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D 000	Initial Comments The Adult Care Licensure Section and the Currituck County Department of Social Services conducted an annual survey and complaint investigation on January 27, 2016-January 29, 2016 and on February 1, 2016.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 7 of 7 sampled medication aides	D 164		

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D 164	Continued From page 1 (Staff A,B,C,D,E,F and G) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: Review of Staff A,B,C,D,E,F and G's personnel records on 1/29/16 revealed: -All were medication aides. -All are currently administering medication independently. -All had completed the Medication Clinical Skills validation prior to resident care. -There was no documentation of training on the care of residents with diabetes. -All had passed the Medication Aide exam. -All had administered insulin based on verification of resident medication administration records. Confidential interview with staff revealed: -There was no specific training on diabetic care. -The skills checklist was all they needed to have to administer insulin. -There was no recollection of a specific class or study guide on care of the diabetic resident. -They did not recall having a nurse educator for teaching diabetic care. Interview with Administrator on 1/29/16 at 3:00pm revealed: -The staff always get trained on everything they need prior to resident care. -She did not know who taught the diabetic care course. -The diabetic training must have been performed upon hire. -The documentation was unavailable and she would look for the training certifications. -She would review all Medication Aide personnel records to make sure that they have had the required training on the care of residents with	D 164		

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D 164	Continued From page 2 diabetes. -She was under the impression it was part of the medication aide training that they could administer insulin and nothing further was needed. -No policy exists to ensure specific diabetic training to employees prior to insulin administration. A second review of Staff A,B,C,D,E,F and G's personnel records on 2/1/16 revealed: -All had diabetic training certificates signed by the corporate nurse consultant on 1/31/16. -No response from the Administrator was received when asked if diabetic training had been performed over the weekend on Sunday 1/31/16 after discovery of the lack of documentation on 1/29/16.	D 164		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building,	D 219		

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or within 500 feet and
immediately available.**
Administrator On call
41-50 Aide 20 20 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
51-60 Aide 24 24 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
61-70 Aide 28 28 24
Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

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121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16

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D 219	Continued From page 5 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 221-230 Aide 92 92 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 231-240 Aide 96 96 64 Supervisor 24 24 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure minimal weekend staffing was provided on the assisted living unit from 12/19/15 to 1/24/16. The findings are: Interview with the Administrator on 1/29/16 at 2:45pm revealed the census had a minimum of 32 residents on the special care unit and 34 on the assisted living side of the facility during the month of December 2015 and January 2016. Review of staff hours on the time sheets for the weekend staffing from 12/19/15 to 1/24/16 for first, second and third shift revealed: (Staffing rules require 24 hours for a census of 31-40 residents on 1st and 2nd shift; 16 hours on 3rd shift) -12/19/15: 16 hours for 1st shift, zero coverage for 3rd shift. -12/20/15: Requirement met -12/26/15: Requirement met -12/27/15: 8 hours for 3rd shift -1/2/16: Requirement met	D 219		

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D 219	Continued From page 6 -1/3/16: 8 hours for 3rd shift -1/9/16: 20 hours for 1st shift -1/10/16: 16 hours for 1st shift -1/16/16: Requirement met -1/17/16: Requirement met -12/23/16: 16 hours for 1st shift. -12/24/16: 16 hours for 1st shift, 8 hours for 3rd shift. -Five out of six weekends had at least one shift or more with understaffing. -One weekend day had zero coverage for 3rd shift. -All staff time records recorded staff titles and time entries for personal care aides, supervisors in charge, medication aides, business manager, cooks, and housekeeping. Confidential interviews with 4 staff regarding staffing on 1st, 2nd and 3rd shift revealed: -Third shift frequently is understaffed. -There were not enough staff to bathe all the residents on posted schedules. -The week-ends "always" seemed to be short on staff. -The residents need a lot of care, especially in the special care unit. -If we had more staff, we could take better care of the residents. -There were "a lot" of staff members who called out of work for various reasons. -There were not any extra staff members to work in place of those who called out of work. -We had staff quit recently and are in the process of hiring and training new staff. -When staff call in, they were supposed to find their own replacement, but sometimes they did not. -When we had staff call-outs, we tried to look unsuccessfully for alternate staff to come in on several occasions.	D 219		

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D 219	Continued From page 7 Interview with the Administrator on 1/29/16 at 2:15pm revealed: -Staff have quit and "I try to hire staff when I need them." -She was not aware of a staffing deficiency. -She has placed advertisements in the past in the local paper when they need staff. -There currnetly was no ad in the newspaper for staffing need. -It has become increasingly difficult to find staff. -Two staff were recently suspended pending investigations which caused scheduling issues. Confidential interviews with residents and resident's family members revealed: -The facility was frequently understaffed on the weekends. -There were insufficient staff on the third shift in the entire facility. -Residents were not getting bathed according to schedule due to low staffing. -There were many falls at the facility which they related to low staffing especially when certain residents needed a 2-person assist. -The RCC tries to assist in both the assisted living side and the special care side when staffing is low but was overwhelmed due to frequent call outs. -The administrator has been told about the need for more staffing. Interview with Administrator related to resident census for December 2015 and January 2016 revealed: -Occupancy for the special care unit on between 12/9/15 to 1/28/16 has been at 32 at the lowest census. -Occupancy for the assisted living unit on between 12/9/15 to 1/28/16 has been at 34 at the	D 219		

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D 219	Continued From page 8 lowest census. Interview with Corporate Director and Administrator on 2/1/16 at 3:00pm revealed: -A new program had been used to keep track of staffing and time keeping for the last two months. -The program was unreliable. -It was impossible that the facility was understaffed and that the timekeeping records were inaccurate. -They would investigate the staffing time logs for any errors as they had no complaints of understaffing by staff or residents. -They could not explain why the staffing hours on their own time tracking system showed understaffing on several shift. -The Administrator had historically placed advertisements in the local newspaper when staffing was needed. -There was not a current advertisement for staff needed. -The Administrator did not respond to the question of whether or not the facility met the minimum staff requirements on all weekend shifts during the months of December and January. -All medication aides could float and have floated between the assisted living side and the special care unit when needed. -He would ensure all staffing levels were at the required level.	D 219		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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D 270	Continued From page 9 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure supervision for 1 of 7 sampled residents with continued falls that resulted in injuries (#5). The findings are: Review of Resident #5's current FL2 dated 1/13/16 revealed the resident's diagnoses included Alzheimer's type dementia, diabetes type II, hypertension, hypothyroidism, and asthma. Review of the Resident's Register revealed Resident #5 was admitted to the facility on 11/12/12. Review of the FL2 dated 1/13/16 for Resident #5 revealed the resident was "ambulatory." Review of Incident Reports revealed: -On 8/19/15 with a closed head injury and was sent to local emergency department for assessment. The resident was found by staff in her bathroom in front of the mirror located in the AL unit. -On 10/22/15 with her right ankle sprained and the resident was sent to the local emergency department. The resident was found sitting on the floor, in the hallway of the AL unit, beside the dining room area -On 11/04/15 there were two separate falls documented with no visible injuries noted that occurred in the AL unit. -On 1/11/16 a head injury due to hitting her head	D 270		

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and was went to the local emergency department. The resident fell twice in the AL unit reported by staff.

Confidential Interview with a staff member on 1/28/16 at 8:41 a.m. revealed:
-The residents were unsupervised on many occasions by facility staff due to staff shortages for 2 - 3 hours or more at times.
-The staff member was unable to specify the number of times the residents were unsupervised due to being short staffed.
-Facility staff were unable to successfully monitor residents who had falls on the Assisted Living and Special Care Units.
-Resident #5 was found with falls and injuries as a result of being short staffed on a "few occasions" but mostly on the evening and night shifts. No specific number of these falls were given.
-The Residential Care Coordinator (RCC) and the Administrator were made aware on the next working day of the residents being unsupervised for extended periods of time due to limited staffing but no changes were made to correct this issue. No specific dates given.
-She was only required by the facility to check on all the residents, including Resident #5, at least every two hours.
-The majority of the residents, including Resident #5, were not consistently checked every two hours.
-The staff member was not required to perform more frequent checks than every two hours for the residents including Resident #5.

Interview with the Nurse's Assistant (NA) on 1/28/16 at 10:18 a.m. revealed:
-She checks on all the residents including Resident #5 in the SCU "every hour or so" but

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knew that only two hour checks were required.
-The residents on the SCU who have falls, Resident #5 included, were kept out of their rooms in the day areas where staff could watch them. "
-Resident #5 fell "a lot" but did not hurt herself.
-The NA was unable to specify the number of times the resident had fallen without injury.
-When she fell, it happened quickly and she would "laugh sometimes at herself."

Interview with the Medication Aide (MA) on 1/28/16 at 12:02 p.m. revealed:
-She was not aware of any falls with Resident #5 where she was found injured.
-She was aware that Resident #5 had falls.
-She monitored all residents every two hours as required by the facility.
-The facility staff who worked with her were asked by her to check on all the residents "every hour or so to make sure that they were okay."
-When a fall occurred, vital signs were taken and the resident would be sent out to the ER for evaluation if injured.

Interview with the second Nurse's Assistant (NA) on 1/28/16 at 2:24 p.m. revealed:
-She was aware that Resident #5 had fallen "often."
-She was unsure of the number of times Resident #5 had fallen.
-The resident was monitored or checked every two hours.
-Resident #5 was identified as a "Fall Risk" person according to her chart, she did not identify the resident as one who was a " Fall Risk. "
-The MAs did not inform her that Resident #5 was a "Fall Risk" resident.
-She was trained that when falls occurred, the resident was not to be moved and the MA was

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informed to complete paperwork and check vitals.
-She only knew Resident #5 was kept mainly with " the group to be in staffs ' view " but was not sure of the reason why she was being kept with " the group " which consisted of other residents in the SCU.

Interview with the third Nurse's Assistant (NA) on 1/29/16 at 9:33 a.m. revealed:
-Resident #5 had falls "in and outside of her bedroom."
-She was unable to specify the number of falls but said most of the resident's falls were without any injuries.
-She was not aware of any falls with injuries for Resident #5.
-The resident had "sudden" falls like "spasms."
-When the resident fell, vital signs were checked and she was sent out to the hospital if she bumped her head.
-The majority of the resident's falls were not observed because the staff would discover her falls "after the fact."
-She had observed the resident after a fall.
-She checked her assigned residents, including Resident #5, every 2 hours as required by the facility.

Telephone Interview with Resident #5's guardian on 1/29/16 at 10:47 a.m. revealed:
-The guardian was not consistently made aware of her falls even those with injury.
-He wanted the resident to be monitored as often as possible to help keep her safe from falls and injuries from falls.
-He said that more frequent checks might help with reducing her falls.
-The guardian made the RCC aware after her recent hospitalization in January 2016 that he wanted to be contacted for "significant events

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including falls with injury" but knew the RCC was just assigned coverage of both the AL and SCU areas of the facility.
-The guardian said that "things have started getting better since the current RCC came on board."
-He knew that the RCC's "plate was full having both areas to cover" but "really appreciated being notified of incidents, although not timely, but at least he was notifying him."
-Prior to the current RCC, the guardian said he was not being notified at all and would receive "updates" on Resident #5's status from the medical provider during routine visits.
-The RCC apologized for not notifying him in a timely manner of falls with injury and other significant events such as receiving the "wrong medications."
-The guardian wanted to be notified immediately following falls with injuries and other significant events.

Confidential Interview with the Healthcare Team revealed:
-Per the Healthcare Team, if they had been informed of all of Resident #5 ' s falls with and without injuries as these occurred, a change in supervision would have been made in addition to her move to the Special Care Unit (SCU).
-The Healthcare Team requested to be made aware of all falls for Resident #5 as these occur with a telephone call or by leaving a message on the 24 hour / 7 days a week answering service after regular office hours.
-Resident #5 was moved to the SCU per their recommendation and with guardian approval in January 2016 due to a decline in her cognitive ability and falls to receive closer monitoring because of the SCU being locked area.
-The Healthcare Team expected the Administrator

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or the RCC to request an increased level of supervision for Resident #5 if needed due to continued falls that were not consistently reported.

Interview with the Resident Care Coordinator (RCC) on 2/01/16 at 12:52 p.m. revealed:
-The RCC was aware Resident #5 had many falls.
-The RCC was familiar with Resident #5 since he was recently assigned to cover both the AL and SCU areas.
-The resident was moved to the SCU in order to receive more staff monitoring and support as needed due to continued falls.
-All residents including Resident #5 were monitored every two hours by facility staff.
-He did not inform the medical provider or Administrator of Resident #5's falls because she was moved to the SCU and he "thought she would receive the additional supervision and supports she needed in the SCU."
-The RCC said the medical provider was made aware of falls with injury that required an ER visit for Resident #5 by telephone call.
-The resident continued to receive the standard two hour facility checks after she was moved to the Special Care Unit.
-The resident was monitored for 72 hours following a fall with injury by facility staff per policy.
-A Falls Risks Assessment was to be completed at admission and after a fall with injury had occurred to determine if a change in supervision was needed per policy.
-A Falls Risk Assessment was not performed for the resident following her falls with injury.
-Changes in supervision were considered to be "interventions" and are implemented on "a case by case basis."

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D 270	Continued From page 15 -Interventions could be recommended by the RCC but none were recommended for Resident #5 following her repeated falls. -The RCC said that "he was unable to make a recommendation to the medical provider regarding repeated falls at that time due to newly acquiring both sides of the facility but that he would take care of this as soon as possible." -The facility had a new Falls Assessment Protocol implemented in December 2015 but he was unable to locate this document. Interview with the Administrator on 2/01/16 at 1:15 p.m. revealed: -She was aware the resident had falls and was a "fall risk." -She was made aware of Resident #5 being at risk for falls from the RCC. -She was not aware of a new Falls Protocol and could not produce this document when asked. -Resident #5 had "several" falls while on the AL unit. -She was unable to specify the number of falls for Resident #5. -Resident #5 was moved to the SCU to receive closer supervision due to her falls. -No change was made or recommended for the resident's level of supervision after falls with and without injuries continued even after being moved to the SCU on 1/12/16. -Two hour checks were the facility's standard for every resident including Resident #5 even for those identified as being at risk for falls. -The facility had adequate staffing to monitor all residents every two hours. _____ The facility submitted a Plan of Protection dated 2/1/16, as follows: -Immediately, all residents will receive 2 hour checks and the checks will be documented on the	D 270		

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D 270	Continued From page 16 Medication Administration Record. -Falls risk residents will receive 30 minute checks. -Two hour and thirty minute checks will be reviewed weekly. -A falls risk assessment will be completed for all the residents. -Nursing staff will be inserviced on fall interventions. -A monthly fall team meeting will be conducted by the Executive Director. -Scheduled staff will not be relieved until relief staff had arrived to assure coverage to the residents. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 2, 2016	D 270		
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: Based on observations, interviews, and record review, the facility failed to ensure the primay care physician was notified for 1 of 5 sampled Residents (#4) with elevated blood sugars. The findings are: Review of Resident #4's current FL-2 dated 9/2/15 revealed: -The resident's diagnoses included high blood	D 273		

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pressure, hyperlipidemia and Type II Diabetes Mellitus and mental retardation.
-An order for Metformin 1,000 milligrams take one tablet twice daily (used to help control high blood sugars.)

Review of the Resident Register revealed Resident #4 was admitted to the facility on 12/28/11.

Review of Resident #4's record revealed:
-An order dated 10/9/15 for blood sugars to be taken twice daily.
-An order dated 12/16/15 for blood sugars to be taken twice daily. Send results every two weeks to the primary care physician.
-There was no order when to contact the physician for elevated blood sugars.

Review of Resident #4's December 2015 Medication Administration Record (MAR) revealed:
-The blood sugars were documented as taken twice daily at 6:00 a.m. and 5:00 p.m. from 12/1-12/31/15.
-The 6:00 a.m. blood sugars ranged from 107-169.
-The 5:00 p.m. blood sugars ranged from 101-474.
-On 12/20/15 at 5:00 p.m., the blood sugar was 474 and on 12/24/15 the blood sugar was 420.

Review of Resident #4's January 2016 MAR revealed:
-The blood sugars were documented as taken at 6:00 a.m. from 1/1-1/28/16 and at 5:00 p.m. from 1/1-1/27/16.
-The 6:00 a.m. blood sugars ranged from 99-150.
-The 5:00 p.m. blood sugars ranged from 118-329.

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D 273	Continued From page 18 Interview with a Medication Aide (MA) on 1/29/16 at 11:11 a.m. revealed: -She did not take Resident #4's blood sugars on 12/20/15 and 12/24/15. -Resident #4 did not have parameters for blood sugars. -The facility did not have a written policy on blood sugar parameters. -As a MA, she was trained if a resident's blood sugars were greater than 400 or 450, she informed the Resident Care Coordinator (RCC) and he notified the physician. -The RCC contacted the primary care physician for elevated blood sugars and faxed the resident's blood sugars every two weeks to the primary care physician. -The MA did not contact the resident's primary care physician for elevated blood sugars. Interview with the RCC on 1/29/16 at 11:19 a.m. revealed: -The facility did not have a written policy on blood sugar parameters. -If Resident #4's blood sugars are greater than 400, the MA's informed him and he contacted the resident's primary care physician. -Resident #4's primary physician monitored the resident's blood sugars closely. -When he faxed blood sugars or contacted the resident's primary care physician about the elevated blood sugars, he did not document the contact with the primary physician in the record unless the physician changed an order. -The RCC could not provide documentation he contacted Resident #4's primary care physician about the elevated blood sugars or he sent the resident's blood sugar results to the physician every two weeks.	D 273		

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D 273	Continued From page 19 Confidential interview with Resident #4's health care team revealed: -If Resident #4's blood sugars were greater than 400, the facility should notify them. -The physician was not aware of Resident #4's elevated blood sugars in December 2015. -If she would have known about the blood sugars greater than 400, she would have sent her staff over to recheck the blood sugars and probably "changed some things." -She had not received results of the resident's blood sugars every two weeks as ordered. Interview with the Administrator on 2/1/16 at 11:24 a.m. revealed: -The facility did not have a policy on blood sugar parameters. -The resident's physician determined the parameters for the blood sugars. -Her expectation was for the MAs to communicate to the RCC and the RCC to contact the resident's primary care physician if the resident's blood sugars were outside of the parameters. -She was not aware the physician had not been notified of Resident #4's elevated blood on 12/20/15 at 5:00 p.m. (474) and on 12/24/15 at 5:00 p.m. (420). The MA who checked Resident #4's blood sugars on 12/20/15 and 12/24/15 could not be reached by the end of the survey.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from	D 276		

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D 276	Continued From page 20 a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 1 of 1 Resident (#9) received a physical therapy evaluation as ordered by the physician. The findings are: Review of Resident #9's current FL-2 dated 6/11/15 revealed: -The residents diagnoses included cerebellar hemorrhage (4/15), vascular dementia, A-Fib, coronary artery disease and vitamin D deficiency. -The resident was ambulatory. The Resident Register revealed Resident #9 was admitted to the facility on 6/12/15. Review of Resident #9's record revealed a physician's order dated 11/9/15 which revealed: -The resident was to have a physical therapy (PT) evaluation. -The resident had a cerebral vascular accident (CVA) April 2015. Observation of Resident #9 on 1/27/16 at 3:30 p.m. revealed the resident was sitting in a wheel chair in the living room. Interview with Resident #9 on 1/27/16 at 3:30 p.m. revealed: -He had resided at the facility for almost a year.	D 276		

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D 276	Continued From page 21 -The resident was told by facility staff he would be getting PT for his weakened left side. They resident did not say which staff told him he would get PT. -The resident had a stroke April 2015. -The resident has not had PT as of 1/27/16. -The resident otherwise liked the care he received. Interview with the Resident Care Coordinator (RCC) on 1/27/16 at 4:30 p.m. revealed: -Resident #9 has an order for PT dated 11/9/15. -Resident #9 has not had the PT evaluation as of 1/27/16. -Resident #9 should have been evaluated for PT. -He was the person who should have followed up with the order for the PT. -Failure to schedule the PT was an oversight on his part. -Anytime a resident's order was received, the Medication Aide (MA) gave the RCC the order to review. -It was facility's protocol for him to schedule any evaluations as soon as they are ordered. Interview with the Administrator on 1/27/16 at 4:40 p.m. revealed: -She was not aware there was a PT evaluation order for Resident #9, which had not been scheduled. -It was the responsibility of the RCC to ensure that the scheduling of the orders were completed. Telephone interview with Resident #9's primary care physician on 1/29/16 at 4:50 p.m. revealed: -She was aware Resident #9 needed a PT evaluation due to the left side weakness caused by the CVA. -Her expectation was for Resident #9 to have had a PT evaluation.	D 276		

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D 276	Continued From page 22 -She was unaware the order for a PT evaluation, dated 11/9/15, had not been scheduled as of 1/29/16. Review of Resident #9's record revealed as of 1/29/16 a PT evaluation had not been scheduled for Resident #9.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to their bedroom doors being unlocked and accessible without the need to ask for staff assistance when entering or exiting their rooms. The findings are: Observations on the Special Care Unit (SCU) on 1/26/16 at 12:30pm during the tour revealed: -Eighteen resident room doors were locked and staff was needed to open the doors as residents did not have keys. -Four of the residents were in their rooms when the doors were unlocked by staff. -Residents were observed walking up to doors trying the door handles and calling to staff to let them in the rooms.	D 338		

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D 338	Continued From page 23 Observation of a resident and resident's room door on 1/26/16 at 3:35pm revealed; -The door was locked. -Resident was unable to open the door and stated "staff lets me in my room." -The inside handle lock button was depressed in the locked position. Interview with a second shift Medication Aide (MA) on 1/26/16 at 3:45pm revealed: -We have wanderers in the building and all rooms are locked to prevent them from going into the wrong rooms. -All of the staff had room keys to open the door. -None of the residents had room keys. -The residents knew to ask the staff to unlock their own rooms if they wanted entry. -Resident #2 had the ability to unlock her door from the inside, but had to ask staff for entry. Interview with another second shift MA on 1/26/16 at 4:00pm revealed: -"We were told to keep all the doors lock to prevent wanderers from entering the wrong rooms." -Some residents took items from other rooms when they were unlocked. -The residents could open their doors from the inside but not from the outside. -If a resident needed to use her bathroom, she would use the common one in the lobby so staff could keep an eye on that resident. -None of the residents had complained about their rooms being locked. -All residents knew to ask to have their doors opened. Confidential interview with a resident on the special care unit on 1/26/16 at 4:45pm revealed:	D 338		

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D 338	Continued From page 24 -The Resident wanted her door was unlocked so she could come and go as she pleased. -The Resident was aware which room was hers. -The Resident was observed testing her locked room door handle several times over the period of one hour, then stated aloud "It's still locked" . -When asked if the Resident had asked the staff for assistance with opening the door, the Resident responded "Oh I forgot I'm supposed to ask." Interview with the Maintenance Director on 1/27/16 at 9:45am revealed: -The SCU doors were locked prior to his employment at the facility. -The facility had locked the doors to keep other residents from wandering into the wrong rooms. -No resident had ever asked him for assistance to open a door. Confidential interviews with staff on SCU revealed: -"Locking the resident's doors helped to keep up with a resident's whereabouts." -The residents always asked when they want to enter their room. -Some of our wanderers took stuff from other residents' rooms, so we had locked all rooms. -No residents had complained about their doors being locked. Confidential interviews with two family members on SCU revealed: -All of the residents' room doors at the facility were locked for safety according to staff. -Each family member did not feel the doors needed to be locked. -Each family member felt that the residents needed to be watched from entering the wrong room, but not prevented from entering their own	D 338		

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D 338	Continued From page 25 room. -Each had witnessed one or more of the residents had to find a staff member to get in their room to use the bathroom on occasion. -Each had mentioned to a staff member on at least one occasion to keep their resident's door unlocked. Interview with the Administrator on 12/10/15 at 1:55pm revealed: -She was unaware that locking the doors was a resident's rights issue. -She had received no complaints from residents or family members. -Locked doors helped the aides in keep up with the residents. -All residents could exit their doors at any time. -All doors are only locked only from entry. -All special care residents know to ask staff if they want to enter their room. The facility submitted a Plan of Protection dated 2/1/2016 as follows: -All doors on the special care unit will be unlocked immediately. -Staff will be instructed to keep doors unlocked permanently. -All staff will be in-serviced on not locking resident's doors. CORRECTION DATE FOR TYPE B VIOLATION NOT TO EXCEED MARCH 17, 2016.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for	D 344		

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D 344	Continued From page 26 medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to contact the physician to clarify medication orders for Tramadol and Marinol for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 1/4/16 revealed diagnoses of Alzheimer's, Chronic Kidney Disease Stage 3, Hypertension, Anorexia, Syncope, history of hip fracture, and Coronary Atherosclerosis. Review of Resident #1's current FL2 dated 1/4/16 revealed no order for Tramadol and Marinol. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 1/4/16 and discharged on 1/21/16. Review of the January 2016 Medication Administration Record (MAR) from 1/4/16 to 1/21/16 revealed all medications ordered on the FL2 were administered as ordered.	D 344		

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Telephone interview with Resident #1's family member on 1/26/16 at 5:00pm revealed:
-She admitted her mother to the facility on 1/4/16.
-She brought in aenvelope containing all of her family member's currently prescribed medications including Tramadol (for pain) and Marinol (for appetite stimulation).
-She reviewed the medications with Staff A during the administration process where paperwork was signed and completed upon entering the facility.
-She gave the medications to Staff G along with the medication administration records from the previous facility.
-She left the facility on 1/4/16.
-She was told it was facility policy that family does not visit for 2 weeks to allow special care residents to adjust to their new surroundings.
-She visited the facility on 1/13/16 for the first time after her family member was admitted to the facility on 1/4/16.
-Her family member was lethargic and not eating her meal upon visiting on 1/13/16.
-She asked the Supervisor which medications her mother was currently taking.
-She became aware on 1/13/16 that the family member had no Tramadol or Marinol on her medication regimen which she had brought in upon her admission to the facility.
-The family member was not eating due to not receiving her pain medication and appetite stimulation medication.
-The facility did not know the whereabouts of the family member's Tramadol or Marinol.
-She made a complaint to the Supervisor on 1/13/16 where order requests for only Tramadol and Marinol were initiated and sent to the physician.
-The Tramadol and Marinol were filled the same day.
-She kept copies of MARs from the previous

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facility including the controlled medication counts which included 48 Tramadol (for pain) and 49 Marinol (for appetite stimulation).

Review of Resident #1's physician orders dated 1/13/16 revealed:
-Fifty Tramadol 50mg were ordered on 1/13/16 for pain control.
-Sixty Marinol 10mg were ordered on 1/13/16 for appetite stimulation.
-The FL2 physician signature on 1/4/16 was the same physician who ordered the Tramadol and Marinol on 1/13/16.

Review of Resident #1's January 2016 MARs from 1/4/16 to 1/21/16 revealed:
-There was an additional order for Tramadol 50mg as needed for pain added to the medication regimen on 1/13/16.
-Marinol 10mg was transcribed on the MAR on 1/13/16.
-All medications were administered as ordered.
-From 1/13/16 to 1/21/16 Tramadol was not administered to Resident #1 due to no reports of pain thoughout her stay at the facility.
-All medications were given to Resident #1's family member upon departure from the facility.
-All remaining medication counts were accurate when compared to the medication administration record when given to Resident #1's daughter upon moving Resident #1 from the facility.

A second telephone interview with Resident #1's family member on 1/26/16 revealed:
-She didn't know why the Tramadol and Marinol were not being given to Resident #1 since admission.
-The facility did not clarify the previous facility's MAR with the listed medications on the FL2.
-The facility said to her that all medications would

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be continued as ordered.
-The Supervisor told her that the facility destroyed the Tramadol and Marinol on 1/13/16.
-The facility did not explain why her family member's Tramadol and Marinol was not being administered.
-The Supervisor initiated contact with the physician and had the medications reinitiated.
-The facility gave no explanation for the lack of Tramadol and Marinol administration between 1/4/16 and 1/13/16.

Confidential interview with a Medication Aide (MA) revealed:
-There were two medication punch cards with 48 Tramadol and 49 Marinol in the medication cart after 1/4/16.
-There were no orders for Resident #1 to be given Tramadol or Marinol.
-The Tramadol and Marinol were placed in the medication cart until 1/10/16 when they were destroyed due to lack of active orders.
-The medications were labeled with Resident #1's name.
-The Administrator was made aware that they were destroyed.
-The medications were wasted in the toilet with 2 other witnesses.

Confidential interview with a second MA revealed:
-The Supervisor observed the disposal of the Tramadol and Marinol.
-The facility never received controlled drugs from a family member as they usually come direct from the pharmacy.
-Resident #1 had no current order for Tramadol and Marinol, they were destroyed.

Interview with the Supervisor on 1/27/16 revealed:

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-The Tramadol and Marinol were disposed of properly.
-An order was requested from the physician for Marinol and Tramadol when Resident #1's family member demanded they be readministered on 1/13/16,
-An order was received from the physician and the prescriptions were filled by our backup pharmacy that day.
-The Tramadol and Marinol were not on the admission orders or FL2.
-He did not know why Tramadol and Marinol were not clarified upon admission of Resident #1 to the facility.
-He did not clarify the Marinol and tramadol with the physician prior to destroying the medications.

Interview with the Administrator on 1/27/16 at 3:00pm revealed:
-She became aware that the Tramadol and Marinol brought in the Resident #1's family member were destroyed, because they were not on the admission orders.
-The facility policy is to follow the orders on the FL2.
-The facility did not clarify the additional Tramadol and Marinol medications and MARs (medications administration records) brought into the facility.
-No clarification of the omitted Tramadol and Marinol on the FL2 orders were questioned.
-The physician was not notified.
-She became aware of Resident #1's previous usage of Tramadol and Marinol after Resident #1's daughter visited on 1/13/16.
-The facility resumed the medications after the physician's approval of the order.
-The facility did not have a policy to clarify admission FL2 medication orders in this situation where 2 additional medications were brought into the facility upon admission.

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D 344	Continued From page 31 -The facility policy is to destroy or send back medications to the pharmacy if the resident was using those medications. -The resident came from another facility and used another pharmacy, so the facility destroyed the medications. -The facility would clarify any extra medications brought in for all future residents admitted to the facility.	D 344		
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 A1 VIOLATION Based on observation, record reviews and interviews, the facility failed to administer medication such as cardiovascular agents, antidepressants, seizure medications, hypnotic medications for diabetes for 2 of 5 sampled Residents (#5, #3). The findings are: 1 A. Review of Resident #5's current FL2 dated 1/13/16 included: -The resident's diagnoses included Alzheimer's type dementia, diabetes type II, hypertension,	D 358		

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hypothyroidism, and asthma.
-An order for Levothyroxine 25 milligrams (mg) once daily (used to help treat low thyroid hormone levels).
-An order for Metformin 1,000 mg twice daily (used to help control high blood sugars).
-An order for Vitamin D 5,000 cap tab once per week (used to help replenish vitamin D deficiency).
-An order for Atorvastatin 20 mg once daily (used to high cholesterol).
-An order for Cyanocobalamin 10,000 mg once monthly (used to treat vitamin B12 deficiency).
-An order for Metoprolol Tartrate 25 mg twice daily (used to treat high blood pressure).
-An order for Glimepiride 2 mg one tab twice daily (used for treating Type II Diabetes).

Review of Resident's Register revealed Resident #5 was admitted to the facility on 11/12/12.

Review of Resident #5 ' s record revealed:
-A subsequent order for Farxiga 5 mg once daily was discontinued 1/15/16 (used to help control high blood sugars).
-An order for Lantus 100 milliliters injection dated 1/25/16 (used to help control high blood sugars).
-An order for Venlafaxine 37.5 mg extended release (ER) cap once daily dated 1/20/16 (used for depression and anxiety).

Review of Resident #5's January 2016 Medication Administration Record (MAR) revealed:
-The resident was hospitalized from 1/06/16 through 1/08/16.
-On 1/06/16 at 8:00 a.m., it was documented the resident was administered Atorvastatin 20 mg tab, Farxiga 5 mg tab, Glimepiride 2 mg tab, Metformin 1,000 mg tab, and Metoprolol Tartrate

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25 mg tab.
-On 1/06/16 at 6:30 a.m., Levothyroxine 25 micrograms tab was documented as administered.

Review of Resident #5's Incident Report dated 1/06/16 revealed:
-The resident was given another resident's morning medications at 8:28 a.m.by facility staff.
-The primary care provider was notified by telephone at 11:30 a.m. by facility staff.
-The guardian of the resident was notified by facility staff at 12:00 p.m.
-The facility was advised to call emergency medical services to transport the resident to the emergency room for evaluation because she had received the medication of another resident.
-Resident remained at the hospital for evaluation overnight.
-The resident was noted to return to the facility on 1/07/16.

Telephone Interview with Resident #5's guardian on 1/29/16 at 10:47 a.m. revealed:
-Her guardian was made aware of the medication error by the facility Resident Care Coordinator (RCC).
-The guardian was notified more than three hours later after the incident had occurred by the RCC.
-The guardian would have wanted to have been informed earlier.
-The guardian was told by the RCC that he had a "heavy workload to contend with due to having both sides of the facility." He said he understood to the RCC.

Interview with the Medication Aide (MA) on 1/29/16 at 3:18 p.m. revealed:

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-The MA said all medications are administered as ordered by the doctor and transcribed on the resident's individual medication administration records.
-She was aware of the incident when the resident was given the wrong medication by another MA.
-The MA was unsure why the medication error occurred but stated that "things had to have been very busy" that day for that incident to occur.
-She was not aware of any other medication errors occurring with the resident or other residents.

Confidential Interview with the Healthcare Team on 1/29/16 at 4:08 p.m. revealed:
-On 1/6/16, Resident #5 was given another resident's medications. The resident received Amlodipine 5 mg (used to help control high blood pressure), Neurontin 100 mg (used for seizures and nerve pain), Lisinopril 30 mg (used to treat high blood pressure and heart failure), Celexa 20 mg (used to help treat depression), Hydrochlorothiazide (HCTZ) 75 mg (used to treat high blood pressure and fluid retension) and Sotalol 160 mg (used to treat an irregular heartbeart).
-According to the computer system for the Healthcare Team, they were notified by the RCC from the facility at 11:45 a.m. regarding the medication error that had occurred for the resident.
-They expressed "great concern about the timeliness" of the call placed by the RCC since the medication error had occurred much earlier that morning at 8:28 a.m.
-The Healthcare Team wanted to have been notified in a timelier manner of the medication error incident.
-The resident had received four or more medications wrongly which caused the resident to

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stay in the hospital for three days (1/06/16 - 1/08/16).
-One of the medications administered in error lowered the resident's blood pressure and caused a decline in her health status.
-According to the Healthcare Team, Resident #5's health status experienced a decline because "she had to stay in the hospital two additional days as a result of receiving another resident's medications, she experienced a cognitive decline requiring a move to the SCU, and her physical appearance did not look well."
-The resident received her prescribed medications in addition to another resident ' s medications.

The facility staff who completed the Incident Report on 1/28/16 at 2:35 p.m. for Resident #5 could not be reached by the end of the survey.

Interview with Resident #5 on 2/01/16 at 10:37 a.m. revealed:
-The resident does not remember taking extra medication or having to stay in the hospital.
-She does remember not feeling "good" and having to go to the hospital a few weeks ago.

Interview with the Resident Care Coordinator (RCC) on 2/01/16 at 12:52 p.m. revealed:
-The RCC was aware of the incident of the resident having received the wrong medications in addition to her own mediations on 1/06/16.
-The RCC said he contacted the medical provider and guardian as soon as he could regarding the medication error incident.
-He was not aware of a facility policy for informing the medical provider or facility management of medication errors but said "it was a known practice to do so."

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-He said it was very busy that morning and he made sure he had contacted the medical provider and guardian as soon as he possible could but the resident was his first priority.
-The resident received immediate care following the medication error once EMS arrived.
-He reminded the MA's to follow the MAR's for each resident as transcribed to help avoid future medication administration errors as a "common practice."

Interview with the Administrator for Resident #5 on 2/01/16 at 1:15 p.m. revealed:
-The Administrator was aware of the medication error incident involving the resident that occurred on 1/06/16.
-She was not aware that the medical provider and guardian had expressed concerns regarding the timeliness of being notified of the incident.
-She asked the RCC to follow-up with the MA's to ensure that medications are administered to each resident as prescribed following the incident.
-The Administrator said that there was not a facility policy to address mediation administration errors.

B. Review of Resident #5's current medication orders on the FL2 dated 1/13/16 revealed:
-An order for Levothyroxine 25 mg once daily (used to help treat low thyroid hormone levels).
-An order for Metformin 1,000 mg twice daily (used to help control high blood sugars).
-An order for Vitamin D 5,000 cap tab once per week (used to help replenish vitamin D).
-An order for Farxiga 5 mg once daily was discontinued 1/15/16 (used to help control high blood sugars).

A record review of Resident #5's chart revealed a subsequent order for Lantus 100 ml injection

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D 358	Continued From page 37 dated 1/25/16 (used to help control high blood sugars). Review of Resident #5's Medication Administration Records (MARs) revealed the following medications: In November 2015, the following medications were documented as not available: -On 11/07/15 - 11/09/15, Farxiga 5 mg tab. -On 11/11/15 - 11/16/15, Farxiga 5 mg tab. -On 11/25/15 and 11/26/15, Levothyroxine 25 mcg tab. -On 11/30/15, Vitamin D 50,000 unit cap. In December 2015, the following medications were documented as not available: -On 12/19/15, Levothyroxine 25 mcg tab. -On 12/21/15 - 12/23/15, Levothyroxine 25 mcg tab. In January 2016, the following medications were documented as not available: -On 01/12/16, Metformin 1,000 mg tab. -On 01/25/16 for Lantus 100ml injection. Medications were not available to be administered to the resident for a total of 18 days from November 2015 through January 2016. Interview with the Medication Aide (MA) on 1/29/16 at 3:15 p.m. revealed: -The MA was aware that there were no medications on hand for the resident on some occasions. -The MA said that she would review the medication administration record (MAR) for the residents and if a medication was not on the cart, she would inform the Resident Care Coordinator	D 358		

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D 358	Continued From page 38 (RCC). -She would document on the MAR for that date that the medication was not in the facility or on hand to give to the resident. -She was not aware of a facility policy but would inform the RCC as a "common" practice. -The MA said she would notify the doctor when the RCC was "not there that day." Confidential Interview with the Healthcare Team on 1/29/16 at 4:08 p.m. revealed: -They were not made aware by the facility at any time that medications were not available in the facility for Resident #5. -The Healthcare Team was not given Resident #5's MAR's when requested from the RCC as well as the Administrator several times which would have shown the dates and specific medications not available in the facility for the resident. -The Healthcare team was unable to make necessary medication adjustments and/or changes because of not being made aware that the medications were not available to Resident #5. -The Healthcare Team wanted to have been made aware of any time prescribed medications were not on hand in the facility to administer to Resident #5. -They further said "when medications were missed due to being unavailable, the facility blamed the pharmacy and the facility would wait for the delivery rather than calling in the missing medication(s) into the " back up " pharmacy which caused Resident #5 to go 2 days or more without meds. " -As a result of missed doses, Resident #5 was deficient on her thyroid medication which caused her "physical issues." The facility never reported this to the Healthcare Team.	D 358		

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-They were unaware of the facility's policy regarding "meds not being available" but had requested the facility inform their office when medications were "not administered."
-The Administrator was aware of the Healthcare Team's concerns which included a lack of reporting especially when medications were "frequently unavailable" and were not being reported to them.
-The Administrator was "often unavailable and long-term problems" were not being addressed such as " mandated notifications for missed meds " for residents.

Interview with the Resident Care Coordinator (RCC) on 2/01/16 at 12:52 p.m. revealed:
-The RCC was aware that there were missed or unavailable medications for the resident on several occasions.
-The RCC said when medications were noted on the MAR as "not in the facility," that this meant either the MA could not locate the medication or the order had not been filled yet by the pharmacy.
-The RCC did not contact the pharmacy when the MA's informed him that there were no medications on hand for the resident the resident "did not miss three consecutive doses of the same medication per facility policy and missing meds usually arrived the next day."
-The RCC had not made the medical provider aware when medications were not available or were missed for Resident #5 because " missing meds usually arrived that same day or the very next day.
-According to the RCC, "the resident would have a missed medication until the medication arrived or was located."

Telephone Interview with pharmacist for the

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facility on 2/1/16 at 1:05 p.m. revealed:
-The facility pharmacist was not notified by the RCC regarding medications not being available or not on hand in the facility for Resident #5.
-All medication orders were currently filled to date for Resident #5.

Interview with the Administrator on 2/01/16 at 1:15 p.m. revealed:
-The Administrator was not aware that there were missed medications or no medications on hand for the resident for at least 12 days.
-In regards to when medications were missed or when medications were not available in the facility to the residents, the Administrator said that there was not a facility policy in place for "missed" medications.
-Her expectation was that the MA's would inform the RCC and he would follow-up as needed when mediations were unavailable in the facility.

2. Review of Resident #3's current FL-2 dated 9/1/15 revealed:
-The resident's diagnoses included dementia, anxiety, depression, emphysema and prosthetic heart valve.
-An order for Zolpidem 10 milligrams (mg) every night (used to treat restlessness).

The Resident Register revealed Resident #3 was admitted to the facility on 8/21/11.

Review of Resident #3's January 2016 Medication Administration Record (MARs)revealed:
-Zolpidem 10 mg daily was transcribed on the MAR.
-Zolpidem 10 mg daily was administered from 1/1/16-1/5/16 and from 1/27/16-1/31/16.
-From 1/6/16-1/26/16, staff intials were circled.

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D 358	Continued From page 41 -Under the exceptions area of the MAR was documented the medication was not in the facility from 1/6/16-1/26/16. Interview with Resident #3 on 1/29/16 at 10 am revealed: -She was "really not sure what medications she takes, as she leaves it up to the Medication Aid (MA)." -She believes she has received all of her medications when she is supposed to take them. -She has not had any problems receiving her mediations. Observation during the interview on 1/29/16 at 10 am revealed Resident #3 was intermittently confused. Interview with Resident Care Coordinator (RCC) on 1/27/16 at 2:25 revealed: -Resident #3 received Zolpidem 10 mg each night to assist her in falling asleep. -From 1/6/16-1/26/16, Resident #3 did not receive her Zolpidem due to the medication not being in the facility. -The medication had "run out" on 1/5/16 and required a new "hard script" from the doctor. -He was not aware the medication needed a "hard script" until 1/20/16. -He obtained a paper script from the doctor on 1/20/16 and faxed it over to the pharmacy on the same date. -The medication came to the facility on 1/27/16 and Resident #3 resumed the medication as prescribed. -If a medication was "running low", the MA reordered the medication. If a new script was required, the MA informed him, he contacted the resident's primary care physician for an order and	D 358		

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D 358	Continued From page 42 he would send the order to the resident's pharmacy. -The resident had not complained of side effects of not receiving medication as prescribed. Telephone interview with a Pharmacist from the local pharmacy on 2/1/16 at 12:45 revealed: -The order for the Zolpidem was faxed to pharmacy by the RCC on 1/26/16. -Once the order was received, the medication was filled and sent to the facility on the same day (1/26/16) it was ordered. Interview with Administrator on 1/27/16 at 4:40 p.m. revealed: -She was not aware that Resident #3's medication had run out and resident was without the medication for 20 days. -It was the responsibility of the medication aides to alert RCC when medication was low and there are no refills. _____ The facility submitted a Plan of Protection dated 2/1/16, as follows: -On 1/6/16, the Care Manager reviewed the 6 Rights of Medication. -The provider was contacted immediately and all ordered post incident were followed per provider's request on 1/6/16. -There will be a re-evaluation of the Medication Aide (MA) skills on 3/1/16. -There will be random and routine audits on the medication cart, physician orders and medication observations. The Executive Director will review the audits weekly for 3 months. -There will be a monthly MA meeting. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 2,	D 358		

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D 358	Continued From page 43 2016.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure minimal weekend staffing on the special care unit was provided from 12/19/15 to 1/24/16. The findings are: Interview with the Administrator on 1/29/16 at 2:45pm revealed the census had a minimum of 32 residents on the special care unit and 34 on the assisted living side of the facility during the months of December 2015 and January 2016. Review of staff hours on time sheets for the weekends between 12/9/15 to 1/24/16 for first, second and third shift on the special are unit revealed: (Staffing rules require 1 staff per 10 residents then .8 hours per each resident, i.e. 33.6 hours for 1st and 2nd shift; 25.6 hours for 3rd shift with a 32 resident census)	D 465		

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D 465	Continued From page 44 -12/19/15: 7.5 hours on 3rd shift -12/20/15: Zero coverage on 3rd shift. -12/26/15: Meets requirements. -12/27/15: Meets requirements. -1/2/16: 8 hours coverage on 3rd shift. -1/3/16: 3.5 hours coverage on 3rd shift. -1/9/16: 7.5 hours coverage for 3rd shift. -1/10/16: Meets requirements. -1/16/16: 16 hours on 2nd shift, 7.5 hours on 3rd shift. -1/17/16: Zero coverage on 3rd shift. -12/23/16: 8 hours coverage on 3rd shift. -12/24/16: 8 hours coverage on 3rd shift -Five out of six weekends had at least one shift or more with understaffing. -Two days had zero staffing on 3rd shift. Confidential interviews with 4 staff regarding special care unit staffing on 1st, 2nd and 3rd shift revealed: -Third shift staff members had been caught sleeping on the job. -Third shift frequently is understaffed. -There were not enough staff to bathe all the residents on posted schedules. -The weekends always seemed to be short on staff. -The residents need a lot of care on the special care unit. -If we had more staff, we could take better care of the residents. -There were "a lot" of staff members who called out of work for various reasons. -There were not any extra staff members to work in place of those who called out of work. -We had staff quit recently and are in the process of hiring and training new staff. -When staff called out, they were supposed to find their own replacement, but sometimes they	D 465		

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D 465	Continued From page 45	D 465		

could not.
-When we had staff call-outs, we tried to look unsuccessfully for alternate staff to come in on several occasions.
-There were activities scheduled daily but there was no one to carry out the activities due to staffing.

Interview with the Administrator on 1/29/16 at 2:15pm revealed:
-Staff have quit "yet its hard for me to believe that the special care unit was understaffed."
-It has become increasingly difficult to find staff.
-Two staff were recently suspended pending investigations which causes scheduling issues.
-Our new time-keeping system was inaccurate.
-The time keeping records provided must be missing certain staff names who must have been on those shifts to account for the appearance of understaffing.

Confidential interviews with residents and resident's family members revealed:
-The facility was frequently understaffed on the weekends.
-There were insufficient staff on the third shift in the entire facility.
-Residents were not getting bathed due to low staffing.
-Residents on the special care unit were huddled into one area of the hallway for monitoring due to having only one staff member on several occasions.
-Special care residents in their rooms no not get checked on during the night.
-There were many falls at the facility due to low staffing where a 2-person assist is needed.
-During the Christmas holidays, there was no staff person on the special care unit on 3rd shift.
-The SIC tried to assist in both the assisted living

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D 465	Continued From page 46 side and the special care side when staffing is low but is overwhelmed due to frequent call outs. -The administrator has been told about the need for more staffing. Refer to interview with Corporate Director and Administrator on 2/1/16 at 3:00pm.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least	D 468		

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D 468	Continued From page 47 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure six of seven sampled staff (Staff B, C, D, E, F and G) assigned to perform duties in the special care unit received 6 hours of training within the first week of employement in addition to the 20 hours additional training within 6 months of employment specific to the population to be served. The findings are: Review of the Staff B, C, D, E, F and G's personnel records revealed: -Each was hired with a dual roles as a medication aides and personal care assistant and worked on the special care unit. -None completed the 6 hours within the first week of employment and the 20 hour training for the special care unit within six months of hire. -Only Staff C's personnel had a dementia certificate with one continuing education credit related to bathing on the special care unit. -All had worked for the facilty for greater than 6 months. Review of the facility work time logs and schedules for December 2015 and January 2106 revealed all staff had worked on the special care unit. Interview with the Administrator on 1/29/16 at 3:00pm revealed: -She was certain that Staff B, C, D, E, F and G had been certified to work the special care unit.	D 468		

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D 468	Continued From page 48 -Staff B, C, D, E, F and G had worked on the special care unit. -She did not know the state requirement specific to staff training on the special care unit. -She was not aware that Staff B, C, D, E, F and G did not have documentation to support each had an initial 6 hours of training required within the first week of employment on the special care unit nor the additional 20-hour training within six months of their employment on the special care unit in their employee files. -She was unable to produce special care unit training for Staff B, C, D, E, F and G. -She would ensure all staff obtain training requirements for the special care unit for all present and future staff. Confidential interviews with 2 staff revealed: -Each did not recall any special training for the special care unit upon hire. -Each remembered a certificate on "Bathing people on the dementia unit or something like that." -Each could not recall being trained by a nurse or management any specific training for the special care unit. -Each did not know there was a special training requirement to work on the special care unit. No further documentation of the 6-hour or 20-hour special care unit training was provided by the end of the survey on 2/1/16 for Staff B, C, D, E, F and G.	D 468		
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	D912		

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D912	Continued From page 49 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, resident rights and medication administration. The findings are: 1. Based on observations, interviews, and record review, the facility failed to ensure supervision for 1 of 7 sampled residents with continued falls that resulted in injuries (#5). [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type A2 Violation)] 2. Based on observations and interviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to their bedroom doors being unlocked and accessible without the need to ask for staff assistance when entering or exiting their rooms. [Refer to Tag D338, 10A NCAC 13F .0909. (Type B Violation)] 3. Based on observation, record reviews and interviews, the facility failed to administer medication such as cardiovascular agents, antidepressants, seizure medications, hypnotic medications and medications for diabetes for 2 of 5 sampled Residents (#5, #3). [Refer to Tag D358, 10A NCAC 13F .1004(a).	D912		

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D912	Continued From page 50 (Type A1 Violation)]	D912		
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: Based on interviews, employee record reviews, the facility failed to assure 5 of 7 sampled medication aides (B, C, D, E and G) had completed the state mandated infection control course. The findings are: 1. Review of Staff B's employee records revealed: -A hire date of 8/6/14 -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff B was unavailable for interview.	D934		

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D934	Continued From page 51 2. Review of Staff C's employee records revealed: -A hire date of 7/25/14 -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff C was unavailable for interview. 3. Review of Staff D's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff D was unavailable for interview. 4. Review of Staff E's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff E was unavailable for interview. 5. Review of Staff G's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff G was unavailable for interview. Interview with Staff B on 1/29/16 at 1:15pm revealed: -Staff completed in-services/trainings on the computer and then management give us forms to sign stating we completed the training. -The Administrator provided training information and updates when we have staff meetings.	D934		

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D934	Continued From page 52 Interview with the Administrator on 1/29/16 at 3:00pm revealed: -She was unaware of the specific state mandated course and certificate. -She did not know how the certificates were obtained. -Staff had taken the infection control course sometimes with the pharmacy. -She was not aware that the infection control course required an appropriate licensed health professional to teach the course. -She did not review the instructions provided for instructors until 1/29/16 until being informed of the omission of the infection control certificates in 5 of 7 of her staff sample. -She would ensure all staff get mandated training per the state rules. A second review of staff personnel records on 2/1/16 at 10:00am revealed: -Staff B,C,D,E and G had the required state-mandated infection control certificates in their personnel files. -All certificates were dated 1/31/16. -All certificates were signed by the visiting Corporate Nurse Consultant after the Administrator was made aware of the lack of documentation on 1/29/16. -No response was given related to the infection control course certificates being issued on Sunday 1/31/16 when Staff B,C,D,E and G were available to be taught the infection control course.	D934		