 358		

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D 358	Continued From page 16 Review of the October 2015 medication administration record (MAR) revealed: - There was an entry for Calcium with D 600/400 take 1 tablet twice daily. - The Calcium with Vitamin D was scheduled to be administered at 8:00 a.m. and 8:00 p.m. Observation of the medication pass on 10/23/15 revealed: - The medication aide administered one Calcium 600mg tablet to Resident #8 at 8:38 a.m. - The Calcium tablet did not contain Vitamin D as ordered. Interview with the medication aide on 10/23/15 at 9:55 a.m. revealed: - They order Resident #8's medications from the veteran's administration (VA) pharmacy. - The facility bought the over-the-counter bottle of Calcium a couple of months ago while they were waiting for the VA to send the resident's medication. - She thought the order was going to be changed because they had bought the plain Calcium without Vitamin D. - She did not notice the order was still for Calcium with Vitamin D on the MAR. - They have ha bottle of Calcium with Vitamin D dispensed from the VA on hand. - She was trying to use of the bottle of Calcium before they started the supply from the VA. - She would start using the Calcium with Vitamin D as ordered. Review of medications on hand for Resident #8 on 10/23/15 revealed: - One bottle of Calcium 600 with Vitamin D 400 was dispensed on 07/30/15. - The bottle had not been opened.	D 358		

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