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{D 000}	Initial Comments The Adult Care Licensure Section and the Henderson County Department of Social Services conducted a follow up survey and complaint investigation on-site December 8-10, 2015. A telephone exit was conducted on December 14, 2015.	{D 000}		
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 A1 Violation Based on interview and record review, the facility failed to notify the prescribing physician when laboratory tests (blood for hematology and stool samples for occult blood) were not completed timely as ordered for 1 of 5 sampled residents (#5), resulting in Resident #5's hospital admission and Resident #5 died. The findings are: Review of Resident #5's current FL2, dated 6/5/15, revealed diagnoses included: -Stage IV kidney disease -Anemia Review of Resident #5's Resident Register revealed an admission date of 5/21/15. Review of physician visit for Resident #5, dated 10/29/15, revealed diagnoses included:	D 273		

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-Raynaud's disease
-FAST stage dementia (FAST means Functional Assessment Staging, a seven stage system based on level of functioning and daily activities.)
-Nomocytic anemia of chronic disease
-Hypercalcemia
-Hyperparathyroidism
-Asthma

A. Review of physician's orders for Resident #5, dated 9/29/15, revealed weekly CBC's (Complete Blood Count) and Procrit 4000 units every week for hemoglobin (Hgb) < 10. (The lab listed normal range for Hgb as 12.0 to 16.0 gm/dL. Procrit is used to treat anemia in patients with chronic kidney disease.)

Review of physician orders, dated 11/17/15, revealed an order for "CBC every week starting next week. Procrit 4000 units every week for Hgb < 10."

Review of Resident #5's CBC lab work drawn on 11/30/15 at the facility revealed a Hgb level of 4.8 and designated as LC (low critically).

Review of record revealed the following Hgb results and Procrit injections from 09/23/15 through 11/17/15:
9/23: 10.8
9/30: 9.2 Procrit administered.
10/7: 8.0 Procrit administered
10/14: 14.5
10/21: 13.0
10/28: 12.7
11/6: 12.4
11/17: 9.8 Procrit administered

Interview with the Administrator on 12/09/15 at 11:25am revealed:

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D 273	Continued From page 2 -The local hospital lab staff routinely came (usually once per week or as ordered) to the facility to draw blood for any residents with orders for lab work. -Lab staff's routine was to come into the facility, pick up requisition forms which have the resident's name and lab required written on each form, draw each lab, and leave a copy of the requisition form in the facility office. -Resident #5 was scheduled to receive a CBC blood draw on 11/25/15 and lab staff were scheduled to be there. -The third shift Medication Aide (MA) wrote all the lab requisitions from a prepared list which was written on a office desk calendar. -The list of residents requiring blood draws written on the desk calendar was written by the Resident Care Care Coordinator (RCC) or the Assistant Resident Care Coordinator (ARCC) in advance when the lab orders were received at the facility. -Facility staff (Administrator did not know who), in error, wrote on the calendar for Resident #5 to receive a Procrit injection, not a CBC blood draw for 11/25/15. -The third shift MA (the Administrator did not know who) wrote the requistion form for Resident #5 to receive a Procrit injection and not to have a CBC blood draw because that was what was written on the calendar. -The Administrator was not on site 11/25/15 through 11/29/15, but the ARCC called her on 11/25/15 to tell her Resident #5 had refused the lab. The Administrator said the ARCC was also on leave on 11/25/15, but came by the facility for a few minutes on that day. -The Administrator did not know who discovered the error, did not know when the error was discovered, but she said the requisition for a Procrit injection was destroyed (unknown by whom or when).	D 273		

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-After the requisition for Procrit injection was discovered, the Administrator said the ARCC went into Resident #5's room to talk to her about having the lab work done, but Resident #5 said she was "sick" and did not want anyone "poking" her so the ARCC did not write a requistion for the CBC (time not known).
-The facility rescheduled the lab to be drawn on 11/30/15.
-The Administrator said she told the ARCC to call Resident #5's family member and inform him the lab was not drawn.
-Resident #5 was admitted to the hospital on 11/30/15 after the lab called the Administrator with the Hgb result of 4.8.
-The facility contacted the family and sent Resident #5 to the local hospital Emergency Room on 11/30/15 because of the low Hgb lab result.
-The facility policy was to notify the physician when labs were missed and the physician usually ordered the labs to be completed on the next scheduled lab staff visit.

Interview with the First Shift Supervisor/MA, Staff A, on 12/10/15 at 2:45pm revealed:
-She was working on 11/25/15 the day the labs were drawn, but had no knowledge Resident #5 was sick or that Resident #5's labs were not drawn.
-She did tell the family member the lab results were locked in the Administrator's office because she thought the labs were in the Administrator's office.
-She was not aware Resident #5 did not have her blood drawn because the lab staff picked up the requistion forms in the office, collected blood specimens and left, and lab results were then faxed to the facility office.
-When the family member questioned her about

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the labs on 11/28/15, the lab faxed her the 11/17/15 results, not any 11/25/15 results.
-She did not call the Administrator to let her know the labs had not been completed because she was not aware of it until 11/28/15.

Review of a hospital Admission Record for Resident #5, dated 11/30/15, revealed:
-Resident #5 was admitted to the hospital on 11/30/15.
-Diagnosis of acute "on chronic anemia."
-Diagnosis of Type 2 non-ST segment elevation myocardial infarction. "I think this is almost certainly related to demand ischemia from her profound anemia today."
-Diagnosis of sepsis of suspected intra-abdominal pathology.
-Hgb level of 5.0.

Review of a hospital admission "Disposition" for Resident #5, dated 11/30/15, revealed "Prognosis is serious."

Review of Resident #5's hospital "Assessment," dated 12/4/15 revealed, Resident #5 "has received 4 units of packed red blood cells since admission."

Review of the local hospital discharge "Summary," dated 11/9/15, revealed Resident #5 was transferred from the hospital to a Hospice Center on 11/9/15.

Interview with the ARCC on at 12/09/15 at 2:55pm revealed:
-The ARCC was not in the facility on 11/25/15 through 12/4/15 and did not come by the facility on the morning of 11/25/15.
-Third shift staff (she did not know who) wrote the requistion for lab work from a list written on the

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office calendar by the RCC or by the Administrator.
-She was not aware the requisition was written in error or that Resident #5's blood was not drawn on 11/25/15 until she returned to work on 12/5/15.
-The Supervisor/MAs were in charge from 11/25/15 through 11/29/15 while the ARCC was out on vacation and when the Administrator was out.

Review of the office calendar for 11/25/15 revealed:
-A list of residents' names with the blood draws needed for that day.
-Resident #5's name was listed with "Procrit" injection beside it.
-Beside the Procrit injection was written, "lab error."

Interview with the ARCC on 12/09/15 at 2:55pm revealed:
-She did not know who had written on the calendar for Resident #5 to receive a Procrit injection on 11/25/15.
-She did not know who had written on the calendar "lab error."
-The current RCC just started working there the end of November, 2015 and the other RCC left before November, 2015.

Interview with the current RCC on 12/10/15 at 10:05 revealed she started work there the end of November and could not answer questions related to Resident #5.

Telephone interview with the local hospital lab supervisor on 12/10/15 at 10:15am revealed:
-Lab staff were routinely scheduled to go to facilities but they did not know which resident's blood to draw until they were in the facility (they

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had no prior information.)
-Lab staff relied on the requistion forms provided by the facility on the day they went into the facility to obtain any physician-ordered labs.
-Lab staff left a copy of each Resident's requistion form for whom they had provided service on that day as well as for whom they could not provide services as requisitioned.
-If the staff could not provide a service as requisitioned, such as if the resident refused services, the lab staff would write on the form the resident refused services and leave a copy with the facility.
-The lab had no documentation related to Resident #5's lab services on 11/25/15.
-The lab staff supervisor spoke to the lab staff who went out to the facility on 11/25/15 and that staff did not remember attempting to get a blood draw from Resident #5, did not remember any resident refusing labs, and did not remember any discussion related to Resident #5 during the visit to the facility.

Review of the lab requisition forms for 11/25/15 revealed no requisition form for Resident #5, but there were copies of requisition forms for other residents who had received lab services that day.

Interview with family member on 12/10/15 at 9:30am revealed:
-He was aware Resident #5's labs were scheduled to be completed on 11/25/15 because he had asked staff before 11/25/15 so he would know when to expect the results.
-He always received a telephone call from the facility on the day the CBC (complete blood count which included the Hgb) was completed because the lab results came back the same day.
-The lab results routinely came back (faxed to the facility) the day the labs were completed and

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facility staff called him in the afternoon with the results.
-Facility staff did not call him or any family member on 11/25/15 with lab results.
-He came to the facility on 11/25/15 and was told by Staff A the lab results were in the Administrator's office and they did not have access to that office.
-On 11/25/15, Resident #5 seemed to be as usual with no increased symptoms or "sick" and staff did not tell him that Resident #5 was "sick" or that she had refused the lab draw.
-Family member went to the facility on 11/26/15 to take Resident #5 for a home visit and at that time asked facility staff for the lab results. Resident #5 ate a meal with the family and returned to the facility on the afternoon of 11/26/15.
-After the family returned to the facility with Resident #5 on 11/26/15, the family member again asked for the lab results and was told the lab results were locked in the Administrator's office.
-Family member went to the facility on 11/27/15 to see Resident #5 and again asked for lab results and informed Staff B Resident #5's "health relied on" lab result numbers, but Staff B told him the lab results were locked in the Administrator's office.
-Family member talked to facility staff (not sure which staff) either by telephone or in person on 11/28/15 and was told the lab results were locked in the Adminsitrator's office.
-On the afternoon of 11/29/15, family member went to the facility to see Resident #5 and asked facility staff about the lab result staff did not know.
-On the afternoon of 11/29/15, Resident #5 was pale and staff said she had not eaten, but staff (not sure which staff) said Resident #5's vitals were good.
-After family member left on the afternoon of

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D 273	Continued From page 8 11/29/15, Resident #5 called family member. -After Resident #5 called family member, family member called the facility to talk to a "nurse," but no one called him back. -Family member returned to the facility (a second time) on the evening of 11/29/15 and family member suggested to Staff B that she give Resident #5 some "Mucinex" for cough and Staff B said she would. -While family member was in the facility, Staff B said she called the Administrator on the evening of 11/29/15 to let her know about Resident #5 and Staff said the Administrator never answered the phone. -On 11/29/15, after family member's second visit to the facility, family member went to the local hospital to obtain the lab results for Resident #5 and was informed they had no labs for Resident #5 which were completed on 11/25/15. -Family member returned to the facility a third time on 11/29/15 and Staff B told him she had found a Hgb result for 11/17/15 but not for 11/29/15. -Family member requested a blood draw for 11/30/15. -Family member was in the facility early on the morning of 11/30/15 and later in the day, the Administrator called him to let him know the Hgb results for 11/30/15 was 4.8 and the family member gave the Administrator his permission to send Resident #5 to the emergency room (ER) hospital by ambulance. -The facility sent Resident #5 to the local ER on 11/30/15 after getting the Hgb lab results and family member met Resident #5 at the ER. -Family member stated that if facility staff would have informed him the labs were not completed on 11/25/15, he would have immediately taken Resident #5 to the lab to get them done at the local hospital lab or at the prescribing physician's	D 273		

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office.
-Family member routinely (daily) visited Resident #5 and took her to her physician/medical appointments.
-Facility staff never called him nor any family member to say the labs were not completed.
-Resident #5 had never refused lab draws or any medical treatment.
-Facility staff did not call family member or tell family member when in the facility on 11/25/15 saying Resident #5 was sick or to say she had refused the lab draw.
-Family member had never refused to allow the facility to send Resident #5 to the local ER.

Telephone interview with two family members on 12/14/15 at 1:15pm revealed:
-Resident #5 passed away on 12/11/15.
-The family members did not receive any telephone calls from the facility from 11/25/15 through 11/29/15 informing them the CBC lab had not been completed as ordered on 11/25/15.
-The family members (one of which was Resident #5's Power of Attorney) did not receive any telephone calls from the facility staff from 11/25/15 through 11/29/15 requesting to send Resident #5 to the local ER.

Telephone interview with staff at the prescribing physician office (the Oncologist) on 12/10/15 at 3:04pm revealed facility staff did not call them to let them know the lab was not completed on 11/25/15 as ordered but they would have expected them to do so.

Review of Resident #5's record revealed:
-No documentation any labs were missed or delayed.
-No documentation Resident #5's physician had been notified of any missed labs.

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-No documentation the family members were notified of missed labs.
-No documentation Resident #5 was sick from 11/25/15 through 11/29/15.
-No documentation of any thing related to Resident #5's health condition or related to refusing any lab draws from 11/25/15 through 11/29/15.
-No documentation Resident #5 had ever refused any lab draws or medical treatment.

Attempted telephone interview with Staff B on 12/11/15 at 12:30pm was not successful.

B. Review of physician (Oncologist) orders dated, 11/17/15, revealed "Stool occult blood guaiac once a week for 6 weeks, please fax [Oncology physician name] ... with results." (The stool guaiac test looks for hidden (occult) blood in a stool sample.)

Review of Resident #5's office visit notes with the Oncologist on 11/17/15 revealed, "I am not convinced that [Resident] is completely free of any bleeding in the colon. I would like to check Hemoccult stools every week for the next 6 weeks. This will be checked at [name of facility]."

Review of Resident #5's record revealed:
-The lab result of the stool blood guaiac tested on 11/30/15 was "Positive."
-No documentation the physician was notified of the delay in obtaining the stool occult blood guaiac.
-No documentation why the stool occult blood guaiac was not obtained 11/17/15 through 11/29/15.

Interview with the Administrator on 12/09/15 at 11:25am revealed:

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D 273	Continued From page 11 -Resident #5 was independent in toileting and staff were not aware when she toileted. -Staff had placed a "cap" in the commode for Resident #5 to obtain a sample. -Resident #5 kept removing the "cap" out of the commode so the facility staff could not get a sample. -She was not aware any staff had contacted the physican that a stool occult blood sample had not been obtained. -The facility did not have any procedure for informing staff when a stool culture was ordered except at Stand-Up meetings and the presence of a "hat" or stool culture cup in the resident's room. -The facility had not been placing the stool culture orders on the Medication Administration Record (MAR) and they had not been placing any signs in the resident's bathroom. Confidential interview with a personal care aide (PCA) revealed: -She had observed a white plastic drinking cup with a tiny "smear" in it beside Resident #5's commode (date not known, but after 11/24/15). -The white plastic cup was not a stool culture cup but a drinking cup. -She asked a medication aide (MA) if Resident #5 was supposed to be obtaining a stool sample and the MA said she was not aware of any stool sample ordered. -The PCA placed the cup in a bag and placed the bag in the trash. -She never saw a "hat" in the commode of Resident #5's room. Interview with the First Shift Supervisor/MA, Staff A, on 12/10/15 at 2:45pm revealed: -She was not aware there was an order for Resident #5 to obtain an occult stool sample until 11/30/15.	D 273		

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D 273	Continued From page 12 -The facility had no system for assuring that staff were aware residents had an order for a stool sample. -The facility did not place any information on the resident's bathroom wall and did not place the occult stool culture orders on the MAR. -She never saw a "hat" in the commode and never saw a stool culture cup in Resident #5's room. Telephone interview with the Assistant Resident Care Coordinator on 12/11/15 at 2:40pm revealed: -The facility had no written system for assuring all staff were aware when a stool specimen was ordered. -The information was usually discussed at Stand-Up meetings or at shift change, but she did not remember anyone discussing Resident #5's physician order for the specimen. Telephone interview with staff at the prescribing physician's office (the Oncologist) on 12/10/15 at 11:15am revealed the facility staff had not called them to let them know the occult stool sample had not been obtained the first week as ordered but they would expect them to do so. --- The Plan of Protection provided by the facility on 12/10/15 revealed: -The Resident Care Coordinator (RCC) and Executive Director will check all current orders to assure completion and notify the ordering physician if any concerns of orders or orders not completed. -Physician orders will be documented in lab book (if labs are ordered) by supervisor in charge and a copy of orders to be placed in the RCC folder. -An audit will be completed by the RCC or designee five times per week for eight weeks and	D 273		

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D 273	Continued From page 13 then twice weekly for 4 weeks to assure orders obtained. -The RCC or designee will notify the ordering physician if unable to obtain labs within 24 hours. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 13, 2016.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights 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: Based on interviews and record reviews, the facility failed to assure Resident #5's family member received a reasonable response to requests from the staff. The findings are: Based on interview and record review, the facility failed to assure Resident #5's family member received a reasonable response to the request for the results of a physican ordered hemoglobin test for Resident #5. [Refer to Tag 917 G.S. 131D-21 (7) Declaration of Resident's Rights]	D 338		
{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	{D912}		

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{D912}	Continued From page 14 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to physician ordered labs for hematology and stool samples for occult blood. The findings are: Based on interview and record review, the facility failed to notify the prescribing physician when laboratory tests (blood for hematology and stool samples for occult blood) were not completed timely as ordered for 1 of 5 sampled residents (#5), resulting in Resident #5's hospital admission and Resident #5 died. [Refer to tag 273 10A NCAC 13F .0902(b)Health Care (Type A1 Violation).]	{D912}		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure Resident #5's family member received a reasonable response to the request for the results of a physican ordered hemoglobin test for Resident #5.	D917		

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D917	Continued From page 15 The findings are: Review of physician's orders for Resident #5, dated 9/29/15, revealed weekly CBC's (Complete Blood Count) and Procrit 4000 units every week for hemoglobin (Hgb) < 10. (The lab listed normal range for Hgb as 12.0 to 16.0 gm/dL. Procrit is used to treat anemia in patients with chronic kidney disease.) Review of physician orders dated 11/17/15 revealed an order for "CBC every week starting next week. Procrit 4000 units every week for Hgb < 10." Review of Resident #5's CBC lab work drawn on 11/30/15 at the facility revealed a Hgb level of 4.8 and designated as LC (low critically). Interview with family member on 12/10/15 at 9:30am revealed: -He was aware Resident #5's labs were scheduled to be completed on 11/25/15 because he had asked staff before 11/25/15 so he would know when to expect the results. -He always received a telephone call from the facility on the day the CBC (complete blood count which included the Hgb) was completed because the lab results came back the same day. -The lab results routinely came back (faxed to the facility) the day the labs were completed and facility staff called him in the afternoon with the results. -Facility staff did not call him or any family member on 11/25/15 with lab results. -He came to the facility on 11/25/15 and was told by the Supervisor/Medication Aide, Staff A, the lab results were in the Administrator's office and they did not have access to that office.	D917		

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D917	Continued From page 16 -On 11/25/15, Resident #5 seemed to be as usual with no increased symptoms or "sick" and staff did not tell him that Resident #5 was "sick" or that she had refused the lab draw. -Family member went to the facility on 11/26/15 to take Resident #5 for a home visit and at that time asked facility staff for the lab results. Resident #5 ate a meal with the family and returned to the facility on the afternoon of 11/26/15. -After the family returned to the facility with Resident #5 on 11/26/15, the family member again asked for the lab results and was told the lab results were locked in the Adminstrator's office. -Family member went to the facility on 11/27/15 to see Resident #5 and again asked for lab results and Staff B told him the lab results were locked in the Administrator's office. -Family member talked to facility staff (not sure which staff) either by telephone or in person on 11/28/15 and was told the lab results were locked in the Adminsitrator's office. -On the afternoon of 11/29/15, family member went to the facility to see Resident #5 and asked facility staff about the lab result but staff did not know. -On the afternoon of 11/29/15, Resident #5 was pale and staff said she had not eaten, but staff (not sure which staff) said Resident #5's vitals were good. -After family member left on the afternoon of 11/29/15, Resident #5 called family member. -After Resident #5 called family member, family member called the facility to talk to a "nurse," but no one called him back. -Family member returned to the facility (a second time) on the evening of 11/29/15 and while family member was in the facility, Staff B said she called the Administrator on the evening of 11/29/15 but the Administrator never answered the phone.	D917		

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D917	Continued From page 17 -On 11/29/15, after family member's second visit to the facility, family member went to the local hospital to obtain the lab results for Resident #5 and was informed they had no labs for Resident #5's which were completed on 11/25/15. -Family member returned to the facility a third time on 11/29/15 and staff B told him she had found a Hgb result for 11/17/15 but not for 11/29/15. -Family member requested a blood draw for 11/30/15. -Family member was in the facility early on the morning of 11/30/15 and later in the day, the Administrator called him to let him know the Hgb results for 11/30/15 was 4.8 and the family member gave the Administrator his permission to send Resident #5 to the emergency room (ER) hospital by ambulance. -The facility sent Resident #5 to the local ER on 11/30/15 after getting the Hgb lab results and family member met Resident #5 at the ER. -Family member stated that if facility staff would have informed him the labs were not completed on 11/25/15, he would have immediately taken Resident #5 to the lab to get them done at the local hospital lab or at the prescribing physician's office. -Family member routinely (daily) visited Resident #5 and took her to her physician/medical appointments. -Facility staff never called him nor any family member to say the labs were not completed. -Resident #5 had never refused lab draws or any medical treatment. -Facility staff did not call family member or tell family member when in the facility on 11/25/15 saying Resident #5 was sick or to say she had refused the lab draw. Telephone interview with two family members on	D917		

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D917	Continued From page 18 12/14/15 at 1:15pm revealed: -Resident #5 passed away on 12/11/15. -The family members did not receive any telephone calls from the facility from 11/25/15 through 11/29/15 informing them the CBC lab had not been completed as ordered on 11/25/15. Interview with the Administrator on 12/09/15 at 11:25am revealed: -The local hospital lab staff routinely came (usually once per week or as ordered) to the facility to draw blood for any residents with orders for lab work. -Lab staff's routine was to come into the facility, pick up requisition forms which have resident's name and lab required written on each form, draw each lab, and leave a copy of the requisition form in the facility office. -Resident #5 was scheduled to receive a CBC blood draw on 11/25/15 and lab staff were scheduled to be there. -The third shift MA (the Administrator did not know who) wrote the requistion form for Resident #5 to receive a Procrit injection and not to have a CBC blood draw because that was what was written on the calendar. -The Administrator was not on site 11/25/15 through 11/29/15, but the ARCC called her on 11/25/15 to tell her Resident #5 had refused the lab. The Administrator said the ARCC was also on leave 11/25/15 but came by the facility for a few minutes on that day. -After the requisition for Procrit injection was discovered, the Administrator said the ARCC went into Resident #5's room to talk to her about having the lab work done, but Resident #5 said she was "sick" and did not want anyone "poking" her so the ARCC did not write a requistion for the CBC (time not known). -The facility rescheduled the lab to be drawn on	D917		

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D917	Continued From page 19	D917		

11/30/15.
-The Administrator said she told the ARCC to call Resident #5's family member and inform him the lab was not drawn.
-Resident #5 was admitted to the hospital on 11/30/15 after the lab called the Administrator with the Hgb result of 4.8.

Attempted telephone interview with Supervisor/MA, Staff B, on 12/11/15 at 12:30pm was not successful.

Interview with the First Shift Supervisor/Medication Aide (MA), Staff A, on 12/10/15 at 2:45pm revealed:
-She was working on 11/25/15 the day the labs were drawn but had no knowledge Resident #5 was sick or that the labs were not drawn.
-She did tell the family member the lab results were locked in the Administrator's office because she thought the labs were in the Administrator's office.
-She was not aware Resident #5 did not have her blood drawn because the lab staff picked up the requistion forms in the office, collected blood specimens and left, and lab results were then faxed to the facility office.
-When the family member questioned her about the labs on 11/28/15, the lab faxed her the 11/17/15 results, not any 11/25/15 results.

Interview with the ARCC on at 12/09/15 at 2:55pm revealed the ARCC was not in the facility 11/25/15 through 12/4/15 and did not come by the facility on the morning of 11/25/15.

Review of Resident #5's record revealed no documentation that staff notified Resident #5's family members of any missed labs or lab refusals.

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