STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019018	A. BUILDING: _____ B. WING _____	R 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 03/01/16 - 03/03/16.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure ordered medication (Ativan) was administered as ordered by licensed prescribing practitioner for 1 of 5 sampled residents (Resident #5). The findings are: Review of Resident #5's current FL-2 dated 6/15/15 revealed diagnoses included dementia with sundowning, renal failure, history of dehydration, and history of falls. Review of documentation on a psychiatric assessment dated 02/10/16 revealed: - [Resident #5] seen in her room in the locked memory care unit for initial psych evaluation of dementia, anxiety, insomnia and agitation/aggressive behavior towards staff. They relate it has gotten worse over past 1-2 months. - The following symptoms are associated with	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019018	A. BUILDING: _____ B. WING _____	R 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 1	D 358		

the patient's chief complaint: paranoid delusions, verbal aggression, physical aggression toward staff, physical aggression toward peers, irritability, confusion, and multiple awakenings.
- Medication orders: Please institute the following orders: Ativan 0.5mg every 6 hours as needed for anxiety/agitation.

Review of documentation on Resident #5's medication administration records from February 10, 2016 through March 15, 2016 revealed:
- On 02/10/16, Lorazepam (generic for Ativan) 0.5mg, take 1 tablet by mouth every 6 hours as needed for agitation (hard copy of prescription required) was added to the resident's MAR.
- No documentation of administration of the Ativan in February or March.

Review of facility's "Nurse's Notes" revealed:
- On 2/14/16, 3rd shift [staff] reported Resident [#5] had black eye and swelling above eyebrow this [morning]. Found resident like that when went to check on resident. Stated don ' t know how the black eye occurred.
- On 2/16/16 (no time), resident refused to eat breakfast, Took medications well. Resident was in a mood all day.
- On 2/16/16, resident ate very little dinner, took medications, and has been up and down out of bed all evening, refuses to use her walker.
- On 2/17/17, resident has been in a terrible mood all day today. Resident refused medications, morning and afternoon, refused breakfast and lunch. Resident threw her alarm across the room 3 times today. Resident asking to go home.

Review of Resident #5's medications in the facility on 3/3/16 at 3:15pm revealed no Ativan was in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019018	A. BUILDING: _____ B. WING _____	R 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 2 Interview with the 1st and 2nd shift medication aides (MA) on 03/03/16 at 3:35pm revealed: - Resident #5 has never had Ativan in the facility and has never been administered Ativan. - The MA's was not aware of a physician's order for Ativan. - The resident continued to be agitated at times and combative at times with the staff during care. Interview with the facility's pharmacist on 03/03/16 at 3:50pm revealed: - The pharmacy received an order for Ativan on 3/10/15 and updated the resident's MAR. - The pharmacy informed the facility an original written prescription was needed from the physician to dispense the medication. - The pharmacy never received a prescription for the Ativan and never dispensed the medication. Interview with the facility's Resident Care Coordinator (RCC) on 03/03/16 at 4:00pm revealed: - The facility has not followed up and requested a written prescription for Resident #5's Ativan. - The medication has never been dispensed for the resident by the pharmacy. - The resident may not need the Ativan. - The psychiatric nurse practitioner will be at the facility on Monday (03/07/16) and will decide whether to write a prescription for the Ativan. - Resident #5 continues to be agitated and aggressive at times with the staff and other residents.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019018	A. BUILDING: _____ B. WING _____	R 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(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 438	Continued From page 3	D 438		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to report injuries of unknown cause (bruise above right eye and contusion on forehead above right eye) to the North Carolina Health Care Personnel Registry (NCHCPR) for 1 of 1 resident (# 5) within 24 hours of facility becoming aware of injuries along with any investigation by facility within 5 working days. The findings are: Review of Resident #5's current FL-2 dated 6/15/15 revealed: - Diagnoses included dementia with sundowning, renal failure, history of dehydration, and history of falls. Review of documentation on a facility's "Accident/Incident Report" dated 2/14/16 at 5:50am revealed: - A nursing assistant (NA) went into Resident [#5] room to get her dressed for breakfast and found the resident with a bruise above her right eye. - The resident had a blood shot eye and a contusion on forehead above her right eye. - The NA called the medication aide (MA) into the room to show her the incident. Asked the	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019018	A. BUILDING: _____ B. WING _____	R 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(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 438	Continued From page 4	D 438		

resident and the resident has Alzheimer's so she did not remember what happened and did not even know that she had the injury.
- Reported [injury] to supervisor-in-charge.
- Resident went to emergency room with [family member]. No fractures or problems reported except to watch carefully for changes.

Review of facility's "Nurse's Note" revealed:
- On 2/14/16, 3rd shift [staff] reported Resident [#5] had black eye and swelling above eyebrow this [morning]. Found resident like that when went to check on resident. Stated don ' t know how the black eye occurred.
- Called [facility's] registered nurse to inform of situation.

Interview with MA/supervisor on 3/2/16 at 2:30pm revealed:
- A 3rd shift NA assisted Resident #5 out of bed and noted a bruise on the resident's face, above her right eye. No one knew how the resident got the bruise.
- The resident normally was up and down throughout night and could have injured self.
- An incident/accident report was completed and the resident was evaluated at a local urgent care on 2/14/16.
- The MA did not know if a report was sent to HCPR.

Interview with the facility's Administrator on 3/02/16 at 3:00pm revealed:
- He was aware Resident #5 had sustained an injury of unknown cause on 2/14/16.
- He and the supervisors had followed up and could not determine how the resident was injured.
- He was not aware resident injuries of unknown cause were required to be reported to the HCPR.
- He will complete a report and send to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019018	A. BUILDING: _____ B. WING _____	R 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(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 438	Continued From page 5 HCPR today.	D 438		