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THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 000	Initial Comments The Adult Care Licensure Section and The Cabarrus County Department of Social Services conducted an annual survey and complaint investigation on 12/29/15, 12/30/15, 12/31/15 and 01/04/16.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interview, the facility failed to assure walls, and ceilings were kept in good repair in regards to leaking water for 1 of 1 single public toilet room on the third floor and the corridor wall adjacent to the toilet room, ceiling tile over 1 of 3 medication aide stations (third floor), four residents' rooms (rooms #217, #309, #317, and #322), the snack store on the third floor, the ceiling outside the elevator on the second floor, and the commons area/television rooms on the second and third floor (with leaking windows). The findings are: Observations on 12/29/15 at various times throughout the day revealed the weather outside the facility was rainy. Observations on 12/30/15 at various times throughout the day revealed the weather outside the facility was heavy downpours of rain.	D 074		

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D 074	Continued From page 1 Observations on 12/30/15 at 1:12 pm and 3:10 pm revealed: -The fax machine in the 3rd floor nurses' station work area was cover with plastic and the ceiling tile located directly above the fax machine had an opening approximately one and one-half feet wide missing from the center of the tile. (The ceiling tile appeared wet around the opening.) -A trash can had been placed below the opening and water was dropping every 3 seconds into the trash can. Observation on 12/30/15 at 2:30 pm of the ceiling in the corridor on the left outside of the second floor elevator revealed: -The corridor led to the primary building of the church. -The elevator was located within the assisted living facility and traveled between the first and third floor of the facility. -The ceiling tile next to the northeast exposure wall was visibly wet, sagging, and cracked open approximately 2 inches next to the wall. -The next tile (second from wall) was wet and visibly stained at both ends of the tile. -The covering for the light fixture, adjacent to the second tile and close to the elevator, was stained with dark residue spots in one corner and a dark colored circle visible in the center of the covering. Observation on 12/30/15 at 2:40 pm of the commons area/television room on the second floor revealed: -The room had angled outside walls, with glass windows in the wall, and horizontal window blinds covering the glass windows. -Each section of the wall and windows had visible water damage at the top and/or bottom of the window section.	D 074		

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-The ceiling board in the right corner, above the window blind, was wet and peeling; the adjacent block wall had bubbled paint at the top.
-Two window sections had standing water on the lower horizontal blinds.
-The ceiling board in the left corner, above the window blind, had an 8 inch by 12 inch section with peeling seam tape and soaked ceiling board: the adjacent block wall had bubbled and stained paint approximately 10 inches from the top and next to the window.

Observation on 12/30/15 at 2:49 pm of resident room #217 revealed:
-The room had a wall mounted heating/cooling unit located under a window on the left side of the room.
-There was a soaked towel on the floor under the left side of the heating/cooling unit.
-The top of the left side of the unit had black residue (mold) in the seam between the unit and the left wall, and the upper left corner of the unit and the window frame above the unit.
-The wallboard, at the floor, was damp and the paint was bubbled.

Interview on 12/30/15 at 2:55 pm with the resident in room #217 revealed:
-Every time there was a big rain, the wall unit leaked in the area where the towel was placed.
-No water had been observed by the resident at the top of the window.
-The maintenance staff were aware of the leaking at the window because she informed the staff each time it leaked.
-The leaking around the window had been ongoing for at least 6 months.

Observation on 12/30/15 at 2:59 pm of a fluorescent light fixture in the hallway outside

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room #217 revealed dark spots of residue and brownish-red staining in the corner of one end of the light diffusing panel (on the light bulb side).

Observation on 12/29/15 at 10:47 am and at 12/30/15 at 3:00 pm of resident room #317 revealed the bathroom had a water soaked ceiling tile next to the fluorescent light fixture in the center of the room.

Observation of a conversation on 12/30/15 at 3:00 pm revealed:
-A resident of room #317 informed the Assistant Maintenance staff member that she was concerned the light would fall from the ceiling in her bathroom due to water leaking onto the ceiling tiles located near the ceiling mounted fluorescent light fixture.
-The Assistant Maintenance staff person informed the resident that the light fixture was secured by a cable and could not fall from the ceiling.
Observation on 12/30/15 at 3:10 pm of the snack store located on third floor revealed:
-There were soaked towels on the right side of the floor at the entrance door.
-The wallboard and covering were wet.

Interview on 12/30/15 at 3:12 pm with a resident volunteer working in the snack store revealed:
-The water came down the wall, near the door, and wet the floor.
-She placed washcloths on the floor to absorb the water.
-Water had been coming in the room at both times the store was open today (9:00 am and 2:30 pm).
-Over the last few months, the water came down the wall in the same area every time there was a heavy rain.
-She stated maintenance staff were aware of the

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D 074	Continued From page 4 leak because she had informed the staff about the leak each time there was water on the floor. Observation on 12/30/15 at 3:18 pm of a public men's toilet room on the back hall of the third floor revealed: -The door to the toilet room was locked and the key was located at the third floor nurse's station. -A wet ceiling tile in the right rear corner on the bathroom. -Peeling wallboard tape and paint in the right corner of the bathroom extending from the ceiling downward for 4 feet. -A tennis ball size bulging bubble in the paint on the right hand wall, 3 feet from the ceiling and 18 to 24 inches from the corner of the bathroom. -A corridor that led to a laundry room was located on the back side of the right side toilet room wall. Continued observation on 12/30/15 at 3:18 pm revealed: -The back side of the right side toilet room wall (in the corridor) also housed 2 electrical panels. -The right hand upper corner of the corridor wall (directly behind the water damaged area of the toilet room) had peeling of the wallboard and wet ceiling tile above the area of the wall. This wall also had 2 electrical panels located on the corridor wall. -There were towels placed on the floor along the wall under the electrical panels that were damp from water accumulating on the floor. Observation on 12/30/15 at 3:20 pm of resident room #322 revealed: -A ceiling mounted heating/air conditioning unit. -The ceiling tile around one side of the unit was wet. -The panel covering the bottom of the unit was rusty looking.	D 074		

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D 074	Continued From page 5 Observation on 12/30/15 at 3:17 pm of the commons area/television room on the third floor revealed: -The room had angled outside walls, with glass windows in the wall, and horizontal window blinds covering the glass windows. -Each section of the wall, and windows had visible water damage at the top and/or bottom of the window sections. -The ceiling board along most of the wall, above the window blind, was wet and peeling. -The wall covering on the wall joining the windows on the left side of the room, just above the window sill, was separating from the wall exposing an area with mold and mildew on both the inside of the wall covering and the wallboard behind the covering. -One ceiling tile above the television had a water stain spot the size of a saucer and a wet spot approximately 10 inches in diameter. Observation on 12/30/15 at 3:30 pm of resident room #309 revealed: -A wet ceiling tile behind the entrance door and radiating out 10 inches. -Wet ceiling tiles along the bathroom wall located on the right side just beyond the entrance door. -Wet and stained ceiling board extending along the interior wall of the bathroom for 4 feet and protruding into the bathroom 3 to 5 inches. -Wet and stained ceiling board around the exhaust fan located toward the center of the bathroom. Interview on 12/29/15 at 10:45 am with a resident in room #317 revealed: -"The roof is leaking and you can hear it in my bathroom when it is raining. The ceiling tile is wet and it is leaking near the fluorescent ceiling light".	D 074		

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-"If they don't soon fix it, I am afraid the ceiling light will fall if it gets too wet."
-There had also been water leaking in the hallway outside her room during a previous rain storm and maintenance had replaced those tiles, "but we are still having leaks".
-She had reported it to the former Administrator, but "he's not here anymore."
-She had not reported her concerns about the leaking room in her bathroom to any other staff person.

Interview on 12/30/15 at 12:35 pm with the Assistant Maintenance staff person revealed:
-He was not aware of the leaking in the residents's bathroom in resident room #317.
-"There are places all over the building that are leaking".
-He had replaced multiple ceiling tiles when the roof leaked during rain storms.
-The public men's bathroom on the back hall of the third floor (the top floor) was currently leaking between the walls.
-He had replaced ceiling tiles in hallways, in the family room on third floor, and in some residents' rooms.
-There had been leaking on numerous occasions in the family rooms on each floor.
-The third floor family room had leaked around the picture windows and there was black mold around the windows.
-"I keep replacing ceiling tiles, but there is only so much I can do. If the main problem is not fixed, we are going to continue to have leaks."
-He had reported his concerns to the Maintenance Supervisor and the current Executive Director several months ago.
-The facility was just leased by another company, but the church (the owner of the building) was responsible for repairing anything "outside" and

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the new company was responsible for inside repairs.
-He knew the former Administrator had contacted "the church" (owners of the building) several months ago and the church had contacted at least 2 roofers.
-He did not know the status of the roof repair, but the leaks had been happening often during rain storms for probably six months.

Interview on 12/30/15 at 1:10 pm with a Medication Aide on the third floor revealed:
-The building's roof had been leaking into the building for "about six months".
-Water was now "pouring down the wall" in the men's public bathroom on the third floor.
-Maintenance was aware of the leak in the men's public bathroom.
-During a previous rain storm about a month ago, there was a leak in the main hallway outside of the nurses station.
-Maintenance had replaced the tiles in the hallway.
-There was currently a leak coming into the nurses station above the fax machine.

Interview on 12/30/15 at 3:05 pm with a third floor Supervisor revealed:
-The ceiling tile over the copier/fax machine was leaking on this day (12/30/15).
-The area leaked in the past, however somebody (not sure who) went on the roof and patched the roof back in the summer (not sure of the date).
-The area over the copier/fax machine had not been leaking until today.

Interview on 12/30/15 at 3:07 pm with the Assistant Maintenance staff member revealed he had removed the area in the ceiling tile above the copier/fax machine earlier in the day because he

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did not want the soaked tile to break and flood the machine and staff.

Further interview on 12/30/15 at 3:20 pm and 3:30 pm with the Assistant Maintenance staff member revealed:
-Room #322 had an air conditioner unit installed in the ceiling and the ceiling tile in front of the air conditioner vents was wet and discolored.
-The room #322 air conditioner did not leak and he thought the wet ceiling tile was from the leaks in the roof and the recent rain storms.
-Residents had been moved from room #309 in the past while repairs were being made to the room; the leaking appeared to be coming from the roof.

Interview on 01/04/16 at 3:00 pm with the Executive Director (ED) revealed:
-She was aware the roof and windows of the facility were leaking.
-The former Administrator had been in charge of contacting a roofer and the window repairman.
-She had done a walk-through with a building representative a couple of months ago and identified leaking areas.
-The building owner representative had not been in further contact regarding fixing the water leaks.
-She had contacted the building owner representatives in regards to the leaking windows and roof. (She provided electronic documentation for contact with the building owner representative regarding water leaks in the facility on 11/09/15, 11/10/15, 12/01/15 and 12/02/15.)
-The building owner had not provided further communication regarding repairs to the leaking roof and windows.

Interview on 01/04/16 at 3:10 pm with a Corporate Vice President revealed:

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D 074	Continued From page 9 -She was aware the facility had been experiencing water leaks from the roof and the windows. -The former Administrator had been working with the building owner representatives to coordinate meetings with the roofing company and the window glass company. -She was aware the ED had done a follow-up to check the status of the repairs. -She was not aware of the extent of the roof leaks and window leaks prior to today (01/04/16). -She had contacted the building owner representative to expedite the repair consults. -A roofing company was supposed to be onsite 01/06/16. Telephone interview on 01/04/16 at 3:55 pm with a building owner representative revealed: -The building owner was responsible for repairs to the roof and windows. -He was aware the building was experiencing water related issues with the roof and the windows. -The previous Administrator had been in the process of arranging repairs when he left. (Documentation revealed the Administrator left around October 16, 2015). -He had not followed up with the roofing company and window glass company recently.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;	D 079		

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D 079	Continued From page 10 This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the environment was free of hazards, as related to safe storage of oxygen cylinders in 4 residents' rooms (Rooms #309, #124, #318, #313). The findings are: A. Observation of resident room #309 during the initial tour of the facility on 12/29/15 at 10:22 am revealed: -An oxygen concentrator running located to the right of the Resident #1's bed, -Resident #1 was awake, lying in the bed with the nasal cannula oxygen applied. -A portable oxygen cylinder in the basket of the resident's rolling walker. -Two free standing Type E 680 liter cylinders sitting on the floor with no plastic guard intact or gauge to determine if there was oxygen in the oxygen cylinders. Interview with Resident #1 residing in room #309 on 12/29/15 at 10:25 revealed: -She was on oxygen at 3 and 1/2 liters per minute continuously. -She used her oxygen concentrator when she was in her room. -She used a portable oxygen cylinder when she was out of her room. -The two free-standing oxygen cylinders were delivered for her to use when she attended a family member's funeral. -She thought the oxygen cylinders were both	D 079		

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empty and "the company needs to come and pick them up."

Observation of resident room #309 on 01/04/16 at 11:50 am revealed previously observed free-standing oxygen cylinders were no longer in the room.

Refer to interview on 12/31/15 at 3:30 pm with the Executive Director.

B. Observation of resident room #124 on 12/31/15 at 10:40 am revealed:
-One Type E oxygen cylinder secured in a holder.
-One free-standing Type E oxygen cylinder sitting on the floor with no plastic guard intact or gauge to determine if there was oxygen in the free-standing oxygen cylinder.

Interview with Resident #5 who resided in room #124, on 12/31/15 at 10:40 am revealed:
-Someone told her this morning that her oxygen cylinder should not "be loose".
-She wanted someone to "come and get the loose tank out of her room".

Observation of resident room #124 on 01/04/16 at 11:15 am revealed previously observed free-standing oxygen cylinders were no longer in the room.

Refer to interview on 12/31/15 at 3:30 pm with the Executive Director.

C. Observation of resident room #318 on 12/31/15 at 9:00 am revealed:
-Seven small oxygen cylinders were stored behind Resident #10's recliner.
-Six of the seven oxygen cylinders were secured in a crate and had plastic tabs around the top of

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the cylinder.
-One of the oxygen cylinders was in a fabric cover and was propped against the bedroom wall.

Interview on 12/31/15 at 9:03 am with Resident #10 residing in room #318 revealed:
-She had not used oxygen "in about six years".
-She was not sure why she still had oxygen, "because I don't need it".

Observation of Resident Room 318 on 01/04/16 at 11:43 am revealed no oxygen stored in the room.

Further interview on 01/04/16 at 11:45 with Resident #10 revealed staff took the oxygen out of her room "sometime last week".

Refer to interview on 12/31/15 at 3:30 pm with the Executive Director.

D. Observation of resident room #313 on 12/31/15 at 9:05 am revealed:
-Six Type D oxygen cylinders securely stored in a crate on the floor
-One free-standing oxygen cylinder (larger than Type D) was standing upright on the floor beside the crate with the six secured oxygen cylinders.
-Resident was asleep in the bed with oxygen applied from an oxygen concentrator located beside the bed.

Further observation of resident room #313 on 01/04/16 at 11:25 am revealed:
-Five Type D oxygen cylinders securely stored in a crate on the floor.
-Two free-standing oxygen cylinders with plastic tabs attached (indicating the cylinders had not been opened) located on the floor beside five secured cylinders.

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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 079	Continued From page 13 Refer to interview on 12/31/15 at 3:30 pm with the Executive Director. _____ Interview on 12/31/15 at 3:30 pm with the Executive Director revealed: -It was the facility's policy that oxygen cylinders be stored securely. -She was not aware there were unsecured oxygen cylinders stored in resident's rooms. -She would immediately contact the company that provided the oxygen and request that they either provide crates for the free-standing oxygen cylinders or remove the empty containers.	D 079		
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 observation, interview and record review, the facility failed to notify the physician for 2 of 7 sampled residents regarding a resident's low blood sugars (Resident #4) and a resident not being weighed daily and receiving eye compresses (Resident #6). A. Review of Resident #4's current FL-2 dated 1/07/15 revealed: -The resident's diagnoses were coronary artery disease, diabetes, hypertension, atrial fibrillation,	D 273		

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chronic gout, sick sinus syndrome and glaucoma.
-The resident was intermittently disoriented.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 1/12/15.

Review of Resident #4's signed Physician Orders dated 12/11/15 revealed an order to obtain FSBS (Finger Stick Blood sugar) four times daily at 6:30 am, 10:30 am, 4:30 pm and 7:00 pm.

Review of Resident #4's signed Standing Orders dated 7/28/15 revealed a physician's order to give 6 ounces of orange juice, call the physician and recheck the FSBS after 30 minutes if the blood sugar was less than 60.

Review of Resident #4's October 2015 electronic Medication Administration Record (eMAR) revealed:
-From 10/1-10/31/15 revealed the blood sugar taken on 10/08/15 at 7:00 pm was 49 and on 10/31/15 at 4:30 pm was 38.
-There was no documentation of interventions provided on the eMAR.

Review of Resident #4's November 2015 eMAR from 11/1-11/30/15 revealed:
-The blood sugar taken on 11/21/15 at 10:30 am was 41.
-The blood sugar taken on 11/25/15 at 10:30 am was 54.
-The blood sugar taken on 11/25/15 at 7:00 pm was 51.
-There was no documentation of interventions provided on the eMAR.

Review of Resident #4's December 2015 eMAR from 12/1-12/30/15 revealed:

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D 273	Continued From page 15 -The blood sugar taken on 12/02/15 at 4:30 pm was 50. -The blood sugar taken on 12/09/15 at 4:30 pm was 56. -The blood sugar taken on 12/02/15 at 4:30 pm was 51. -There was no documentation of interventions provided on the eMAR. Review of Resident #4's Staff Progress Notes revealed: -An entry dated 10/31/15 at 4:30 pm documented Resident's #4's blood sugar was 38, orange juice and supper were given. The follow-up blood sugar was 66 at 5:00 pm and the physician was called. An on-call physician ordered to hold the 5:00 pm insulin and to monitor Resident #4. Resident #4's FSBS was 156 upon re-check at 7:45 pm. -There was no follow-up with the primary care physician in regards to this episode. -There was no other documentation indicating staff had notified the primary care physician about any of the other episodes of hypoglycemia. -There were no other documented interventions with the other hypoglycemic episodes. Interview with the Medication Aide (MA) on 12/31/15 at 10:30 am revealed: -She knew if a resident's blood sugar was less the 60, they were to give orange juice and the resident's primary care physician should be called. -She did not know if staff had called Resident #4's primary care physician in November, October and December 2015 when the resident's blood sugar was less than 60. -She expected the MAs to call the primary care physicians and notify them of hypoglycemic episodes.	D 273		

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-She was able to provide the staff progress notes regarding the 10/31/15 episode of hypoglycemia, but could not find any other documentation Resident #4's physician was notified of FSBS below 60 or documentation of interventions.
-She thought staff may have called Resident #4's physician and did not document it in Resident #4's Record.

Interview with a second MA on 12/31/15 at 11:02 am revealed:
-She knew to give orange juice if a blood sugar dropped below 60 and to notify the physician.
-She would tell her supervisor if the FSBS was below 60 as well as call the doctor to notify them of the hypoglycemic episodes.
-She had called residents' physicians in the past and may not have documented she called and left a message.

Interview with Resident #4 on 12/30/15 at 11:26 am revealed:
-She was admitted to this facility after having been hospitalized for low blood sugar.
-She knew her blood sugar had dropped on several occasions since she had been admitted and it dropped as low as 35 on one occasion.
-She said staff did give her orange juice when her sugar drops and that she had "been given gallons and gallons of orange juice" because her blood sugar had dropped so much.
-She did not know if staff notified her primary care physician.
-She used to be able to detect when her blood sugars were low, but she did not have the signs or symptoms that she had in the past and especially while she was asleep.
-She was afraid her sugars were going to drop and she would not wake up.
-The staff was supposed to wake her up and

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D 273	Continued From page 17 make sure that she got up to eat. Interview with Resident #4's Responsible Party on 12/29/15 at 11:40 am: -He was very concerned about Resident #4's hypoglycemia because of her hospitalization and the recurrent episodes that Resident #4 informed him about. -The staff took her blood sugar and administered her insulin early in the morning and she would fall back asleep. -He had addressed these concerns with the Executive Director but did not give dates of these conversations. -The facility staff was to wake her up every morning and if she did not get up they were to call him. -They did not call him and inform him about the hypoglycemic episodes. -He did not know if they contacted Resident #4's physician. -Last weekend on either Saturday or Sunday the staff did not get Resident #4 up out of bed and they did not call him to notify him she was not up. Interview with the Executive Director on 12/31/15 at 11:18 am revealed: -She was aware Resident #4 had experienced hypoglycemia episodes. -She was not aware staff had not notified Resident #4's physician. -She expected the MAs to notify the physician when a resident had a hypoglycemic episode at the time it occurred. -She expected the MAs to document in the resident record when the physician was contacted. -She did wake Resident #4 up every morning she worked which was Monday through Friday. -She did instruct staff to wake Resident #4 up	D 273		

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when she was not in the facility and ensure that she ate breakfast.

B. Review of Resident #6's current FL-2 dated 09/09/15 revealed:
-Diagnoses included coronary artery disease, hypertension, congestive heart failure with diastolic dysfunction, chronic renal insufficiency, peripheral vascular disease, diabetes mellitus, and dementia.
-An order to weigh every day and report weight gain of 3 pounds in one day or five pounds in one week.

Review of Resident #6's Resident Register revealed an admission date of 08/04/12.

1. Review of Resident #6's record revealed:
-A renewal of the orders for daily weights the physician's orders dated 11/05/15.

Review of the October 2015 Treatment Administration Record (TAR) revealed:
-The order for daily weights with parameter orders to report weight gain of 3 pounds in one day or five pounds in one week was transcribed to the TAR.
-Daily weights were documented on the following days:
-On 10/01/15, weight was documented as 170.
-On 10/02/15, weight was documented as 171.
-On 10/03/15, weight was documented as 169.
-On 10/06/15, weight was documented as 171.4.
-On 10/08/15, weight was documented as 174.
-Resident refusals were documented on 10/04/15, 10/05/15, 10/09/15, 10/10/15, 10/14/15, 10/16/15, 10/18/15, 10/19/15, 10/20/15, 10/22/15 to 10/27/15, and 10/31/15.

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Review of the November 2015 TAR revealed:
-The order for daily weights with parameter orders was transcribed to the TAR.
-Daily weights were documented on the following days:
-On 10/04/15, weight was documented as 174.4.
-On 10/27/15, weight was documented as 176.6.
-Resident refusals were documented on 11/02/15, 11/03/15, 11/05/15, 11/07/15 to 11/11/15, 11/13/15 to 11/16/15, 11/18/15, 11/21/15 to 11/25/15, 11/29/15, and 11/30/15.

Review of the December 2015 TAR revealed:
-The order for daily weights with parameter orders was transcribed to the TAR.
-Daily weights were documented on the following days:
-On 12/20/15, weight was documented as 176.
-On 12/21/15, weight was documented as 176.
-Resident refusals were documented on 12/03/15 to 12/06/15, 12/08/15 to 12/11/15, 12/18/15, 12/23/15 to 12/26/15, and 12/28/15 to 12/30/15.

Review of Resident #6's record revealed:
-There was no documentation staff had notified the medical provider of the resident's refusals of daily weights.
-Documentation on 12/31/15 that a Medication Aide (MA) spoke with the in-house Nurse Practitioner (NP) about Resident #5's weight refusal.
-The NP had the Quality Control staff person to explain to the resident the importance of daily weights and her diagnosis of congestive heart failure.

Interview with Resident #6 on 01/04/15 at 11:43 am revealed:
-She did not want to get up at 6:30 am to be weighed.

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D 273	Continued From page 20 -She did not want to have to go downstairs in her pajamas to first floor to be weighed. -She did not think she needed to be weighed everyday. -She told a MA "last week" that she would go at 5:30 pm to be weighed. Interview on 12/30/15 at 5:20 pm with a MA revealed: -The third shift Nurse Aides (NA) were responsible for obtaining weights for residents. -Resident #6 received services from the medical group that visited the facility several times a week. -The MAs communicated with Resident #6's medical provider by leaving notes in a folder at the nurse's station. -She did not know if the physician had been notified Resident #6 was refusing daily weights. Interview on 12/30/15 at 10:15 am with a MA revealed: -The NAs on third shift were responsible for weighing Resident #6 daily. -Resident #6 frequently refused treatments, including daily weights. -Resident #6 did not like to leave her room except for meals. -The scales were on the first floor and Resident #6 resided on the third floor, "so she has to be taken down to first floor to be weighed." -She thought the medical provider wanted her weighed in the morning because they were monitoring for weight gain as a sign of possible congestive heart failure. -She would discuss Resident #6's refusals of being weighed with the medical provider to see if another time of day to weigh her could be considered.	D 273		

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D 273	Continued From page 21 Interview on 12/31/15 at 4:15 pm with Resident #6's medical provider revealed: -Her practice provided services to Resident #6 at the facility. -There was a medical provider at the facility at least three times a week. -Staff were good with communicating with the medical providers. -She had not been notified of Resident #6 refusing daily weights. -She wanted Resident #6 weighed daily to monitor for congestive heart failure. -"The staff should have let me know and we could have changed the time of day or the frequency. A weekly weight would be better than no weights." -She had discussed today with a MA and the time of day would be changed. 2. Review of Resident #6's record revealed: -A telephone order dated 09/21/15 for staff to apply warm compresses to both eyes at 6:30 am daily. -A renewal of the order for daily eye compresses on the physician's orders dated 11/05/15. Further review of the October 2015 TAR revealed: -The order to apply warm compresses to both eyes once daily at 6:30 am had been transcribed to the TAR. -The scheduled time for the daily eye compresses was 6:30 am. -Documented application of the eye compresses to both eyes at 6:30 am on 10/02/15, 10/03/15, 10/06/15, 10/11/15, 10/12/15, 10/13/15, 10/16/15, 10/17/15,10/23/15, 10/25/15, and 10/30/15. -Resident refusals were documented on 10/01/15, 10/04/15, 10/05/15, 10/8/15 to 10/10/15, 10/14/15, 10/18/15 to 10/22/15, 10/24/15, 10/26/15 to 10/29/15, and 10/31/15.	D 273		

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D 273	Continued From page 22 Further review of the November 2015 TAR revealed: -The order to apply warm compresses to both eyes once daily at 6:30 am had been transcribed to the TMR. -Documented application of the eye compresses to both eyes at 6:30 am on 11/01/15, 11/06/15, 11/12/15, 11/14/15, 11/17/15, and 11/26/15. -Resident refusals were documented on 11/02/15 to 11/15/15, 11/07/15 to 11/11/15, 11/13/15, 11/15/15, 11/16/15, 11/19/15 to 11/22/15, 11/24/15, 11/25/15, 11/27/15, 11/28/15, and 11/30/15. Further review of the December 2015 TAR revealed: -The order to apply warm compresses to both eyes once daily at 6:30 am had been transcribed to the TAR. -The scheduled time for the daily eye compresses was 6:30 am. -Documented application of the eye compresses to both eyes at 6:30 am on 12/01/15, 12/02/15, 12/03/15, 12/06/15 to 12/08/15, 12/10/15, 12/11/15, 12/14/15 to 12/17/15, 12/20/15 to 12/23/15, and 12/27/15 to 12/28/15. -Resident refusals were documented on 12/04/15, 12/05/15, 12/12/15, 12/13/15, 12/18/15, 12/19/15, 12/24/15 to 12/26/15, and 12/30/15. Further review of Resident #6's record revealed there was no documentation staff had notified the medical provider of the resident's refusals of application of daily warm eye compresses. Interview with Resident #6 on 01/04/15 at 11:40 am revealed: -"They haven't ever tried to get me to have eye compresses. They can get rid of that."	D 273		

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-She did not think she needed eye compresses.
-She "rinsed her eyes" with eye drops ordered by the physician two or three times a day and this helped her eyes.
-The MAs administered the eye drops to her.
-Sometimes she did not take her eye drops because "sometimes three makes my eyes too wet".

Review of Resident #6's record revealed an order on 10/28/15 for Refresh eye drops one drop in each eye three times a day.

Review of Resident #6's November 2015 Medication Administration Record revealed the Refresh Eye drops were administered as ordered with no documented refusals.

Interview on 12/30/15 at 5:15 pm with a Medication Aide (MA) revealed:
-Third shift staff were responsible for ensuring the resident received daily warm compresses to her eyes.
-She did not know if the physician had been notified Resident #6 was refusing daily warm compresses to her eyes.

Interview on 12/30/15 at 10:15 am with a MA revealed:
-The MAs were responsible for notifying the medical provider of multiple refusals.
-She did not know if the medical provider had been notified that Resident #6 was refusing the daily warm compresses to her eyes.
-The medical providers had access to treatment records in the computer.

Interview on 12/31/15 at 4:23 pm with Resident #6's medical provider:
-The eye compresses were ordered when the

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D 273	Continued From page 24 resident was having cough and cold symptoms. -She was not aware the resident had been refusing them. -Resident #6 had a history of refusing treatments in the past. Interview on 12/31/15 at 11:20 am with the Executive Director revealed the facility policy was for the MA to notify the medical provider if a resident refused medications or treatment more than three times in a row. The facility provided a Plan of Protection on 1/04/16 as follows: -Immediately, staff will be retrained on the identification and reporting of residents' needs to assure the appropriate referral and follow up on 01/05/16 through 01/08/16. -Immediately audit charts to assure that resident's health care needs have been followed up and referred as ordered. -Random chart audits by the Executive Director and Quality Control Staff to assure referral and follow up is done in a timely and accurate manner starting 01/05/16 and on-going. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 18, 2016.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.	D 296		

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D 296	Continued From page 25 This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure matching therapeutic menus for food service guidance for 2 of 5 sampled residents with physician orders for 1500 Calorie American Diabetic Association (ADA), and 2200 Calorie ADA diets (Residents #4 and #24). The findings are: Review of the facility's therapeutic menus on 12/29/15 during the initial tour at 11:00 am revealed: -There were diets listed for Regular/No Added Salt, 2 gram sodium, cardiac, liberal renal, finger foods, low fiber, soft, mechanical altered, pureed, small portions, high calorie/protein, lacto-ovo (vegetarian), low-concentrated sweets, and 1800 calorie diabetic. -There were no therapeutic menus for 1500 calorie ADA or 2200 calorie ADA diets. A. Review of Resident #4's current FL2 dated 01/07/15 revealed: -Diagnoses included coronary artery disease, diabetes, and hypertension. -No diet order was included. Review of Resident #4's Resident Register revealed an admission date of 01/12/15. Review of Resident #4's record revealed: -The range for fasting blood sugar levels for November 2015 was _____. -The range for fasting blood sugar levels for December 2015 was _____. Review of a physician's order dated 01/12/15	D 296		

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THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 296	Continued From page 26 revealed a diet order for a 1500 Calorie ADA diet. Review of the diet list posted on the bulletin board in the kitchen revealed Resident #4 was on a 1500 Calorie ADA diet. Review of the diet list posted at the serving line where resident's plates were prepared revealed Resident #4 was on a diabetic diet. Review of the regular diet menu posted for dinner on 12/29/15 revealed: -Residents were to be served: -Vegetable frittata -Home fries, -Scalloped Tomatoes -Muffin -Margarine -Chocolate Chip Cookie -Milk and beverage of choice Observation on 12/29/15 from 5:00 pm to 6:00 pm of the dinner meal revealed Resident #4 was served the following: -A hot dog with a hot dog roll, slaw, and chili -Diced potatoes (1/2 cup) -Three sugar-free cookies -Sugar-free hot chocolate -6 ounces of water -Resident #4 consumed all of the meal and 3/4 of the beverages. It could not be determined if the meal was appropriate for a 1500 calorie ADA diet because there was no 1500 calorie ADA therapeutic menu available for staff guidance. Refer to interview on 12/31/15 at 10:15 am with a kitchen server.	D 296		

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Refer to interview on 12/29/15 at 12:30 pm with the Director of Food Service.

Refer to second interview on 12/30/15 at 10:15 am with the Director of Food Service.

Refer to interview on 12/30/15 at 10:25 am with the Acting Executive Director.

B. Review of Resident #24's current FL2 dated 08/25/15 revealed:
-Diagnoses included diabetes neuropathy, diabetes mellitus, hypertension, pancreatitis, morbid obesity, and chronic kidney disease.
-An order for a 2200 calorie diabetic diet.

Review of Resident #24's Resident Register revealed an admission date of 10/22/15.

Review of the diet list posted on the bulletin board in the kitchen revealed Resident #24 was on a 2200 Calorie ADA diet.

Review of the diet list posted at the serving line where resident's plates were prepared revealed Resident #24 was on a diabetic diet.

Review of the regular diet menu posted for dinner on 12/29/15 revealed:
-Residents were to be served:
-Vegetable frittata
-Home fries,
-Scalloped Tomatoes
-Muffin
-Margarine
-Chocolate Chip Cookie
-Milk and beverage of choice

Observation on 12/29/15 from 5:00 pm to 6:00 pm of the dinner meal revealed Resident #24 was

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D 296	Continued From page 28 served the following: -A hot dog with a hot dog roll, slaw, and chili -Diced potatoes (1/2 cup) -Three sugar-free cookies -6 ounces of water -10 ounces Sugar-free punch -Resident #24 consumed all of the meal and beverages. It could not be determined if the meal was appropriate for a 2200 calorie ADA diet because there was no 2200 calorie ADA therapeutic menu available for staff guidance. Interview with Resident #24 on 12/29/16 at 10:40 am revealed: -He was a diabetic, "but my blood sugars are pretty good". -His diabetes was controlled by his diet and not insulin. -The facility served "a lot of chicken, turkey, and ham". -He would prefer a "better variety of meats". Second interview with Resident #24 on 12/29/16 at 5:45 pm revealed he enjoyed the meal he was served for dinner. Refer to interview on 12/31/15 at 10:15 am with a kitchen server. Refer to interview on 12/29/15 at 12:30 pm with the Director of Food Service. Refer to second interview on 12/30/15 at 10:15 am with the Director of Food Service. Refer to interview on 12/30/15 at 10:25 am with the Acting Executive Director.	D 296		

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Interview on 12/31/15 at 10:15 am with a kitchen server revealed:
-Her main duties included serving residents' meals, including therapeutic diets.
-There was a reference list posted on the serving line that was used to let the server know what diet a person was to receive.
-There was also a resident list of special diets posted on the bulletin board in the kitchen.
-She checked the board daily to see if there were any changes.
-Before each meal, the cook would tell the servers what was to be served to residents who were diabetics.
-The cooks determined by the therapeutic diet menus what residents were to be served.
-All diabetics sat at the front of the dining room and were served first.
-"All diabetics get wheat toast instead of white toast for breakfast".
-The facility had sugar-free beverages, snacks, and desserts available at the serving line for residents who were diabetics.

Interview on 12/29/15 at 12:30 pm with the Director of Food Service revealed:
-Residents were served from the serving line located in the dining room.
-Residents went through the line themselves to be served or the Nurse Aides (NA) would assist residents by obtaining their plates from the servers.
-The servers, who were kitchen staff, served each resident according to the diet ordered by the physician.
-There was a therapeutic diet list posted in the kitchen for staff reference.
-There was also a resident diet list posted on the serving line for reference by the cooks.
-The list posted on the serving line did not list the

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D 296	Continued From page 30 specific orders for diabetics, it just said "diabetic". Second interview on 12/30/15 at 10:15 am with the Director of Food Service revealed: -The facility recently received new therapeutic diet menus. -The therapeutic diet menus did not have specific diets, such as 1500 calorie ADA or 2200 calorie ADA diets. -The therapeutic diet menus did have an 1800 calorie ADA diet, so that was what all diabetics were served. -"We usually try to catch it when the doctor writes an order for a diabetic diet we do not have and have them change it to an 1800 calorie ADA diet." -The Medication Aides for each unit were responsible for obtaining clarification of diet orders and communicating the orders to the Dietary Manager. -The line staff prepared the plates for diabetics, but do not have access to the specific therapeutic spreadsheet that showed what a resident was to be served. -The cooks were responsible for cooking the food according to the therapeutic menu and then told the servers what to serve. Interview on 12/30/15 at 10:25 am with the Executive Director revealed: -She was not aware there was not a therapeutic diet menu for each diet ordered. -The Medication Aides each unit were responsible for obtaining clarification of diet orders and communicating the orders to the Dietary Manager. -She would work with the Food Service Director to consider having a Resident Diet Order form that physician's may use to select from diets that were offered by the facility.	D 296		

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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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #5, #6) with orders for Clonidine, Albuterol via multidose inhaler and Albuterol via nebulizer. The findings are: A. Review of Resident #6's current FL-2 dated 09/09/15 revealed diagnoses included coronary artery disease, hypertension, congestive heart failure with diastolic dysfunction, chronic renal insufficiency, peripheral vascular disease, diabetes mellitus, and dementia. Review of Resident #6's Resident Register revealed an admission date of 08/04/12. 1. Review of Resident #6's FL-2 dated 09/09/15 revealed: -An order to check Resident #6's blood pressure	D 358		

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three times a day and as needed (all shifts).
-An order for Clonidine (a medication to treat high blood pressure) 0.1mg take one daily as needed for blood pressure greater than 175 - recheck blood pressure in 1 hour and report to physician if systolic is greater than 160.

Review of Resident #6's electronic Medication Administration Record (eMAR) for October 2015 revealed:
-There was a transcribed order to the eMAR to give Clonidine HCL 0.1mg as needed every 8 hours and only give if systolic blood pressure is greater than 175.
-Blood pressure checks were scheduled for first shift, second shift, and third shift with no time specified.
-There were 5 of 7 opportunities where Clonidine HCL 0.1mg was not administered as ordered as follows:
-Resident #6's blood pressure on 10/05/15 on second shift was 170/90 (not within parameters ordered), and was administered Clonidine 0.1mg at 9:53 pm.
-Resident #6's blood pressure on 10/13/15 on second shift was 148/76 (not within parameters ordered) and was administered Clonidine 0.1mg at 4:55 pm.
-Resident #6's blood pressure on 10/15/15 on third shift was 180/100 and Clonidine 0.1mg should have been administered.
-Resident #6's blood pressure on 10/17/15 on second shift was 178/80 and Clonidine 0.1mg should have been administered.
-Resident #6's blood pressure on 10/17/15 on third shift was 190/84 and Clonidine 0.1mg should have been administered.

Review of Resident #6's eMAR for November 2015 revealed:

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D 358	Continued From page 33 -There was a transcribed order to the eMAR to give Clonidine HCL 0.1mg as needed every 8 hours and only give if systolic blood pressure is greater than 175. -Blood pressure checks were scheduled for first shift, second shift, and third shift with no time specified. -There were 2 of 7 opportunities where Clonidine HCL 0.1mg was not administered as ordered as follows: -Resident #6's blood pressure on 10/09/15 on third shift was 160/75 (not within parameters ordered) and Clonidine 0.1mg was administered at 6:05 am. -Resident #6's blood pressure on 10/16/15 on second shift was 178/80 and Clonidine 0.1mg should have been administered. -Resident #6's blood pressure on 10/23/15 on third shift was 175/75 and Clonidine 0.1mg should have been administered. Review of Resident #6's eMAR for December 2015 revealed: -There was a transcribed order to the eMAR to give Clonidine HCL 0.1mg as needed every 8 hours and only give if systolic blood pressure is greater than 175. -Blood pressure checks were scheduled for first shift, second shift, and third shift with no time specified. -There were of 8 of 11 opportunities where Clonidine HCL 0.1mg was not administered as ordered as follows: -Resident #6's blood pressure on 12/02/15 on second shift was 190/76 and Clonidine 0.1mg should have been administered. -Resident #6's blood pressure on 12/04/15 on second shift was 180/80 and Clonidine 0.1mg should have been administered. -Resident #6's blood pressure on 12/07/15 on	D 358		

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second shift was 180/92 and Clonidine 0.1mg should have been administered..
-Resident #6's blood pressure on 12/10/15 on first shift was 180/80 and Clonidine 0.1mg should have been administered.
-Resident #6's blood pressure on 12/12/15 on second shift was 176/88 and Clonidine 0.1mg should have been administered.
-Resident #6's blood pressure on 12/18/15 on second shift was 180/80 and Clonidine 0.1mg should have been administered.
-Resident #6's blood pressure on 12/27/15 on second shift was 180/90 and Clonidine 0.1mg should have been administered.
-Resident #6's blood pressure on 12/30/15 on second shift was 178/82 and Clonidine 0.1mg should have been administered.

Review of Resident #6's record revealed there was no documentation on the October, November, or December 2015 MAR's of the BP's being rechecked 1 hour after administering Clonidine within the parameters ordered or physician called.

Interview with Resident #6 on 01/04/16 at 4:10 pm revealed:
-Sometimes her blood pressure was higher than 175 on third shift and she "did not get her pink pill within 30 minutes like I am supposed to".
-The Nurse Aides (NA) took her blood pressure and they told the Medication Aide (MA) when her BP was higher than 175.
-She had family members who had strokes and one died from a brain aneurysm which concerned her about her own blood pressure.

Interview with a Medication Aide (MA) on 12/30/15 at 5:18 pm revealed:
-She primarily worked on second shift.

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-The NAs were responsible for obtaining blood pressures for residents.
-The NAs entered the BPs into a handheld device.
-She did not know if the BPs the NAs entered were accessible to the MAs because "it is not on my screen when I give medicines".
-If Resident #6's systolic BP was greater than 175, the NA was supposed to let her know so she could give the Clonidine.
-She gave Resident #6's Clonidine when she knew her systolic BP was greater than 175.
-She was unaware of the parameters to recheck the blood pressure after administering Clonidine and contacting the physician if the systolic was greater than 160.

Interview with a MA on 12/30/15 at 10:15 am revealed:
-The NAs on third shift were responsible for obtaining blood pressures for Resident #6 as ordered.
-The MAs were responsible for administering the Clonidine as ordered.
-They had recently hired new MAs and they may need further education with using the computer system for medication administration.
-The MAs had access to Resident #6's blood pressures on the treatment screen in the computer.
-She thought she could "link" the blood pressure screen with the order for the Clonidine so the BP information would be available to the MA when they were administering medications.

2. Review of Resident #6's FL-2 dated 09/09/15 revealed an order for Albuterol 90 mcg/act aerosol solution inhale one puff four times a day.

Review of Resident #6's record revealed an order

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on 09/15/15 to change the Albuterol 90 mcg/act aerosol solution to inhale one puff twice a day.

Review of a medical provider visit note dated 09/15/15 revealed:
-Resident #6 had a history of chronic cough, with possible cause of seasonal allergies and post-nasal drip.
-She coughed mostly at night.
-She denied fever, chills, shortness of breath, or chest pain.

Review of Resident #6's electronic Medication Administration Record (eMAR) for October 2015 revealed:
-ProAir HFA (Albuterol sulfate inhalation aerosol) was scheduled on the eMAR to be administered as one puff by inhalation twice a daily at 8:00 am and 9:00 pm.
-Documentation that ProAir inhaler was not administered on the following dates and times:
-10/03/15 to 10/07/15 at 9:00 pm.
-10/08/15 at 8:00 am and 9:00 pm.
-10/11/15 at 9:00 pm.
-10/14/15 at 8:00 am and 9:00 pm.
-10/16/15 at 8:00 am and 9:00 pm.
-10/17/15 at 8:00 am and 9:00 pm.
-10/18/15 at 9:00 pm.
-10/19/15 at 8:00 am.
-10/20/15 at 8:00 am and 9:00 pm.
-10/21/15 at 9:00 pm
-10/22/15 at 8:00 am.
-There was no documentation as to the reason the ProAir inhaler was not administered.

Review of Resident #6's eMAR for November 2015 revealed ProAir HFA was administered as ordered from 11/01/15 to 11/30/15.

Review of Resident #6's eMAR for December

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D 358	Continued From page 37 2015 revealed ProAir HFA was administered as ordered from 12/01/15 to 12/30/15. Interview with Resident #6 on 12/29/15 at 9:55 am revealed: -She had a history of congestive heart failure, high blood pressure, and diabetes. -She had "a bad cough" from June 2015 until December 2015. -The medical provider ordered cough syrup and "I used two bottles of it", but it was expensive. -Several months ago the facility did not have the Albuterol inhaler "for a couple of weeks" because the insurance wouldn't pay for it. Second interview with Resident #6 on 01/04/16 at 4:05 pm revealed: -She missed the Albuterol for several days several months ago "because I was doing two puffs instead of one." -"I was using too much medicine and that is why I ran out early." -The insurance would not pay to refill the prescription for the Albuterol. -She was supposed to get the Albuterol twice a day. -She was receiving the Albuterol twice a day now. -She had not run out of Albuterol since it was refilled by the pharmacy. Observation on 01/04/16 at 4:10 pm revealed a Medication Aide administered Resident #6's medications and remained with her in the room until she had taken the medications. Interview with the facility's pharmacy on 12/31/15 at 12:30 pm revealed: -On 09/13/15 the pharmacy received a fax request from the facility for a refill of the Albuterol 90 mcg/act aerosol solution inhale one puff four	D 358		

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times a day.
-On 09/14/15 the pharmacy refilled the Albuterol 90 mcg/act aerosol solution inhale one puff four times a day (200 puffs = 50 days supply) and sent it to the facility.
-On 09/15/15 the pharmacy received a new order to decrease the dosage of the Albuterol to twice a day.
-"Since we just sent them a new inhaler, they would now have 100 days supply since the dosage was decreased to twice a day."
-The pharmacy did not fill the new prescription because they had sent an inhaler to the facility on 09/14/15.
-The facility could have requested a new label to apply to the inhaler for the new dosage.
-On 10/02/15 the pharmacy received a fax request from the facility for a refill with the prescription label to administer the Albuterol four times a day.
-The pharmacy faxed the request back to the facility with a note "Too soon. Should have enough".
-On 10/03/15 the pharmacy received a call from the facility requesting a refill of the Albuterol inhaler.
-The pharmacy responded to the 10/03/15 request with a fax stating "insurance will not pay until 10/22/15.
-On 10/05/15 the pharmacy received a fax again requested a refill for the Albuterol.
-The pharmacy responded to the 10/05/15 request with a fax stating "not refillable until 10/22/15".
-On 10/13/15 the pharmacy received a call from the facility requesting a refill and they told them they could not refill until 10/22/15.
-On 10/22/15 the pharmacy refilled the prescription for the Albuterol inhaler with directions to administer one puff twice a day and

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D 358	Continued From page 39 sent it to the facility. Interview with a MA on 12/31/15 at 10:40 am revealed: -She was aware Resident #6 was out of her Albuterol in October 2015. -She had tried to reorder the Albuterol but the insurance company would not pay for it because "it was too soon". -She did not know why Resident #6 had run out of the Albuterol inhaler prior to the time the insurance would pay for a refill. -She had sent a request to the pharmacy for a refill of the Albuterol inhaler, but she thought the fax machine had not completed the fax because they did not receive the refill from the pharmacy. -She thought it was only a couple of days that Resident #6 was out of the Albuterol inhaler. -She did not think there was additional documentation as to why the Albuterol inhaler was not available. Second interview with a MA on 01/04/16 at 11:15 revealed: -The reasons why a medication was not administered should be entered on the nurse progress notes. -The MA was unable to locate progress notes for Resident #6 for October 2015 to see if there was documentation regarding the facility's communication with the pharmacy and physician related to Resident #6 not having the Albuterol receiving the Albuterol inhaler as ordered. Interview with Resident #6's medical provider on 12/31/15 at 4:20 pm revealed: -Her practice provided care for Resident #6. -She was not sure if their group had been notified when Resident #6 did not receive the Albuterol inhalers for several days in October 2015.	D 358		

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D 358	Continued From page 40	D 358		

-She knew a MA had tried to reorder the Albuterol inhaler, but Resident #6's insurance would not pay for it.
-Resident #6 had not required acute care as a result of not receiving the Albuterol inhaler.

B. Review of Resident #5's current FL2 dated 7/28/15 revealed:
-Diagnoses included chronic obstructive pulmonary disease, congestive heart failure, atrial fibrillation.
-A physician order for oxygen (no liter flow or frequency indicated).
-A physician order for Albuterol Sulfate (2.5mg/3mL) 0.083% nebulizer solution - inhale one vial via nebulizer three times a day (albuterol sulfate is used to prevent and treat wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease).

Review of the Resident Register revealed Resident #5 was admitted to the facility 2/17/13.

Review of Resident #5's electronic Medication Administration Record (eMAR) for October 2015 revealed:
-Albuterol was entered on the eMAR and documented as administered daily at 8:00 am, 1:00 pm and 7:00 pm except for 5 documented refusals (7:00 pm on the 10/02, 10/04, 10/07, 10/13, and 10/26/15).

Review of Resident #5's eMAR for November 2015 revealed:
-Albuterol was entered on the eMAR and documented as administered daily at 8:00 am, 1:00 pm and 7:00 pm except for 13 documented refusals (1:00 pm on 11/09, 11/16, 11/16/15 and 7:00 pm on 11/01, 11/05, 11/06, 11/08, 11/09,

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D 358	Continued From page 41 11/13, 11,24, 11/26, 11/28 and 11/29/15). Review of Resident #5's eMAR for December 2015 revealed: -Albuterol was entered on the eMAR and documented as administered daily at 8:00 am, 1:00 pm and 7:00 pm except for 15 documented refusals (8:00 am on 12/28/15, 1:00 pm on 12/09, 12/14, 12/17, 12/28/15 and 7:00 pm on 12/01, 12/10, 12/12, 12/13, 12/17, 12/18, 12/21, 12/22, 12/24 and 12/25/15). Telephone interview with a representative from the facility's contracted pharmacy on 12/30/15 at 10:30 am revealed: -60 vials of albuterol sulfate was dispensed on 10/07/15. -60 vials of albuterol sulfate was dispensed on 11/05/15. -60 vials of albuterol sulfate was dispensed on 12/23/15. -The facility ordered the albuterol sulfate as they needed it and it was not automatically sent to the facility. -The albuterol sulfate was ordered by the physician three times a day. -A total of 180 vials were dispensed between 10/07/15 and 12/23/15. Observation of Resident #5's medications on hand on 12/29/15 at 4:15 pm revealed one box with 60 vials of albuterol vials dispensed on 12/23/2015 and 57 vials remained. -Review of the eMARs from October 7, 2015 through December 29 2015 revealed: -249 vials of albuterol sulfate were needed to administer the medication as ordered. -33 vials of albuterol were documented as not given and denoted as "Med Refused".	D 358		

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D 358	Continued From page 42 -A total of 216 vials of albuterol sulfate were required to administer the treatment as ordered including the refused vials. According to the amount of albuterol dispensed and amounts administered between 10/07/16 to 12/23/15, there would not have been enough albuterol available to administer as ordered. Interview with Resident #5 on 12/12/15 at 9:28 am revealed: -She did not know she took the albuterol to help her breathe. -She had refused it on occasion, but normally did want to take the medication. -She thought she was to take the treatments three times a day, but was not positive. -She received the treatments maybe once or twice a day. -Staff did not watch her complete the treatments and they do not have the time to come back and turn off the machine. -She often falls asleep during the treatments and had in the past dropped the nebulizer. Once she dropped the machine. -She used oxygen, but only at night while she was in bed. Interview with a Medication Aide (MA) on 12/30/15 at 11:36 am revealed: -She was to notify the doctor via phone or fax if a resident refused three doses of a medication. -She never called the doctor in regards to Resident #5's nebulizer treatments because Resident #5 never refused the treatments when she administered them. -She did not check to see if the Resident #5 completed her nebulizer treatments. -She knew Resident #5 refused treatments on occasion.	D 358		

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D 358	Continued From page 43 Interview with the MA on 12/31/2015 at 10:30 am revealed: -She would notify the physician if a resident refused a medication for a week. -She usually told the visiting physician or nurse practitioner about refusals when they made their weekly visit. -She did not call Resident #5's physician about the albuterol sulfate refusals and expected the MA would call or fax the physician. -She did know about Resident #5's refusals of the nebulizer treatments. -She did not know if a MA had ever called and notified Resident #5's physician. Interview with the Executive Director on 12/31/15 at 11:18 am revealed: -It was their policy to notify the physician if a resident refused three doses of a medication. -She expected the MA to call or fax the physician and notify them of the refusals. -She did know Resident #5 refused the albuterol sulfate treatments. -She did not know if facility staff notified the physician of the refusals. The facility provided a Plan of Protection on 1/04/15: -Re-training of staff on administering medications per physicians orders. -Revise Medication Aides responsibilities to include FSBS and checking vitals signs that are part of parameters for medication administration. -Immediately audit medication administration records to assure that medications are given per physicians orders. -The Executive Director and Quality Control Staff will randomly audit medication administration records to assure medications are given per	D 358		

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D 358	Continued From page 44 physicians orders. -The Executive Director and Quality Control Staff will randomly follow medication passes to assure that all staff are following the procedures for FSBS and vitals. -Any staff found not following procedures will receive discipline to include, retraining, write up and/or termination. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 18, 2016. .	D 358		
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, health care referral and follow up, ACH Infection Prevention Requirements and ACH Infection Prevention Requirements with training.	D912		

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D912	Continued From page 45 The findings are: A. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled resident (Residents #5, #6) with orders for clonidine, albuterol via nebulizer and albuterol via multidose inhaler. [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] B. Based on observation, interview and record review, the facility failed to notify the physician for 2 of 7 residents sampled regarding a resident's low blood sugars (Resident #4) and a resident not being weighed daily and receiving eye compresses (Resident #6). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment for 7 of 7 sampled residents (Residents #4, #12, #13, #14, #15, #16, and #17). [Refer to Tag 932, G.S. 131D-4.4 A(b)(Type B Violation).] D. Based on interview and record review, the facility failed to assure all medication aides received annual in-service training for infection control for 4 of 4 sampled Medication Aides (Staff B, E, F and G). [Refer to Tag 934, G.S. 131 D-4.5 B(a) (Type B Violation).]	D912		

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D932	Continued From page 46	D932		
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 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,	D932		

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D932	Continued From page 47 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 Centers for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment for 7 of 7 sampled residents (Residents #4, #12, #13, #14, #15, #16, and #17). The findings are: Observation on 12/30/15 at 11:00 am of the treatment cart and glucometer storage revealed: -There was one treatment cart on the first floor with a total of 15 glucometers that were labeled with a resident's name. -Each of the 15 labeled glucometers was in a separate basket labeled with a resident's name, along with single use lancets and alcohol swabs. -The medication cart had a container of Environmental Protection Agency (EPA)-approved disinfectant wipes located on top of the cart. -The glucometers were manufactured by various companies. Interview with the Executive Director on 12/30/15 at 6:30 pm revealed: - The facility had 47 residents receiving fingerstick blood sugar checks. - None of the residents receiving fingerstick blood	D932		

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D932	Continued From page 48 sugar checks had a diagnosis of blood borne infectious disease such as hepatitis or Human Immunodeficiency Virus (HIV). Based on the Center for Disease Control (CDC) guidelines for infection control, the recommendations were that blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list the disinfection information, the glucometer should not be shared between residents. Review of the glucometer Brand B's operation manual revealed: -"The meter and lancing device are for single patient use. Do not share them with anyone including other family members! Do not use on multiple patients!" -"All parts of the kit are considered biohazardous and can potentially transmit infectious diseases, even after you have performed cleaning and disinfection." Telephone interview on 12/30/15 at 4:41 pm with a representative from glucometer Brand A's customer service department revealed: -That this glucometer could be used on more that one person if proper disinfection protocols were adhered to. -The protocol for proper disinfection required the use of a .55% sodium hypochlorite wipe be used to clean the glucometer and then wrapped for 5 minutes. Telephone interview on 12/30/15 at 4:46 pm with a representative from glucometer Brand B's customer service department revealed that Brand	D932		

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D932	Continued From page 49 B was not intended for multi-patient use and there was no manufacturer's recommended cleaning or disinfecting instructions that would allow this machine to be used on multiple people. Telephone interview on 12/30/15 at 5:11 pm with a representative from glucometer Brand D's customer service department revealed the Brand D was not approved by the manufacturer to be used on more than one person. A. Review of Resident #14's current FL2 dated 10/06/15 revealed: -Diagnoses included diabetes mellitus. Review of Resident #14's physician's orders dated 12/08/15 revealed an order dated 12/08/15 for FSBS two times daily. Review of Resident #14's October 2015, November 2015 and December 2015 electronic Medication Administration Records (eMAR) revealed the FSBS was completed twice daily at 6:00 am and 4:30 pm. Review of the memory for the glucometer labeled with Resident #14's name revealed: -The glucometer used for Resident #14 was "Brand D". -The date and time was accurately set. -The values in the glucometer history were inconsistent with the values entered on the eMAR. -The FSBS result for 12/08/15 at 6:06 am of 149 was consistent with the result entered on the eMAR for 12/08/15 at 6:00 am. -There were two additional readings in the glucometer for 12/08/15 with values of 115 at 1:40 am and 157 at 4:36 am that did not match the documentation on Resident #14's eMAR.	D932		

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D932	Continued From page 50 -The FSBS result for 12/11/15 at 6:09 am of 258 and 4:22 pm of 318 were both consistent with the result entered on the eMAR. -There were two additional readings in the glucometer for 12/11/15 with values of 290 at 7:31 pm and 314 at 10:20 pm that did not match the documentation on Resident #14's eMAR. -The 12/11/15 FSBS of 314 in the glucometer memory at 10:20 pm was consistent with values documented on another resident's eMAR for the corresponding day and time. -On 12/12/15 there were four readings found in the glucometer (343 at 6:10 am, 234 at 10:22 am, 310 at 4:16 pm and 345 at 8:58 pm). -There were no values entered on Resident #14's eMAR for 12/12/15 and it could not be determined which blood sugars belonged to Resident #14. -The FSBS result for 12/23/15 at 6:07 am of 156 and at 4:04 pm of 160 were consistent with the results entered on Resident #14's eMAR for 12/23/15. -There were two additional readings in the glucometer for 12/23/15 with values of 115 at 1:40 am and 229 at 4:15 am. -The 12/23/15 reading of 229 at 4:15 am was consistent with a value documented on another resident's eMAR for the corresponding day and time. Review of Resident #14's FSBS of the December 2015 eMAR and the glucometer memory for 12/01/15 through 12/30/15 revealed: -The FSBS was documented as completed daily at 630 am and 4:30 pm. -There were 4 occasions in which the documented FSBS on the eMAR did not appear in Resident #14's glucometer memory. Documented FSBSs which did not appear in	D932		

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D932	Continued From page 51	D932		

Resident #14's glucometer memory included:
-FSBS 164 on 12/05/15 at 4:30 pm.
-FSBS 169 on 12/08/15 at 4:30 pm.
-FSBS 136 on 12/17/15 at 6:00 am
-FSBS 236 on 12/19/15 at 4:30 pm

Interview with Resident #14 on 12/31/15 at 2:25 pm revealed:
-She had her blood sugar taken twice a day.
-She knew she had her own glucometer because they gave it to her when she went to her family member's house.
-She was not aware if they used a different glucometer on her.

Refer to interview on 12/30/15 at 5:30 pm with the Executive Director.

Refer to interview on 12/31/15 at 11:02 am with a Medication Aide (MA).

Refer to interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am.

Refer to interview with a second PCA on 12/31/15 at 11:28 am.

B. Review of Resident #12's current FL2 dated 10/28/15 revealed a diagnoses of diabetes mellitus.

Review of Resident #12's physician's orders dated 12/08/15 revealed an order dated 12/08/15 for FSBSs two times daily.

Review of Resident #12's December 2015 electronic Medication Administration Record (eMAR) revealed the FSBS was completed twice daily at 6:00 am and 4:30 pm.

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D932	Continued From page 52 Review of the memory for the glucometer labeled with Resident #12's name revealed: -The glucometer used for Resident #12 was "Brand B". -The date and time was accurately set. -The values in the glucometer history were inconsistent with the values entered on Resident #12's eMAR. -The FSBS result for 12/11/15 at 5:55 am of 134 and at 4:10 pm of 260 were consistent with the results entered on Resident #12's eMAR. -There were two additional readings in the glucometer for 12/11/15 with values of 141 at 5:59 am and 471 at 7:22 pm. -The FSBS result for 12/21/15 at 4:16 pm of 187 was consistent with the result entered on the MAR. -The FSBS result for 12/21/15 at 6:00 am documented on the eMAR was consistent with a value found in another residents glucometer for the same date and time. -The FSBS for 12/24/15 at 4:19 pm of 180 was consistent with the results entered on Resident #12's eMAR. -There were two additional readings in the glucometer for 12/24/15 with values of 130 at 6:20 am and 271 at 4:22 pm that did not match the documentation on Resident #12's eMAR. -The 12/24/15 FSBS of 271 at 4:22 pm was consistent with a value documented on another resident's eMAR for the corresponding day and time. Review of Resident #12's FSBS of the December 2015 eMAR and the glucometer memory for 12/11/15 through 12/30/15 revealed: -The FSBS was documented as completed daily at 630 am and 4:30 pm. -There were 4 occasions in which the documented FSBS did not appear in Resident	D932		

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D932	Continued From page 53 #12's glucometer memory. Documented FSBSs which did not appear in Resident #12's glucometer memory included: -FSBS 183 on 12/14/15 at 6:00 am. -FSBS 161 on 12/17/15 at 6:00 am. -FSBS 131 on 12/21/15 at 6:00 am. -FSBS 111 on 12/28/15 at 6:00 am. Interview with Resident #12 on 12/31/15 at 2:52 pm revealed: -He did not know how often he had his blood sugar checked, but thought it was taken twice a day. -He did not know if they used the same machine each time they took his blood sugar. Refer to interview on 12/30/15 at 5:30 pm with the Executive Director. Refer to interview on 12/31/15 at 11:02 am with a Medication Aide (MA). Refer to interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am. Refer to interview with a second PCA on 12/31/15 at 11:28 am. C. Review of Resident #13's current FL2 dated 12/08/15 revealed: -Diagnoses included diabetes mellitus. Review of Resident #13's physician's orders dated 11/12/15 revealed an for FSBSs once daily. Review of Resident #13's December 2015 eMAR revealed the FSBS was completed once daily at 6:00 am.	D932		

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D932	Continued From page 54 Review of the memory for the glucometer labeled with Resident #13's name revealed: -The glucometer used for Resident #13 was "Brand B". -The date and time was accurately set. -The values in the glucometer memory were inconsistent with the values documented on Resident #13's eMAR. -The FSBS for 12/08/15 at 6:08 am of 91 was consistent with the results entered on Resident #13's eMAR. -There was one additional reading in the glucometer for 12/08/15 with a value of 208 at 6:10 am and this value was consistent with values documented on another resident's eMAR for the corresponding day and time. -The FSBS for 12/10/15 at 6:09 am of 109 was consistent with the results entered on Resident #13's eMAR. -There was one additional reading in the glucometer for 12/10/15 with a value of 60 at 10:27 am that did not match the documentation on Resident #13's eMAR. -The FSBS result for 12/11/15 at 6:08 am of 130 was consistent with the results entered on Resident #13's MAR. -There were three additional readings in the glucometer for 12/11/15 with values of 165 at 6:09 am, 140 at 6:11 am and 214 at 10:36 am that did not match the documentation on Resident #13's eMAR. -The 12/11/15 readings of 165 at 6:09 am and 140 at 6:11am were consistent values documented on another resident's eMAR for the corresponding day and time. Review of Resident #13's FSBS results on the December 2015 eMAR and the glucometer memory for 12/07/15 through 12/30/15 revealed: -The FSBS was documented as completed daily	D932		

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at 630 am and 4:30 pm.
-There was 1 occasion in which the documented FSBS did not appear in Resident #13's glucometer memory, which was a FSBS 127 on 12/28/15 at 6:00 am.

Refer to interview on 12/30/15 at 5:30 pm with the Executive Director.

Refer to interview on 12/31/15 at 11:02 am with a Medication Aide (MA).

Refer to interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am.

Refer to interview with a second PCA on 12/31/15 at 11:28 am.

D. Review of Resident #4's current FL-2 dated 1/07/15 revealed:
-Diagnoses included diabetes mellitus.

Review of Resident #4's physician's orders revealed an order dated 12/11/15 for FSBSs four times daily.

Review of Resident #4's December 2015 electronic Medication Administration Records (eMAR) revealed the FSBS was completed four times daily at 6:30 am, 10:30 am, 4:30 pm and 7:00 pm.

Review of the memory for the glucometer labeled with Resident #4's name revealed:
-The glucometer used for Resident #4 was "Brand A".
-The date and time was accurately set.
-The FSBS in the glucometer memory were inconsistent with the values entered on the MAR.
-There were 14 occasions that the FSBS

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documented on the eMAR were inconsistent with the glucometer memory and some examples include:
-FSBS documented on the eMAR on 12/05/15 at 7:00 pm was documented as 108 and the FSBS recorded in Resident #4's glucometer memory for the corresponding date and time was 130.
-FSBS on eMAR on 12/15/15 at 7:00 pm was documented as 193 and the FSBS recorded in Resident #4's glucometer memory for the corresponding date and time was 293.
-FSBS documented on the eMAR on 12/25/15 for 10:30 am, 4:30 pm and 7:00 pm was documented as 251, 167 and 138 and the FSBS recorded in Resident #4's glucometer memory for the corresponding date and time was 312, 67 and 249, respectively.
There were 14 occasions in which the documented FSBS did not appear in Resident #4's glucometer memory as follows:
-Documented FSBSs which did not appear in Resident #4's glucometer memory and include examples as follows:
FSBS 108 on 12/03/15 at 4:30 pm.
FSBS 136 on 12/03/15 at 7:00 pm.
FSBS 196 on 12/06/15 at 10:30 am.
FSBS 75 on 12/06/15 at 4:30 pm.
FSBS 121 on 12/06/15 at 7:00 pm.
FSBS 116 on 12/12/15 at 4:30 pm.
FSBS 121 on 12/14/15 at 7:00 pm.

Interview with Resident #4's Responsible Party (RP) on 12/31/15 at 2:13 pm revealed:
-When Resident #4 was admitted to the facility the RP was charged full price for test strips and lancets, but not a glucometer.
-Approximately a month after Resident #4 was admitted to the facility he obtained a glucometer and since then the RP had provided all the test strips and lancets.

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-The RP did not know what glucometer they were using prior to the RP obtaining one.
-The RP was prompted to obtain the new glucometer because the facility's contracting pharmacy was charging full price and not billing medicare.

Refer to interview on 12/30/15 at 5:30 pm with the Executive Director.

Refer to interview on 12/31/15 at 11:02 am with a Medication Aide (MA).

Refer to interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am.

Refer to interview with a second PCA on 12/31/15 at 11:28 am.

E. Review of Resident #15's current FL2 dated 09/29/15 revealed
-Diagnoses included diabetes mellitus.
-The resident was assessed as intermittently disoriented.
-An order for finger stick blood sugars (FSBS) every day at 6:30 am.

Review of Resident #15's physician's orders revealed an order dated 11/12/15 for FSBS daily.

Review of Resident #15's December 2015 electronic Medication Administration Records (eMAR) revealed the FSBS results were documented daily at 6:30 am .

Review of the memory for the Brand B glucometer labeled with Resident #15's name revealed:
-The date and time was accurately set.
-Values in the glucometer history were

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inconsistent with the values documented on the eMAR.
-Multiple FSBS values within a short period of time were recorded in Resident #15's glucometer's memory.
-There were 35 FSBS recorded in the glucometer's memory from 12/01/15 to 12/30/15.
-There were 2 occasions in which the FSBS documented on the eMAR did not appear in Resident #15's glucometer's memory.

Examples of FSBS values recorded in Resident #15's glucometer memory that were not consistent with FSBS values documented on the December 2015 eMAR were as follows:
-On 12/11/15 at 6:18 am, FSBS of 98 recorded in glucometer's memory and not documented on the eMAR. (FSBS value of 111 was documented on the eMAR and recorded in Resident #15's glucometer's memory for 6:17 am on 12/11/15.)
-On 12/17/15 at 6:30 am, FSBS of 126 documented in the eMAR and not recorded in the glucometer's memory.
-On 12/17/15 at 6:37 am, FSBS of 160 recorded in glucometer's memory and not documented on the eMAR.
-On 12/17/15 at 6:38 am, FSBS of 305 recorded in glucometer's memory and not documented on the eMAR.
-On 12/17/15 at 6:39 am, FSBS of 213 recorded in glucometer's memory and not documented on the eMAR.
-On 12/17/15 at 6:41 am, FSBS of 161 recorded in glucometer's memory and not documented on the eMAR.
-On 12/28/15 at 6:30 am, FSBS of 120 documented on the eMAR and not recorded in the glucometer's memory.

Interview on 12/31/15 at 4:05 pm with Resident

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#15 revealed:
-Staff obtained FSBS regularly for the resident.
-The resident was not aware of the type of glucometer used to take FSBS.
-Resident relied on staff to use proper equipment for obtaining FSBS.

Refer to interview on 12/30/15 at 5:30 pm with the Executive Director.

Refer to interview on 12/31/15 at 11:02 am with a Medication Aide (MA).

Refer to interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am.

Refer to interview with a second PCA on 12/31/15 at 11:28 am.

F. Review of Resident #16's current FL2 dated 04/30/15 revealed
-Diagnoses included Type II Diabetes.
-The resident was not assessed as disoriented.
-An order for finger stick blood sugars (FSBS) every day.

Review of Resident #16's physician's orders revealed an order dated 12/08/15 for FSBS daily.

Review of Resident #16's December 2015 electronic Medication Administration Records (eMAR) revealed the FSBS results were documented daily at 6:30 am .

Review of the memory for the Brand D glucometer labeled with Resident #16's name revealed:
-The date and time was accurately set.
-Values in the glucometer history were inconsistent with the values entered on the

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D932	Continued From page 60 eMAR. -Multiple FSBS values within a short period of time were recorded in Resident #16's glucometer's memory. -There were 27 FSBS recorded in the glucometer's memory from 12/01/15 to 12/30/15. -There were 5 occasions in which the FSBS documented on the eMAR did not appear in Resident #16's glucometer's memory. Examples of FSBS values recorded in Resident #16's glucometer memory that were not consistent with FSBS values documented on the December 2015 eMAR were as follows: -On 12/03/15, 12/08/15, 12/10/15, 12/21/15, and 12/18/15 at 6:30 am, FSBSs of 161, 143, 213, 240, and 237 respectively were not recorded in Resident #16's glucometer's memory and were documented on the December 2015 eMAR. -On 12/09/15 at 7:00 am, FSBS of 204 was recorded in the glucometer's memory and documented on the December 2015 eMAR. -On 12/09/15 at 7:20 am, FSBS of 120 was recorded in the glucometer's memory and was not documented on the eMAR. (FSBS value was consistent for FSBS value documented on another sampled resident's eMAR but not recorded their glucometer's memory.) -On 12/11/15 at 5:30 pm, FSBS of 109 was recorded in glucometer's memory and was not documented on the eMAR. (FSBS value was consistent for FSBS value documented on another sampled resident's eMAR but not recorded their glucometer's memory.) Interview on 12/31/15 at 4:10 pm with Resident #16 revealed: -Staff obtained FSBS regularly each day for the resident. -He did not pay attention to the type of	D932		

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glucometer used to take FSBS.
-He was not familiar with the brand of glucometer routinely used for his FSBS.
-Resident relied on staff to use proper equipment for obtaining FSBS.

Refer to interview on 12/30/15 at 5:30 pm with the Executive Director.

Refer to interview on 12/31/15 at 11:02 am with a Medication Aide (MA).

Refer to interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am.

Refer to interview with a second PCA on 12/31/15 at 11:28 am.

G. Review of Resident #17's current FL2 dated 12/22/15 revealed
-Diagnoses included Type II Diabetes.
-An order for finger stick blood sugars (FSBS) 2 times every day.

Review of Resident #17's previous physician's orders dated 11/17/15 revealed an order for FSBS 2 times daily.

Review of Resident #17's December 2015 electronic Medication Administration Records (eMAR) revealed the FSBS results were documented daily at 6:00 am and 4:30 pm.

Review of the memory for the Brand D glucometer labeled with Resident #17's name revealed:
-The date and time were not accurately set. (Date and time displayed 12/29/15 at 12:32 pm and actual date and time were 12/30/15 at 6:45 pm.)
-Values in the glucometer history were

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inconsistent with the values entered on Resident #17's eMAR.
-There were 35 FSBS recorded in the glucometer's memory from 12/07/15 to 12/30/15 with 47 FSBS values documented on the December 2015 eMAR. (Resident #17 was documented as out of the facility on 12/28/15 at 4:30 pm and no FSBS value was recorded in the glucometer's memory for that time.)

Review of FSBS values documented on Resident #17's December eMAR revealed the following examples:
-There were 11 occasions in which the FSBS documented on the December 2015 eMAR did not appear in Resident #17's glucometer's memory.
--On 12/09/15 at 6:00 am, FSBS of 120 was documented on the eMAR and was not recorded in Resident #17's glucometer's memory. (FSBS value was consistent for FSBS value documented on another sampled resident's eMAR but not recorded their glucometer's memory.)
-On 12/11/15 at 4:30 pm, FSBS of 109 documented on the eMAR and was not recorded in Resident #17's glucometer's memory. (FSBS value was consistent for FSBS value documented on another sampled resident's eMAR but not recorded their glucometer's memory.)

Examples of FSBS values recorded in Resident #17's glucometer memory that were not consistent with FSBS values documented on the December 2015 eMAR were as follows:
-On 12/08/15 at 6:00 am, FSBS of 89 was documented on the eMAR; not recorded in the resident's glucometer's memory.
-On 12/08/15 at 4:30 pm, FSBS of 116 was documented on the eMAR; not recorded in the resident's glucometer's memory.

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D932	Continued From page 63 -On 12/09/15 at 4:30 pm, FSBS of 99 was documented on the eMAR; not recorded in the resident's glucometer's memory. -On 12/10/15 at 6:00 am, FSBS of 106 was documented on the eMAR; not recorded in the resident's glucometer's memory. -On 12/10/15 at 4:30 pm, FSBS of 196 was documented on the eMAR; not recorded in the resident's glucometer's memory. -On 12/11/15 at 6:00 am, FSBS of 116 was documented on the eMAR; not recorded in the resident's glucometer's memory. -On 12/11/15 at 4:30 pm, FSBS of 109 was documented on the eMAR; not recorded in the resident's glucometer's memory. Interview on 12/31/15 at 3:35 pm with Resident #17 revealed: -Staff obtained FSBS regularly 2 times each day for the resident. -Staff had used 2 different types of glucometer to check FSBS recently. -She was not certain which staff used each type of glucometer. Refer to interview on 12/30/15 at 5:30 pm with the Executive Director. Refer to interview on 12/31/15 at 11:02 am with a Medication Aide (MA). Refer to interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am. Refer to interview with a second PCA on 12/31/15 at 11:28 am. Interview on 12/30/15 at 5:30 pm with the Executive Director (ED) revealed: -The facility policy was for each resident receiving	D932		

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fingerstick blood sugar checks to have a glucometer assigned to the individual resident.
-Staff were not supposed to share glucometers between residents.
-The facility had an Environmental Protection Agency (EPA) approved disinfecting wipe that was effective against Hepatitis A and B, tuberculosis, and Human Immunodeficiency Virus (HIV).
-Staff were supposed to wipe the glucometer's with the EPA approved disinfecting wipe after each use.
-The facility did not have a procedure in place to routinely clean and disinfect glucometers.
-The facility did not currently have a system in place to audit FSBS values recorded in residents' glucometer's memory compared to values documented on the electronic Medication Administration Records for consistency.
-She was not aware staff were sharing glucometers between residents.

Interview on 12/31/15 at 11:02 am with a Medication Aide (MA) revealed:
-She had been employed at this facility for over a year.
-She had received training and knew that she was not to share glucometers between residents.
-She was taught that she could clean the glucometers with antibacterial wipes or alcohol swabs.
-There was a glucometer that staff could use if a resident ran out of test strips.

Interview with a Personal Care Aide (PCA) on 12/31/15 at 11:24 am revealed:
-She had worked at this facility for approximately a year.
-She was checked off for glucometer use by a nurse.

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	HAL013044	A. BUILDING: _____ B. WING _____	C 01/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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
D932	Continued From page 65 -She knew not to share glucometers. -She was taught by another MA that she could clean the glucometers with alcohol pads. Interview with a second PCA on 12/31/15 at 11:28 am revealed: -She worked at this facility for over a year. -She was trained by a Registered Nurse on glucometer use. -She was trained not to use alcohol swabs to clean glucometers but was trained to use antibacterial wipes that were kept on the cart. -She was told by her supervisor that she could borrow anther resident's glucometer when a resident ran out of test strips. The facility provided a Plan of Protection on 12/30/15: -Immediate training of staff on the use of glucometer machines and not sharing the machines. -All policies related to diabetic procedures will be reviewed and revised. -Each individual resident will have their own glucometer and it will be labeled with their names. -Individual glucometers are kept inside the zippered glucometer bag and will be labeled with the resident's name. The glucometer bag will be stored inside a zipper lock bag also with the resident's name. -Prior to checking a resident's blood sugar, ensure that the name on the glucometer, zipper bag and zip lock bag all match the resident who is having their sugar checked. -Notify the Executive Director whenever you have a glucometer, glucometer bag or a zip lock bag that does not have a label with the residents' name. -The physician will be contacted to hold blood sugars until individual glucometer machines are	D932		

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D932	Continued From page 66 received. -Glucometer machines will be received on the evening of 12/30/15, stored labeled according to policy. -The Executive Director and the Quality Control Staff will monitor glucometer usage to assure that machines are not shared. -Any staff found not following policy and procedures will be disciplined by a write up, retraining and up to termination. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 18, 2016.	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 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	D934		

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D934	Continued From page 67 Based on interview and record review, the facility failed to assure all medication aides received annual in-service training for infection control for 4 of 4 sampled Medication Aides (Staff B, E, F and G). The findings are: A. Review of Staff B's personnel record revealed: -A hire date of 9/10/12 and employed as a Medication Aide (MA). -A Medication Clinical Skills checklist completed on 10/24/12. -Documentation of a passing score on the Medication Aide test on 12/20/07. -There was no signed certificate of annual infection control training. Interview with Staff B on 12/31/15 at 2:35 pm revealed: -She had been a MA at this facility for approximately three years. -She had taken a class on infection control since her employment. -She thought the class was the state annual infection control class, but was not sure. -She did not think she had an infection control class over the last year. Refer to interview with the Executive Director on 12/31/15 at 2:35pm. Refer to interview with the Executive Director on 12/31/15 at 2:35pm. B. Review of Staff E's personnel record revealed: -A hire date of 10/21/10 and employed as a Medication Aide (MA). -A Licensed Practical Nurse verification with a Licensed Expiration date of 10/31/17.	D934		

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D934	Continued From page 68 -She functioned as a MA, not an LPN in this facility. -There was no signed certificate of annual infection control training. Staff E was unavailable for interview. Refer to interview with the Executive Director on 12/31/15 at 2:35pm. C. Review of Staff F's personnel record revealed: -A hire date of 12/15/04 and employed as a Personal Care Aide and promoted to Medication Aide (MA). -A Medication Clinical Skills checklist completed on 6/08/07. -Documentation of a passing score on the Medication Aide test on 7/16/09. -There was no signed certificate of annual infection control training. Interview with Staff F on 12/31/15 at 3:06 pm revealed: -She had been an employee for over 10 years. -She functioned as a MA. -She had taken an infection control course, but did not know when. -She did not think there was one held this year, but was not sure. Refer to interview with the Executive Director on 12/31/15 at 2:35pm. D. Review of Staff G's personnel record revealed: -A hire date of 10/18/12 and functions as a Personal Care Aide and a Medication Aide (MA). -A Medication Clinical Skills checklist completed on 1/28/13. -Documentation of a passing score on the Medication Aide test on 7/27/05.	D934		

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D934	Continued From page 69 -There was no signed certificate of annual infection control training. Interview with Staff G on 12/31/15 at 3:13 pm revealed: -She has worked at the facility for about 3 years. -She functioned as a MA and a PCA. -She had taken an infection control class, but not within the last year. Refer to interview with the Executive Director on 12/31/15 at 2:35pm. Interview with the Executive Director on 12/31/15 at 2:35pm revealed: -She knew that the state annual infection control course was required annually. -She had [named instructor] come and teach the course. -They kept all the infection control training in a separate binder and they were unable to locate this binder. -She called the instructor to see if she had a record of staff that took her course and the instructor informed the ED that she had not been there within the last year. The facility provided a Plan of Protection on 1/04/15 as follows: -A training has been scheduled for staff on G.S. 131D 4.5(b) Adult care Home Infection Control. -Training will be scheduled biannually to assure that all required staff receive the mandatory infection control class. -The Executive Director and the Quality Control staff will randomly audit staff training to assure that staff are trained per G.S. 131D 4.5(b) Adult care Home Infection Control. CORRECTION DATE FOR THE TYPE B	D934		

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D934	Continued From page 70 VIOLATION SHALL NOT EXCEED FEBRUARY 18, 2016.	D934		