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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 3/23/16, 3/24/16, and 3/28/16-3/30/16.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interview, and record review, the facility failed to assure personal care assistance was provided in accordance with the assessed needs for 3 of 10 sampled residents (#1, #3, and #5) by not providing showers/baths to Residents #1 and #5 and incontinence care and grooming to Resident #3. The findings are: 1. Review of Resident #3's current FL-2 dated 02/24/16 revealed: - The resident's diagnoses included vascular dementia, lung cancer, chronic obstructive pulmonary disease, hypertension, status post myocardial infarction, hyperlipidemia, gastroesophageal reflux disease, depression, osteoarthritis, gout, and tobacco abuse. - The resident was noted to be constantly disoriented. - The resident was non-ambulatory and	D 269		

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incontinent of bowel and bladder.
- The resident required assistance with bathing and dressing.

Review of the Resident Register revealed Resident #3 was admitted to the facility on 05/07/15.

Review of the resident's assessment and care plan dated 02/19/16 revealed:
- The resident was oriented but forgetful and needed reminders.
- The resident was non-ambulatory with limited strength.
- The resident was incontinent of bowel and bladder.
- The resident required total assistance with dressing, grooming, bathing, toileting, ambulation, and transferring.

Review of hospital admission forms for Resident #3 dated 01/26/16 revealed:
- The resident presented with increasing shortness of breath, hypoxia and cough.
- The resident had a history of oxygen dependent chronic obstructive pulmonary disease and a history of left upper lobe cancer.
- The chest x-ray showed extensive pulmonary fibrosis and left upper lobe mass.
- The resident was treated for pneumonia and was discharged on 02/02/16 on 4 to 5 liters of oxygen.

Review of hospice notes for Resident #3 revealed the resident was admitted to hospice services on 02/06/16.

Interview with a PCA on 03/28/16 at 5:50 p.m. revealed:
- Resident #3 was on hospice and had become

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weaker over the last few days.
- The resident was too weak to feed himself and they want facility staff to feed him because he got short of breath.
- The PCAs provide incontinence care at least every 2 hours or more often as needed.
- The hospice aide usually bathed the resident on Mondays, Wednesdays, and Fridays.

Interview with a hospice aide on 03/28/16 at 2:05 p.m. revealed:
- She had been working with Resident #3 for about 3 weeks.
- She came to the facility 3 times a week and bathed the resident and changed his clothes.
- She usually gave the resident a bed bath because he was too weak to get out of bed and he refused to take showers.
- The resident complained of shortness of breath a lot.
- The resident had been wet 2 out of 3 days each week for the last 3 weeks when she had come to the facility.
- She could not say how long the resident had been wet when she arrived.
- The resident did not have any skin breakdown or irritation.

Interview with Resident #3's family member on 03/29/16 at 12:05 p.m. revealed:
- The resident was not feeling well and not talking much today.
- The resident had on the same navy blue shirt that he was wearing on the previous day when the family visited.
- The shirt was soiled and needed changing.

Observation of Resident #3 on 03/29/16 at 12:05 p.m. revealed:
- The resident was wearing a navy blue collared

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short-sleeved shirt.
- The front of the shirt had white and brown stains up and down the front of the shirt.

Interview with two personal care aides (PCAs) in the dining room at 12:15 p.m. revealed:
- They usually change Resident #3's clothes if they get soiled or stained.
- They did not change the resident's shirt that morning because the resident was having trouble breathing and they did not want to take his oxygen off.
- They would change his shirt after they finished helping with lunch in the dining room.

Observation of Resident #3 on 03/30/16 at 9:15 a.m. revealed:
- The resident was lying in bed wearing the same soiled navy blue collared short sleeved short as the previous day.
- The resident was weak and unable to indicate if his clothes had been changed.

Interview with the Executive Director on 03/30/16 at 9:20 a.m. revealed she would get staff to change the shirt right now.

Observation of Resident #3 on 03/30/16 at 9:30 a.m. revealed the resident was wearing a clean green t-shirt.

2. Review of Resident #1's current FL2 dated 2/10/16 revealed:
-Resident #1's diagnoses included muscle weakness, diaphragmatic obstruction, dysphagia, headache, gastroesophageal reflux disease, depression, anxiety, hypertension, and hypothyroidism.
-Resident #1 was semi-ambulatory.
-Resident #1 required the use of a walker and/or

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wheelchair for ambulation.
-Resident #1 required personal care assistance for bathing and dressing.

Review of Resident #1's Resident Register revealed an admission date of 3/20/15.

Review of Resident #1's Care Plan dated 2/8/16 revealed:
-Resident #1 was oriented and had adequate memory.
-Resident #1 had "limited ability" with ambulation/locomotion and "used walker at times while in her room, wheelchair use all other times."
-Resident #1's Activities of Daily Living (ADL) assessment revealed Resident #1 was independent with eating, toileting, ambulation, grooming and transferring; required supervision for bathing and limited assistance for dressing.
-Resident #1 was to receive a bath/shower on Monday, Wednesday, and Friday.

Review of Resident #1's Personal Care Service (PCS) Flow Sheet for February and March 2016 revealed:
-The level of assistance coded for bathing, personal hygiene, and grooming was extensive assistance.
-Resident #1 required extensive assistance for toileting, dressing, and ambulation/transfers.
-Instructions on the PCS Flow Sheet revealed "staff to put a check mark in box if assistance matches codes. If assistance does not match code notify the SIC."
-The documentation for February and March indicated that the assistance Resident #1 required matched the code.

Review of the 1st Shift Shower List revealed that Resident #1 was to receive a shower on Monday,

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Wednesday, and Saturday, and notify the Interim Executive Director (ED) if the bath was not given.

Review of the "Head to Toe Assessment" form for February 2016 revealed:
-Documentation at the top of the form included "head to toe assessment to be done every shower/bath day."
-On 2/5/16, 2/8/16, 2/17/16, and 2/29/16 there was no documentation that Resident #1 received a bath/shower.
-There was no documentation that the Interim ED was notified that the bath/shower was not given.

Review of the "Head to Toe Assessment" form for March 2016 revealed:
-Documentation at the top of the form included "head to toe assessment to be done every shower/bath day."
-On 3/5/16, 3/16/16, and 3/21/16 there was no documentation that Resident #1 received a bath/shower.
-There was no documentation that the Interim ED was notified that the bath/shower was not given.

Interview with Resident #1 on 3/23/16 at 11:36am revealed:
-Resident #1 received no help from staff.
-Resident #1 was supposed to get a shower three times a week, but usually only got a shower once or twice a week.
-Resident #1 had to bathe herself.
-Resident #1 needed help washing her feet, because she was unable to stand on her left foot.
-Resident #1 did the best she could.

Review of the "D Hall PCS Book" kept at the nurse's station on 3/24/16 at 11:30am revealed:
-Each resident's Care Plan was inside the notebook in front of the PCS Flow Sheets for the

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month.
-There was no Care Plan in the "D Hall PCS Book" for Resident #1.
-There was a PCS Flow Sheet for March 2016 for Resident #1.
-Resident #1 resided on D Hall of the facility.

Interview with a Personal Care Aide (PCA) on 3/24/16 at 4:30pm revealed:
-Resident #1 could do for herself.
-Resident #1 did not require assistance from staff unless she needed assistance with her pull ups.
-Resident #1 showered every two days, but it was on first shift.
-If a resident refused a shower, staff was to notify the Resident Care Coordinator (RCC).

Observation of Resident #1 on 3/28/16 at 9:45am revealed that Resident #1 was coming out of the shower room.

Interview with Resident #1 on 3/28/16 at 10:15am revealed:
-Resident #1 took a shower in the D Hall shower room.
-No staff assisted Resident #1 with her shower other than to bring a towel to her.

Interview with a second PCA on 3/28/16 at 1:00pm revealed:
-Resident #1 took a shower this morning.
-Resident #1 could bathe herself.
-Resident #1 would let staff know if she needed help.
-The PCAs did not fill out the PCS Flow Sheet because the RCC usually filled them out or whoever had to start a new sheet for the new month.
-If a resident refused a bath, staff was supposed to report it to the RCC.

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D 269	Continued From page 7 -Each shower/bath was supposed to be documented for all residents on the PCS Flow Sheet and assessment form in the PCS books. Telephone interview with a family member for Resident #1 on 3/29/16 at 10:50am revealed: -There was no concerns about the care Resident #1 was receiving. -The only complaint Resident #1 had voiced was that staff was not bathing her three times each week. -From what the staff was reporting to him when he visited Resident #1, she was being bathed three times each week unless Resident #1 did not want a bath that day. Interview with a third PCA on 3/30/16 at 1:00pm revealed: -Resident #1 had not had a bath yet on 3/30/16. -It was Resident #1's scheduled shower day. -Resident #1 had not told staff she was ready to get her shower. -Resident #1 was usually able to shower herself, but sometimes she would ask staff to help wash her feet. Interview with Resident #1 on 3/30/16 at 1:25pm revealed: -The staff had not asked her if she was ready to take her shower. -Resident #1 would have to go down to the shower room by herself and take her shower if she wanted one. -She would have to go and get her own towels and wash cloth if she wanted to take a shower, because the staff did not bring her any. 3. Review of Resident #5's current FL2 dated 12/8/15 revealed: -Resident #5's diagnoses included dementia,	D 269		

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anxiety, heart disease, hypertension, reflux, hypoxemia, osteoporosis, dysphagia, and chronic obstructive pulmonary disease.
-Resident #5 was non-ambulatory.
-Resident #5 required the use of a wheelchair.
-Resident #5 was incontinent of bladder and required toileting every 2 hours.
-Resident #5 required personal care assistance with bathing and dressing.

Review of Resident #5's Resident Register revealed an admission date of 3/17/15.

Review of Resident #5's Care Plan dated 2/25/16 revealed:
-Resident #5 was confused.
-Resident #5's Activities of Daily Living (ADL) assessment revealed Resident #5 was independent with eating and ambulation, required limited assistance with toileting, dressing, and transferring, supervision for grooming, and extensive assistance for bathing.
-Resident #5 was to receive a bath on Monday, Wednesday, and Friday.
-Resident #5 was to be toileted every two hours and as needed.

Review of Resident #5's Personal Care Services (PCS) Flow Sheet for February and March 2016 revealed:
-The level of assistance coded for bathing, personal hygiene, and grooming was extensive assistance.
-Resident #5 required extensive assistance for toileting and dressing.
-Resident #5 required limited assistance for ambulation/transfers.
-Instructions on the PCS Flow Sheet included "staff to put a check mark in box if assistance matches codes. If assistance does not match

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code notify the SIC."
-The documentation for February and March indicated that the assistance Resident #5 required matched the code.

Review of the 1st Shift Shower List revealed that Resident #5 was to receive a bath/shower on Tuesday, Thursday, and Saturday.

Review of the "Head to Toe Assessment" form for February 2016 revealed:
-Documentation at the top of the form included "head to toe assessment to be done every shower/bath day."
-On 2/4/16 and 2/16/16 there was no documentation that Resident #5 received a bath/shower.
-On 2/11/16, 2/19/16, 2/23/16, and 2/27/16, "bottom red" was documented on the form.

Review of the "Head to Toe Assessment" form for March 2016 revealed:
-Documentation at the top of the form included "head to toe assessment to be done every shower/bath day."
-On 3/3/16 and 3/15/16 there was no documentation that Resident #5 received a bath/shower.
-On 3/18/16, "between buttocks red" was documented on the form.
-On 3/22/16 and 3/26/16, "red bottom" was documented on the form.

Interview with Resident #5 on 3/23/16 at 9:00am revealed:
-Resident #5 usually received a bath three times a week she thought.
-Resident #5 was not able to give herself a bath because she had trouble walking, but the therapist was helping her to walk.

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-Resident #5 had fallen several times and had to go to the hospital.
-Resident #5 fell because she was in a slippery place every time.
-Staff usually responded when she pushed her button for help.
-Staff complained that the work was too hard.

Observation of Resident #5 in her room on 3/28/16 at 10:45am revealed that Resident #5 was receiving a bath with staff assistance.

Interview with a PCA on 3/28/16 at 1:45pm revealed:
-Resident #5 received a bath this morning with staff assistance.
-Resident #5 was not able to bathe herself due to her history of falls and being unable to walk on her own.
-Resident #5's skin was clear, no redness.
-If a resident refused a bath, staff was to report it to the RCC or RCD.
-Staff was supposed to document the baths and showers in the PCS books at the nurse's station.

Interview with a second PCA on 3/28/16 at 2:30pm revealed:
-Resident #5 required staff assistance for personal care needs.
-Resident #5 was not able to stand or walk without staff assistance.
-Resident #5 had a history of falls.

Attempts to contact Resident #5's family member were not successful upon exit.
Interview with the Interim ED on 3/28/16 at 5:10pm revealed:
-The PCS Flow Sheets in the PCS book should match the Care Plan in the resident chart.
-Resident #1's Flow Sheet was coded a 3 in

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D 269	Continued From page 11 grooming and bathing, but the Care Plan in her chart was coded a 1. -The Interim ED was not sure if the Resident Care Coordinator (RCC) or the Resident Care Director (RCD) was completing the PCS Flow Sheets. Interview with the Interim ED and the Executive Director (ED) on 3/28/16 at 6:10pm revealed: -The nurse aides were filling out the PCS Flow Sheets and what they were filling out was not matching the Care Plans in the residents' charts. -The RCD was told to make sure the PCS Flow Sheets were filled out correctly. -The nurse aides could initiate the PCS Flow Sheets at the beginning of the month.	D 269		
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 observation, interview, and record review the facility failed to notify the prescribing physician for finger stick blood sugars that were greater than 401 for 1 of 1 sampled residents who was diabetic and required finger stick blood sugars with a parameter to call if greater than 401. (Resident #2). The findings are: Review of Resident #2's FL2 dated 6/25/15 revealed:	D 273		

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-Resident #2's diagnoses included diabetes type 2, hypothyroidism, depression, chronic renal insufficiency, cognitive impairment, osteoarthritis, and diabetic neuropathy.
-Orders included finger stick blood sugars before meals.

Medication orders included on the FL2 dated 6/25/15 revealed:
-Humalog (a rapid acting insulin used to lower blood glucose) 100u/ml kwikpen sliding scale order as follows: 0-150 = 0 units; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; above 401, give 12 units and call MD.

Review of Resident #2's Resident Register revealed an admission date of 10/10/13.

Review of the Admission/Discharge Report provided by the facility on 3/23/16 revealed that Resident #2 was discharged to a Skilled Nursing Facility on 3/1/16.

Review of Resident #2's Medication Administration Record (MAR) for January 2016 revealed:
-There entries to check blood sugar once daily before breakfast at 7:30am, before lunch at 11:30am, and before supper at 4:30pm.
-On 1/8/16, Resident #2's blood sugar was documented as 408 mg/dl at 4:30pm and 12 units of Humalog insulin was documented as administered.
-On 1/17/16, Resident #2's blood sugar was documented as 446 mg/dl at 4:30pm and 12 units of Humalog insulin was documented as administered.
-On 1/22/16, Resident #2's blood sugar was documented as 456 mg/dl at 4:30pm and 12 units

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of Humalog insulin was documented as administered.
-On 1/23/16, Resident #2's blood sugar was documented as 402 mg/dl at 4:30pm and 12 units of Humalog insulin was documented as administered.
-On 1/24/16, Resident #2's blood sugar was documented as 487 mg/dl at 11:30am and 12 units of Humalog insulin was documented as administered.
-On 1/29/16, Resident #2's blood sugar was documented as 543 mg/dl at 4:30pm and 12 units of Humalog insulin was documented as administered.
-There was no documentation that the physician was notified of the blood sugar readings above 401 mg/dl for these dates.

Review of Resident #2's MAR for February 2016 revealed:
-There were entries to check blood sugar once daily before breakfast at 7:30am, before lunch at 11:30am, and before supper at 4:30pm.
-On 2/1/16, Resident #2's blood sugar was documented as 409 mg/dl at 4:30pm and 12 units of Humalog insulin was documented as administered.
-There was no documentation that the physician was notified of the blood sugar reading of 401 mg/dl on 2/1/16.

Review of the Progress Notes in Resident #2's record revealed no documentation that the physician was notified of the blood sugars being greater than 401.

Interview with the Physician Assistant (PA) on 3/28/16 at 11:00am revealed:
-The PA recalled Resident #2 and remembered the blood sugars being elevated.

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-The PA knew that changes were made in Resident #2's Levemir insulin orders, but could not recall if changes were made to the sliding scale.
-The PA did not recall being notified specifically about a blood sugar being greater than 401, but the on call practitioner may had been notified.
-Staff should have called if that was the order.

Interview with the Resident Care Director (RCD) on 3/28/16 at 12:30pm revealed:
-The RCD provided the Medication Aide (MA) trainings for the facility.
-The MA should have called the physician if the blood sugar readings were greater than 401 since that was the order based on the sliding scale.
-The RCD had taught the MAs to call her if they ever had a question or were not sure about what to do in a situation.
-The MAs had also been taught to document their interventions and any contact made with the physicians should be documented in the progress notes or on the MAR notes on the back of the MAR.

Interview with a MA on 3/28/16 at 5:50pm revealed:
-If the MA had a question about insulin or a resident's blood sugar, she would call the RCD for her input.
-Usually, the RCD would tell the MA to call the physician.
-The MA would document what she did on the MAR and in the log book at the nurse's station so the RCD and the next shift would know what had happened.

Interview with a second MA on 3/29/16 at 4:05pm revealed:
-If the sliding scale order said to call the physician

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D 273	Continued From page 15 for a blood sugar reading over a certain parameter, I would always call. -The MA always documented when she called the physician in the resident's record.	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 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: TYPE B VIOLATION Based on observation, interview, and record review, for 4 of 10 residents sampled, the facility failed to measure and document urinary output as ordered for Resident #10 who had a history of urinary retention and failed to obtain urinalysis as ordered by the licensed provider for Residents #2, #7, and #8. The findings are: 1. Review of Resident #10's current FL2 dated 5/13/15 revealed: -Diagnoses included bladder atonic, retention of urine unspecified, and gait instability. -Resident was noted to have an indwelling catheter. Review of Resident #10's resident register	D 276		

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D 276	Continued From page 16 revealed he was admitted to the facility on 5/19/15. Observation of Resident #10 on 3/24/16 at 9:50am revealed: -Resident #10 was sitting in a recliner next to his bed. -He had an external catheter that was connected to a gravity drainage bag. -The drainage bag had numbers on the side of it for urine measurement. -There was less than 50 milliliters (ML) in the bag and there was urine in the tube leading from the resident to the bag. Review of note dated 2/19 above the recliner in Resident #10's room revealed: -The note was signed by the home health Nurse. -The note said the nurse spoke with the urology office about ongoing bleeding/ retention. -The urologist wrote an order that the home health Nurse could not change or flush the resident's catheter unless directed by the doctor. -The urologist wrote an order instructing the staff if Resident #10 had no urine output or less than 100ml in 3 hours and/ or complains of pelvic pain they staff needed to call the urologist. -There was a phone number listed for business hours and for after hours for the urologist. -There was a number to call the home health agency if the urologist ordered flushing of the catheter or a catheter change, along with a number to reach the on-call Nurse during the after-hours. Review of Home Health documents revealed an order from the Urologist dated 2/29/16, for staff to call the on-call Doctor with no urinary output or urine output of less than 300ml in 4 hours and/ or pelvic pain, for direction and will call an on-call	D 276		

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D 276	Continued From page 17 RN if directed. Review of a physician order from Resident #10's primary care physician dated 2/22/16 revealed an order to monitor urine output every shift and write on MAR. Interview with Resident #10 on 3/24/16 at 9:50am revealed: -The staff at the facility empty his catheter drainage bag. -He did not know how frequently his drainage bag was emptied. Interview with the medication aide on 3/24/16 at 12:30pm revealed: -The personal care aides (PCAs) are responsible for emptying the drainage bag for Resident #10. -If the PCA was busy and was unable to empty the catheter, then she would empty it. -There was not an output flowsheet to document the output on for Resident #10. -The urine output was to be documented on Resident #10's medication administration record (MAR). -The PCAs do not document anything on the MAR, the PCA would tell the medication aide the amount of urine output and the medication aide would document on the MAR. -She had not emptied the catheter for Resident #10 (today), she did see it when she first got to work around 7:00am and there was "barely anything" in the bag. Interview with the PCA on 3/24/16 at 1:05pm revealed: -She was assigned Resident #10 and she had not checked or emptied his drainage bag yet. -This was the first time she had worked with Resident #10 and she did not know what she was	D 276		

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supposed to do, she was going to check with the MA.
-She asked the medication aide said she would empty the drainage bag at the end of her shift, and relay the amount of to the medication aide, so the medication aide could document on the MAR.
-She had checked the bag 3 times today, she had not notified the medication aide that there was hardly anything in the bag for urine output..
-When she first got to work at 7:00am, before breakfast there was "hardly anything" in the bag.
-When she checked the bag just before 12:00pm there was still "hardly anything" in the bag.
-There had not been enough in the bag to empty, so she had not reported anything to the MA.
-She did not inform the medication aide, the bag was empty and the medication aide had not asked.

Observation of Resident #10's drainage bag on 3/24/16 at 1:10pm revealed:
-The tube was filled with clear yellow urine and there was drainage in the bag up to the 175ml mark.
-Resident #10 was resting comfortably in his recliner.

Review of the February 2016 MAR for Resident #10 revealed:
-There was a notation written on the MAR for staff to monitor urine output for Resident #10.
-The documentation started on 3/22/16.
-There were 4 lines for each shift to document urine output.
-There was no space to document urine output and initials.
-The only documentation of urine output 7:00am -3:00pm was on 2/22/16, 2/25/16, 2/27/16, and 2/28/16.

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D 276	Continued From page 19 -The only documentation of urine output 3:00pm -11:00pm was on 3/26/16. -On the 11:00pm-7:00am shift there was urine output documented on each day with exception of 2/24/16 (left blank) and 2/29/16 staff initials with no amount written. Review of the March 2016 MAR for Resident #10 revealed: -An order was printed on the MAR to monitor urine output every shift and write on the MAR. -There were 4 lines for each shift to document urine output. -The staff documented their initials on each shift. -The only documentation of urine output 7:00am -3:00pm was on 3/4/16, 3/5/16, 3/9/16, 3/11/16, 3/12/16, 3/16/16, 3/17/16 and 3/23/16. -There was no urine output documented on the 3:00pm - 11:00pm shift for the month of March 2016. -There was documented urine output on the MAR for the 11:00pm - 7:00am shift for each day of March 2016 through 3/29/16. Interview with a 2nd medication aide on 3/24/16 at 3:30pm revealed: -She never emptied the urinary drainage bag for Resident #10, she thought the Home Health Nurse was the only person to empty the bag. -She had not been told that she or any other staff was responsible for emptying the drainage bag. -Once in a while she had seen the PCA empty the drainage bag. -She did not know she was supposed to be recording the output. -She would ask the PCA if she emptied the bag, and she will write down the amount. -If there was no urine in the bag she didn't think she needed to do anything, because there would be nothing to empty.	D 276		

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-She had not written down the urine output in the past, because she did not know she was supposed to.
-If there was an order to record the urine output for Resident #10 she would.

-Interview with a 3rd PCA on 3/24/16 at 3:40pm revealed:
-She was assigned Resident #10 on many occasions.
-She would empty his drainage bag 3 times per shift when she worked.
-There was a little tablet on his dresser where she documented his urine output.
-If there was just a little urine output in the bag she did not do anything.
-She usually would check around 4:00pm, 7:00pm and again around 10:00pm.
-If there wasn't any output when she checked it, or if there was just a little urine output, she did not report that to anyone.
-She had not checked it yet today.

Observation of Resident #10 on 3/24/16 at 4:00pm revealed:
-There was no urinary output in the bag.
-There was 3 sticky notes on his dresser dated 3/20/16, 3/21/16, and 3/24/16.
-The note on his dresser dated 3/24/16 at 3:50pm documented urine output of 200ml.

Interview with the Resident Care Director (RCD) on 3/24/16 at 4:05pm revealed:
-She was not aware of any orders to document urine output for Resident #10.
-The Resident Care Coordinator (RCC) would be the one that would have managed any orders for Resident #10.

Interview with the RCC on 3/24/16 at 4:10pm

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revealed:
-Staff should be checking the urinary drainage bag for resident #10 every 2 hours and notify the medication aide every 2 hours, if there is not enough to empty.
-The home health Nurse wrote the note that was over the recliner in Resident #10's room.
-The home health Nurse instructed the PCAs and MAs to check urine output every 2 hours and contact the urologist if there was less than 100ml of urine output in 3 hours and or Resident #10 complained of pain in the lower abdomen.
-The medication aide was to document the urine output on the MAR at the end of each shift.
-She was not aware there were only 3 lines on the MAR to document urine output and staff initials.
-The staff were documenting their initials instead of urine output because there was not space to write the urine output on the MAR.
-She would need to create a flowsheet so that staff would be able to document the urine output and their initials on the MAR.
-She and the RCD were responsible for auditing the MARs monthly to ensure all documentation was accurate.
-She would ask the medication aide about it when she did not see the urine output documented on the MAR.
-She did not know the last time she spoke with the staff about the documentation of urine output on the MAR.

A second interview with the RCC on 3/24/16 at 5:25pm revealed:
-They had 2 orders for Resident #10.
-The order over the resident ' s bed is not an order from the physician, it was an order written from the home health nurse on behalf of the urologist and should have never been put up

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there.
-The other order in the record dated 2/22/16 from the primary care physician said to check resident's urine output each shift and document on the MAR.
-They should have gotten clarification.
-The staff had been following the order written by the Nurse, instead of what the primary care physician wrote.

Interview with the Executive Director (ED) on 3/24/16 at 5:40pm revealed:
-The primary care physician wrote the order on 2/22/16 to check urine output each shift and document on the MAR.
-She would contact the primary care physician and get clarification.

Interview with the Interim Executive Director on 3/28/16 revealed:
-She received a clarification of the urine output order for Resident #10.
-They created a flowsheet for staff to document their initials and urine output at the end of each shift.

Review of a physician order dated 3/28/16 at 5:10pm revealed:
-Monitor total urine in ccs [cubic centimeteres are the same as mls] and the end of each shift and record on the MAR.
-Notify the primary physician if less than 300ml in 1 shift.
-If no urine output or resident complains of pelvic pain call the urologist.

Review of the catheter output flowsheet for Resident #10 revealed, staff have documented the urine output for Resident #10 at the end of each shift since 2/25/16.

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Interview with the physician for Resident #10 on 3/30/16 at 10:45am revealed;
-There had not been any call from the facility reporting low or no urine output in the last week.
-The latest order to the facility was 3/29/16 to monitor urine output every shift and call if urine output was less than 300mls.

2. Review of Resident #2's FL2 dated 6/25/15 revealed diagnoses included diabetes type 2, hypothyroidism, depression, chronic renal insufficiency, cognitive impairment, osteoarthritis, and diabetic neuropathy.

Review of Resident #2's Hospice Comprehensive Assessment and Plan of Care Update Report dated 2/11/16 revealed Resident #2 was admitted to hospice services on 12/15/15 with a diagnosis of bladder cancer.

Review of subsequent physician orders revealed:
-There was an order dated 12/29/15 for a urinalysis to rule out urinary tract infection.
-There was a second order dated 1/7/16 for a urinalysis to rule out urinary tract infection.

Review of lab results for Resident #2 revealed:
-There were results for a urinalysis obtained on 12/17/15.
-There was a urine culture and sensitivity report from a urine sample collected on 1/30/16.
-There was no other lab results in Resident #2's record for a urinalysis.

Review of Progress Notes for Resident #2 revealed:
-There were no entries for 12/29/15.
-There was an entry dated 1/7/16 at 12:30pm and written by the RCD that read, "Resident in good

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spirits ...collecting urine today for UA."
-There were no other entries that indicated that the urine specimen was obtained on 1/7/16.

Interview with the RCD on 3/28/16 at 12:30pm revealed:
-The hospice agency should have obtained the labs ordered for Resident #2 since she was receiving hospice services at the time.
-If the physician wrote an order for labs on Resident #2, the facility was supposed to fax those orders to the hospice agency so the hospice nurse could obtain the labs.

Telephone interview with the hospice agency on 3/28/16 at 2:35pm revealed:
-The agency did not have results for any lab work for dates 12/29/15 and 1/7/16.
-The agency did not have orders on file for Resident #2 to obtain a urinalysis on 12/29/15 or 1/7/16.
-The only order for a urinalysis on file for Resident #2 was obtained by the hospice nurse on 1/30/16.

3. Review of Resident #8's current FL-2 dated 03/25/16 revealed:
- The resident's diagnoses included dementia, anxiety, hypertension, cardiomyopathy, hypothyroidism, and history of breast cancer.
- The resident was constantly disoriented.
- The resident was ambulatory.
- The resident was incontinent of bowel and bladder.
- The resident required assistance with bathing and dressing.

Review of the Resident Register revealed Resident #8 was admitted to the facility on 01/12/11.

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D 276	Continued From page 25 Review of Resident #8's assessment and care plan dated 03/23/16 revealed: - The resident was always disoriented and had significant memory loss. - The resident required extensive assistance with toileting, bathing, dressing, and grooming. Review of a progress note dated 01/06/16 for Resident #8 revealed: - The resident had a fall on 01/05/16 and was sent to the hospital. - The resident complained of back pain. Review of a physician assistant (PA) visit form dated 01/07/16 for Resident #8 revealed: - The resident had a fall with left leg pain and weakness. - The PA ordered a urinalysis to rule out urinary tract infection. Review of Resident #8's record revealed no documentation of a urinalysis being done as ordered on 01/07/16. Interview with the Interim Executive Director on 03/30/16 at 9:05 a.m. revealed: - She did not know if the urinalysis ordered for Resident #8 on 01/07/16 had been done. - She would contact the lab and the PA's office to check for any results. Interview with the Resident Care Director (RCD) / Registered Nurse (RN) on 03/30/16 at 1:50 p.m. revealed: - When an order for a urinalysis was received, the medication aides (MAs) were responsible for collecting the urine specimen. - They should collect the urine specimen when the order was received.	D 276		

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- The MAs would document in the lab book when the urine specimen was collected.
- The MAs would call the lab company and the lab company would pick up the urine specimen.
- She was usually aware a urine specimen needed to be collected because it was usually documented in the communication book.
- She usually asked the MAs if they had collected a urine specimen for an order for a urinalysis.
- She could not recall if the urinalysis was done for Resident #8.

Interview with the Administrator on 03/30/16 at 4:20 p.m. revealed:
- She contacted the lab company and the PA's office and they have no record the urinalysis ordered for Resident #8 on 01/07/16 was done.
- She did not know why the urinalysis was not done.

Attempt to contact the PA on 03/30/16 was unsuccessful.

Based on observation, interview, and record review, Resident #8 was not interviewable due to diagnoses of dementia.

4. Review of Resident #7's current FL-2 dated 2/29/16 revealed:
-The resident's diagnoses included dementia, recurrent urinary tract infections and osteoarthritis.
-The resident was constantly disoriented.
-There was an order for Macrodantin 50 milligrams (mg) take one capsule by mouth at bedtime (an antibiotic used to help treat urinary tract infections).

Review of Resident #7's Resident Register revealed the resident was admitted to the facility

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D 276	Continued From page 27 on 2/2/14. Review of Resident #7's record revealed: -A urinalysis (UA) had been completed on 1/6/16. -An order dated 2/22/16 for a urinalysis (UA) to rule out a urinary tract infection. -There was no documentation a UA had been completed as ordered. Interview with a Medication Aide (MA) on 3/30/16 at 1:37 p.m. revealed: -If Resident #7 had an order for a UA to be completed, the MA collected the urine from the resident, placed it in the biofreeze, contacted the physician's office and the physician's office would contact the lab company to pick up the urine sample. -When the representative from the lab company picked up the urine sample, the MA and the lab company's representative signed a document, which indicated the urine sample was picked up. Interview with a second MA on 3/30/16 at 2:30 p.m. revealed: -If Resident #7 had an order to be completed, the MA collected the urine from the resident, contacted the residents physician, the physician contacted the lab company to pick up the resident's urine sample. -The lab company picked up the urine sample within 24 hours. -The MA did not document in the communications book if the urine sample was collected. Interview with the Resident Care Director (RCD) on 3/30/16 at 2:10 p.m. revealed: -If a resident had an order for a UA, the MA collected the urine and documented in the lab book when the urine was collected. -If a UA was completed for Resident #7, it should	D 276		

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D 276	Continued From page 28 have been documented in the communications book. Interview with the Resident Care Coordinator (RCC) on 3/30/16 at 4:28 p.m. revealed: -She reviewed her assigned residents' orders, which included Resident #7, Mondays, Wednesdays and Fridays. -She was responsible for making sure staff followed the physicians' orders for Resident #7. -When Resident #7 had an order for a UA, a MA collected the urine, contacted the resident's primary care physician and the physician contacted the lab company to pick up the urine sample. -The lab company had to collect the urine sample within 24 hours of the urine collection. -She was responsible for checking behind the MA's and making sure Resident #7 had a UA completed as ordered by the physician. -She did not "recall" Resident #7 having a UA completed February 2016. -The MA's document the UA on a new tracking form. -The facility had an old tracking form, but it was revised within the past week (between 3/20-3/26/16). -She unaware if the MA's knew UA's should have been documented on the prior tracking form. Observation of the RCC's telephone interview with a representative from the lab company on 3/30/16 at 4:43 p.m. revealed the company did not complete a UA or have an order to complete a UA on Resident #7 February 2016. Interview with the Administrator and the Interim Administrator on 3/30/16 at 5:00 p.m. revealed: -If a resident had an order for a urine sample, the MA collected the sample, labeled, dated and	D 276		

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D 276	Continued From page 29 placed the sample in the refrigerator. -A new lab tracking log was started on 3/25/16, which included when the urine was collected and picked up by the lab company. -Before the lab tracking log started, the MA's documented in the communication log when the lab was completed. -The RCC and the RCD were responsible to make sure the labs had been completed for the residents. -They were not aware Resident #7 did not have a UA completed as ordered by the physician. Resident #7's physician could not be reached by the end of the survey. Based on observation, interview and record review, Resident #7 was not interviewable. Resident #7's Responsible Party could not be reached by the end of the survey. _____ The facility provided the following Plan of Protection on 3/24/16: -A new flow sheet added to the Medication Administration Record. The new flow sheet has place for Med-Tech initials and output amount. -Begin a chart to MAR audit to ensure accuracy of all orders to include and follow through. -Educate all care staff on proper documentation of urine output every shift. To be monitored by RCC, RCD, ED and/or designee daily for one week and weekly thereafter. -RCD, RCC, ED and/or designee to ensure orders are being followed and followed through as ordered to be monitored daily for one week then weekly thereafter.	D 276		

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D 276	Continued From page 30 The facility made the following addendum to the Plan of Protection on 3/30/16: -Implement lab order checklist and new order tracking form. All staff in-serviced. -RCD, RCC, ED and designee to ensure lab order checklist is completed and followed per doctors' orders daily times one week and monthly thereafter. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 14, 2016.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure Personal Care Aides (PCAs) followed sanitation and safety guidelines while providing feeding assistance to 2 of 6 residents (#11, #13) who required assistance with feeding in the back hall dining room. The findings are: Observation of the dinner meal on 3/24/16 at 5:51 p.m. revealed: -A PCA was providing assistance with feeding to Resident #11 and Resident #13. -The PCA was wearing gloves and did not change gloves or wash her hands between feedings.	D 283		

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D 283	Continued From page 31 Observation on 3/24/16 at 6:02 p.m. revealed: -The same PCA rolled another resident, who was in the dining room and in a wheelchair, to the hall. -The PCA was wearing the same gloves she used to help feed Resident #11 and Resident #13. -The PCA did not change gloves or wash her hands and continued to feed both residents while wearing the same gloves. Interview with the same PCA on 3/24/16 at 6:02 p.m. revealed: -She had been working at the facility for 21 years. -She was trained on assistance with feeding when she first started working at the facility by a Supervisor who no longer worked at the facility. -If she was feeding two residents, she was told to sit between both residents and feed the residents at the same time. -She never knew gloves needed to be changed between feeding residents. Observation of the lunch meal on 3/29/16 at 12:28 p.m. revealed: -A Medication Aide (MA) was wearing gloves while assisting Resident #13 with feeding assistance. -The MA went to roll another resident, who was in a wheelchair, out from the dining room table. -The MA kept on the same gloves and did not change gloves after she rolled the resident from the dining room table. -The MA opened the ketchup packet to continue to feed the resident she was assisting with feeding. Interview with the MA on 3/29/16 at 12:28 p.m. revealed: -She usually did not keep the same gloves on when assisting residents with feeding assistance	D 283		

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and with moving from the dining room table .
-She forgot to change gloves.

Observation on 3/29/16 at 12:28 p.m. revealed the MA changed gloves and continued feeding Resident #13 who required assistance with feeding.

Observation of the dinner meal on 3/29/16 at 5:10 p.m. revealed:
-A second PCA was sitting between Resident #11 and Resident #13 and providing assistance with feeding.
-The PCA was wearing gloves and was feeding Resident #11 with the right hand and Resident #13 with the left hand.

Interview with the same PCA on 3/24/16 at 6:23 p.m. revealed:
-Resident #11 and Resident #13 required assistance with feeding.
-Usually one staff fed both of the residents.
-When she assisted with feeding assistance, she sat between both residents, wore gloves, she used one hand to feed one resident and she used the other hand to feed the other resident.
-She was trained on assistance with feeding by the Resident Care Coordinator (RCC) less than one year ago.
-She changed gloves before returning to feed residents, if she had to leave out of the dining room to assist another resident with personal assistance.

Interview with the Resident Care Director (RCD) on 3/30/16 at 2:10 p.m. revealed:
-The RCD was responsible for the care in the facility.
-She monitored assistance with feeding at least monthly.

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D 283	Continued From page 33 -The RCC monitored meals in the back hall. -If staff was assisting a resident with feeding and another resident need personal assistance in the dining room, staff should remove gloves off of the hands, assist the resident, wash hands, put back on gloves and continue feeding the resident who required assistance with feeding. -She was not aware staff continued to wear the same gloves while providing assistance with feeding and assisting residents in the dining room. -If she would have known, she would have "stopped it." Interview with the RCC on 3/30/16 at 4:28 p.m. revealed: -She monitored the meals on the back hall dining at least weekly. -If staff was assisting a resident with feeding and another resident needed personal assistance in the dining room, staff should remove gloves off of the hands, assist the resident, wash hands and continue assistance with feeding the resident. -Staff should not wear gloves while feeding residents. -She was not aware staff used the same gloves while providing assistance with feeding and while assisting in the dining room. Interview with the Executive Director and the Interim Executive Director on 3/30/16 at 5:00 p.m. revealed: -If staff was providing assistance with feeding and another resident in the dining room needed assistance, staff should assist the resident, wash their hands, put on gloves and continue feeding the resident who required assistance with feeding. -Staff are allowed to use gloves while providing assistance with feeding.	D 283		

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D 283	Continued From page 34 -The RCC was responsible for making sure staff was following sanitation and safety guidelines while providing assistance with feeding to residents. -If the RCC was not available, the MA was responsible for making sure staff are following sanitation and safety guidelines while providing assistance with feeding. -One staff should not feed two residents. -She was not aware one staff was feeding two residents at the same time, who required assistance with feeding. -If she would have known, she would have "stopped it."	D 283		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 6 residents (#11, #13) who required feeding assistance, were assisted with feeding upon receipt of the meal in a timely manner. The findings are: 1. Review of Resident #11's current FL-2 dated 12/1/15 revealed: -The resident's diagnoses included dementia with	D 312		

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behavioral disturbance, high blood pressure and diabetes mellitus.
-The resident was semi-ambulatory.
-The resident was constantly disoriented.
-There was a low concentrated sweets diet order.
-There was an order to feed and encourage the resident to eat.

Review of Resident #11's Resident Register revealed the resident was admitted to the facility on 9/16/15.

Review of Resident #11's Care Plan dated 12/1/15 included staff fed the resident.

Review of the feeding assistance list (not dated) revealed Resident #11 required feeding assistance.

Observation of Resident #11 during the dinner meal on 3/24/16 at 5:51 p. m. revealed:
-The resident was served and fed 1 chicken wing and 1 chicken leg with sweet and sour sauce, ½ cup broccoli, ½ cup rice, 1 roll, ½ cup apple sauce, 1 cup water and 1 cup milk.
-A PCA fed Resident #11 and another resident at the same time.

Observation on 3/24/16 at 6:34 p.m. revealed Resident #11 finished the dinner meal.

Observation of the lunch meal on 3/29/16 at 11:55 a.m. revealed:
-Resident #11 was sitting at the dining room table.
-The resident had fallen asleep at the table.
-The resident was served a hamburger buns, 1 three ounce hamburger patty with 1 slice cheese, 1 slice tomatoe, 3 onion rings, 1 slice lettuce, 1 cup water, 1 cup tea and 1 cup milk.

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D 312	Continued From page 36 Observation on 3/29/16 at 12:43 p.m. revealed Resident #11 had completed the meal. Based on observation, interview and record review, Resident #11 was not interviewable. Refer to interview with a PCA on 3/24/16 at 6:02 p.m. Refer to interview with a second PCA on 3/24/16 at 6:23 p.m. Refer to interview with a MA on 3/29/16 at 1:00 p.m. Refer to interview with a third PCA on 3/30/16 at 9:57 a.m. Refer to interview with the RCD on 3/30/16 at 2:10 p.m. Refer to interview with the RCC on 3/30/16 at 4:28 p.m. Resident #11's Responsible Party could not be reached by the end of the survey. 2. Review of Resident #13's current FL-2 dated 12/22/15 revealed: -The resident's diagnoses included dementia with behavioral disorder, moderate protein calorie malnutrition and anorexia. -The resident was non-ambulatory. -The resident was constantly disoriented. -There was an order for ensure twice daily. Review of Resident #13's Resident Register revealed the resident was admitted to the facility on 12/21/15.	D 312		

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D 312	Continued From page 37 Review of Resident #13's record revealed: -There was no Care Plan in the resident's record. -There was a diet order dated 1/15/16 for a soft diet. -There was a current order dated 2/10/16 for a Regular diet ground meats. Review of the feeding assistance list (not dated) revealed Resident #13 required feeding assistance. Observation of Resident #13 on 3/24/16 at 5:48 p.m. revealed: -Resident #13 was served 3 oz ground chicken with sweet and sour sauce, ½ cup rice, ½ cup chopped broccoli, ½ cup pudding, 1 cup water, 1 cup tea. -A PCA was feeding Resident #13 and another resident. Observation on 3/24/16 at 6:11 p.m. revealed Resident #13 had finished the dinner meal. Observation of Resident #13 during lunch on 3/29/16 at 11:58 a.m. revealed: -The resident was sitting at a dining room table located in the back hall dining room. -The resident was served 1 cup of water, 1 cup of tea and 1 cup of milk. Observation of Resident #13 during lunch on 3/29/16 at 12:10 p.m. revealed the resident was served 2 hamburger buns with 3 ounces ground hamburger meat, 4 pickles, 1 slice tomatoe, 1 cup raw lettuce, ½ cup mandarin oranges and 10 potato logs. Observation of Resident #13 on 3/29/16 at 12:20 p.m. revealed a Personal Care Aide (PCA) was	D 312		

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D 312	Continued From page 38 encouraging the resident to eat the meal. Observation on 3/29/16 at 12:24 p.m. revealed: -The Interim Executive Director asked a Medication Aide (MA) to help assist Resident #13 with eating. -The MA assisted the resident with eating. Interview with the same MA on 3/29/16 at 12:24 p.m. revealed Resident #13's plate was warm. Observation on 3/29/16 at 12:26 p.m. revealed the Interim Executive Director asked dietary staff to give Resident #13 another plate, which included 2 hamburger buns and potato logs. Observation on 3/29/16 at 12:35 p.m. revealed: -Resident #13's new plate was warm and included 2 hamburger buns, 3 ounces ground hamburger meat and 10 potato logs. -An MA fed Resident #13 after the plate was brought out of the kitchen. Observation on 3/29/16 at 12:58 p.m. revealed Resident #13 had finished eating the lunch meal. Observation of Resident #13 during the dinner meal on 3/29/16 at 5:10 p.m. revealed: -The resident was served 6 oz turkey Ala King, 1 biscuit, ½ cup broccoli, ½ cup rice, 1 3 inch by 3 inch brownie, 1 cup milk, 1 cup water and 1 cup tea. -A PCA started feeding the resident as soon as the plate was on the table. Observation on 3/29/16 at 5:44 p.m. revealed Resident #13 had finished eating the meal. Based on observation, interview and record review, Resident #13 was not interviewable.	D 312		

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D 312	Continued From page 39 Refer to interview with a PCA on 3/24/16 at 6:02 p.m. Refer to interview with a second PCA on 3/24/16 at 6:23 p.m. Refer to interview with a MA on 3/29/16 at 1:00 p.m. Refer to interview with a third PCA on 3/30/16 at 9:57 a.m. Refer to interview with the RCD on 3/30/16 at 2:10 p.m. Refer to interview with the RCC on 3/30/16 at 4:28 p.m. Resident #13's Responsible Party could not be reached by the end of the survey. _____ Interview with a Personal Care Aide (PCA) on 3/24/16 at 6:02 p.m. revealed: -The feeders were usually fed after the non-feeders received the meal. -One staff usually fed the residents who required feeding assistance. -The dinner meal on 3/24/16 happened very fast, which was not normal. Interview with a second PCA on 3/24/16 at 6:23 p.m. revealed: -The feeders usually received the meals after the entire meal was passed out to the non-feeders. -It usually took 10-15 minutes to pass out the meals to the non-feeders. -The back hall dining room had two residents who needed assistance with feeding (Resident #11, Resident #13.)	D 312		

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-One staff usually fed the feeders.
-One staff had been feeding the feeders since she had been working at the facility (1 year).

Interview with a Medication Aide (MA) on 3/29/16 at 1:00 p.m. revealed:
-During feeding, there was usually 2 PCAs who passed out the plates in the dining room and an MA who poured the beverages in the dining room.
-Once the feeders received the plate, staff usually started feeding them within 2-3 minutes.

Interview with a third PCA on 3/30/16 at 9:57 a.m. revealed:
-There was usually one PCA in the dining room and another PCA in the hall to assist the residents who ate in the room.
-The trays were passed out to the feeders before the non-feeders received the dessert.
-The feeder's plate may sit for 15 minutes before someone can feed the feeder.
-If the food got cold, staff had to reheat the food.

Interview with the Resident Care Director (RCD) on 3/30/16 at 2:10 p.m. revealed:
-She was responsible for the care at the facility.
-The RCC was responsible for making sure residents were provided feeding assistance on the back hall dining room.
-The feeders should be fed as soon as the resident received the meal.
-She monitored meals on the back hall dining room at least monthly.

Interview with the Resident Care Coordinator (RCC) on 3/30/16 at 4:28 p.m. revealed:
-She was responsible for making sure residents were provided feeding assistance on the back hall dining room.
-The feeders were served the meal before the

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non-feeders received the dessert.
-Once the feeder received the plate, staff should immediately sit down and feed the resident.
-She monitored the meals in the back hall dining room at least weekly.

Observation of the lunch meal being served in the back hall dining room on 3/23/16 from 12:10pm-12:55pm revealed:
-There were 35 residents in the dining room for lunch.
-Resident #11 had her head down on the table prior to her plate being served.
-At 12:15pm, Resident #11 received her plate of food.
-Staff prompted Resident #11 to eat, and Resident #11 took a few bites of her food unassisted.
-Resident #13 was seated at the same table as Resident #11, and received her plate of food at 12:15pm.
-Resident #13 picked at her food with her fingers.
-At 12:30pm, a staff sat down to help feed both Resident #11 and Resident #13.
-The staff would feed Resident #11 a bite of food from Resident #11's plate and then feed Resident #13 a bite of food from Resident #13's plate.

Observation of the lunch meal being served in the back hall dining room on 3/24/16 from 12:00pm-1:00pm revealed:
-There were 37 residents in the dining room for lunch.
-The residents were seated at 12:00pm.
-The residents' plates were served from 12:20pm-12:35pm.
-Residents #11 and #13 were served their plates at 12:25pm.
-Resident #13 began picking at her food with her fingers.

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-Resident #13 ate a dinner roll.
-Resident #13 dropped a bowl of vegetables into her lap and began yelling.
-Staff responded to Resident #13 by taking the bowl off of Resident #13's lap and getting a new bowl of vegetables for Resident #13.
-At 12:35pm, staff began feeding Resident #11 her lunch meal.
-At 12:50pm, the same staff offered to help Resident #13 who did not want her lunch.
-Resident #13 did allow the staff to feed her banana pudding at 12:55pm.

Observation of the dinner meal being served in the back hall dining room on 3/24/16 from 5:10pm-6:10pm revealed:
-Dinner plates began being served at 5:20pm.
-At 5:30pm, Resident #13 spilled a cup of water onto Resident #11.
-Another resident who was seated at the same table as Resident #11 and #13 was picking food off of Resident #11's plate.
-At 5:40pm, desserts were passed out to the residents; Resident #11 had not eaten her dinner.
-At 5:48pm, the Interim Executive Director (ED) asked a staff to get Residents #11 and #13 a new plate of food since their plates had been sitting for several minutes and was likely cold.
-The Interim ED asked this staff to provide feeding assistance to Residents #11 and #13.
-The staff brought Residents #11 and #13 a new plate of food and fed both Residents #11 and #13 at the same time.

Interview with the Interim ED on 3/24/16 at 6:20pm revealed:
-Any resident who required feeding assistance should get meals served last so that their food was not cold.
-Once staff served the other residents, they

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D 312	Continued From page 43 should serve those that need assistance with feeding so that the staff are available to help those residents to eat.	D 312		
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 interview and observation, the facility failed to maintain the rights of all residents as it relates to residents being treated with respect and dignity by staff including a named staff person, Staff A, Personal Care Aide (PCA). The findings are: Confidential interview with a resident revealed: -There was a Medication Aide (MA) who was bossy. -There was a Personal Care Aide(PCA) who swore all the time and talked about other residents and staff in the dining room. Confidential interview with second resident revealed: -There were residents who were not able to feed themselves and staff would put their trays down and leave. -The resident had seen a staff "pop" the residents who were not able to feed themselves on the hand.	D 338		

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D 338	Continued From page 44 -There was a resident who yelled out and staff would tell the resident to "shut up if she couldn't do no better than that or they would take her back to her room." Confidential interview with a third resident revealed: - A medication aide (MA) hollered at and scolded the resident and accused the resident of saying another resident had died. The resident did not say that another resident had died. - The MA hollered at the resident and said, "Don't do that anymore". - It hurt the resident's feelings. - The MA had hollered at the resident on more than one occasion. - If the resident asked the MA about checking the resident's blood pressure, the MA did not want to check the blood pressure. - The MA would say she was busy and "I'm trying to do my job." - The MA accused the resident of hollering at the MA. - The resident reported hollering back at the MA 2 or 3 times. - The MA threatened to call the resident's case worker. Confidential interview with a fourth resident revealed: - They have "teenagers" working at the facility. - The resident was not treated the way the resident wanted to be treated by staff. - The staff complain about having to help the resident. - The staff give a "nasty remark" and go out the resident's room. - A few of the staff are real good but others are disrespectful and "could care less" about the residents.	D 338		

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D 338	Continued From page 45 Confidential interview with a fifth resident revealed: - Most of the staff treat the resident real good. - Some of the staff would not even speak to the resident. Observation of the dining room on 3/24/16 from 5:20pm-6:10pm revealed: -A resident asked Staff A for a salad instead of the meal served. -Staff A threw her hands in the air and told the resident, "I don't have time for this." -Staff A returned at 5:25pm with the resident's salad; the resident asked Staff A for something else, and Staff A sighed loudly, turned around, and stomped off toward the kitchen. -The resident left the dining room and returned a few minutes later with his own salad bowl. -A second resident was speaking to Staff A, and Staff A put her hands on her hips and rudely stated to a dietary staff, "I don't know what she's talking about." -At 5:48pm, the Interim Executive Director (ED) had asked Staff A to get new plates of food for two residents whose plates were served at 5:20pm and who had not been assisted with eating. -One of the residents was yelling out, and swinging at Staff A when Staff A tried to assist the resident with eating. Staff A grabbed the resident's wrists and told the resident to calm down. Confidential interview with a resident revealed: -Staff A was like that all the time. -The resident ignored Staff A. -He had not reported Staff's A behavior to the ED or any of the other staff.	D 338		

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D 338	Continued From page 46 Confidential interview with another resident revealed: -Staff A was the staff who would "pop" the residents' hands. -Staff was "ugly" to the residents all the time. -Staff A treated the residents and the staff rudely. -The resident had not told any staff or the ED about Staff A's behaviors or how Staff A treated the residents. Interview with Staff A on 3/24/16 at 6:02 p.m. revealed: -She had been working at the facility for the past 21 years. -She had been trained by a former Supervisor on feeding assistance and techniques when she first started working at the facility. -She received training on resident rights when she was first hired to work at the facility. Interview with the Area Director of Operations and the Interim Executive Director on 3/24/16 at 6:20pm revealed: -Staff A had been removed from the dining room and was taken off the hall. -That kind of behavior was not tolerated in the facility. Confidential interview with a resident revealed: -Staff A talked mean to the resident every day. -It was normal for Staff A to talk to the resident in a "hateful" way. -The resident thought Staff A was playing most of the time. -The resident did not know if Staff A talked to other residents in a disrespectful way because the resident stayed in the resident's room most of the time.	D 338		

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D 338	Continued From page 47 The facility provided the following Plan of Protection on 3/24/16: -Removed CNA from providing direct resident care. -During shift change meeting review of 131D-21 Resident Rights to ensure staff knowledge of resident rights communication and approach. -ED, RCD, RCC and/or designee will work building for observation and interviews of Resident Rights being upheld daily times one week and weekly thereafter. -ED or designee will coordinate with Ombudsman to coordinate complete Resident Rights training. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 14, 2016.	D 338		
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 observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed	D 358		

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prescribing practitioner and in accordance with the facility's policies and procedures for 4 of 10 residents (#3, #15, #16, #17) observed during the medication passes, including errors with insulin (#16), medications for nebulizer treatments (#15, #17), and a diuretic (#3) and 3 of 10 residents (#2, #3, #9) sampled for record review including errors with insulin (#2), errors with medications for depression and heart disease prevention (#3), and errors with a medication for congestive heart failure and atrial fibrillation(#9). The findings are:

1. The medication error rate was 19% as evidenced by the observation of 5 errors out of 26 opportunities during the 8:00 a.m./9:00 a.m., 11:30 a.m./12:00 noon, and 2:00 p.m. /3:00 p.m. medication passes on 03/24/16 and the 11:30 a.m./12:00 noon medication pass on 03/28/16.

A. Review of Resident #17's current FL-2 dated 06/30/15 revealed:
- The resident's diagnoses included dementia, chronic obstructive pulmonary disease, history of right lower lobe pneumonia, congestive heart failure, hypertension, history of coronary artery disease, hyperlipidemia, diabetes mellitus, gastroesophageal reflux disease, and bipolar disorder.
- There was an order for Duoneb, inhale 1 vial via nebulizer 4 times a day. (Duoneb is used for breathing problems / lung disease.)

Review of the March 2016 medication administration record (MAR) revealed Duoneb was scheduled to be administered 4 times a day at 8:00 a.m., 12:00 noon, 8:00 p.m., and 12:00 midnight.

Observation during the 8:00 a.m. medication pass on 03/24/16 revealed:

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D 358	Continued From page 49 - The medication aide (MA) put the contents of one 3ml Duoneb vial into the nebulizer machine at 10:18 a.m. - The MA turned on the nebulizer and held the mouthpiece in the resident's mouth. - The resident was sitting in a chair and kept falling asleep during the nebulizer treatment. - The resident did not take any deep breaths to allow the medication to reach her lungs. - The MA did not instruct the resident to inhale the medication or take deep breaths. - The MA asked the resident to wake up on one occasion during the treatment. - At 10:24 a.m., the MA turned off the nebulizer machine and told the resident she was not going to make the resident "suffer anymore". - There was approximately 1ml of medication left in the nebulizer machine. - The resident woke up and stated she felt okay. Interview with the MA on 03/24/16 at 10:30 a.m. revealed: - The resident had been drowsier and was in the hospital recently to try to figure out why she was so sleepy. - The resident was more awake some days and was better at taking the treatment. Interview with the Resident Care Director (RCD) on 03/24/16 at 1:56 p.m. revealed: - MAs had been trained on nebulizer treatments and should instruct residents to inhale and take deep breaths. - MAs were supposed to pour the medication into the nebulizer machine and if a resident was able to hold the mouthpiece and oriented, the MAs could leave the room during the treatment and check on the resident periodically throughout the treatment. - If a resident was not oriented or able to hold the	D 358		

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mouthpiece, the MAs were supposed to hold it and stay with the resident during the nebulizer treatment.
- All of the contents of the vial should be nebulized during the treatment.

B. Review of Resident #17's current FL-2 dated 06/30/15 revealed the resident's diagnoses included dementia, chronic obstructive pulmonary disease, history of right lower lobe pneumonia, congestive heart failure, hypertension, history of coronary artery disease, hyperlipidemia, diabetes mellitus, gastroesophageal reflux disease, and bipolar disorder.

Review of a physician's order dated 03/18/16 revealed an order for Budesonide 0.25mg/2ml inhale 1 vial via nebulizer twice daily. (Budesonide is a corticosteroid used to treat inflammation of the lungs.)

Review of the March 2016 medication administration record (MAR) revealed Budesonide was scheduled to be administered twice daily at 8:00 a.m. and 8:00 p.m.

Observation during the 8:00 a.m. medication pass on 03/24/16 revealed:
- The medication aide (MA) could not find any Budesonide on the medication cart for Resident #17.
- The MA did not know if any Budesonide had been ordered.
- She circled her initials on the MAR and noted the Budesonide was not on the cart and not administered.

Interview with the Resident Care Director (RCD) / Registered Nurse (RN) on 03/24/16 at 1:53 p.m. revealed:

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- The facility's primary pharmacy sent monthly cycle fills for scheduled oral pills.
- MAs would have to order medications like nebulizer treatments.
- MAs should reorder those medications about a week before the resident runs out.
- She did not know why the Budesonide was not ordered for Resident #17.
- They reordered it today.

C. Review of Resident #16's current FL-2 dated 12/10/15 revealed:
- The resident's diagnoses included diabetes mellitus, dementia, chronic renal insufficiency, falls, hypertension, depression, hyperlipidemia, hypothyroidism, overactive bladder, and Vitamin B12 deficiency.
- There was an order for Humalog Kwikpen inject 6 units subcutaneously 3 times a day with meals. (Humalog is rapid-acting insulin used to lower blood sugar.)

[According to the Humalog manufacturer, the pen should be primed before each injection. A dose of 2 units should be dialed up and the injection button pressed until the dose window shows a "0" and a stream of insulin is seen coming from the needle. This removes air bubbles and ensures the pen and needle are working properly. (Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.)]

Observation during the 11:30 a.m. medication pass on 03/24/16 revealed:
- The medication aide (MA) checked Resident #16's blood sugar and it was 177 at 11:41 a.m.
- The MA dialed the Humalog pen to 6 units and injected the insulin into Resident #16 at 11:44 a.m.

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D 358	Continued From page 52 - The MA did not prime the Humalog pen with a 2 unit air shot prior to dialing the 6 units ordered and administering the insulin. Interview with Resident #16 on 03/24/16 at 12:16 p.m. revealed: - Resident #16 usually got her lunch time insulin before she came to the dining room. - She was unsure how long she usually waited for her meal after getting her insulin. - She was feeling okay and denied any current symptoms of low blood sugar. Observation of Resident #16 in the dining room on 03/24/16 revealed she was served the lunch meal at 12:23 p.m., 39 minutes after receiving Humalog, a rapid-acting insulin. Interview with the medication aide on 03/24/16 at 1:35 p.m. revealed: - She did not realize the insulin pen had to be primed with a 2 unit air shot before each use. - The lunch meal was usually served at 12:00 noon. - She thought the facility's policy was short-acting or sliding scale insulin could be administered 15 minutes prior to a meal and long-acting insulin could be administered at the scheduled time. - If insulin was ordered with a meal, they would have to wait to administer it until the dining room doors were opened and the meal was served. - She had not noticed Resident #16's Humalog was ordered with meals since it was scheduled to be administered at 11:30 a.m. Interview with the Resident Care Director (RCD) on 03/24/16 at 1:56 p.m. revealed: - Staff have had training on insulin administration and insulin pens. - They should prime the pen with 2 unit air shot	D 358		

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prior to each use.
- Insulin ordered with meals should be administered just prior to the meal as the resident was about to go into the dining room with the food on the table.

Review of the March 2016 medication administration records (MARs) revealed Resident #16's blood sugar ranged from 80 - 290.

D. Review of Resident #15's current FL-2 dated 03/23/16 revealed:
- The resident's diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, hypertension, anemia, anxiety, depression, and schizophrenia.
- There was an order for Atrovent 0.02% use 1 vial via nebulizer every 6 hours. (Atrovent is used as maintenance treatment for chronic lung diseases.)

Review of the March 2016 medication administration record (MAR) revealed Atrovent was scheduled to be administered at 6:00 a.m., 12:00 noon, 6:00 p.m., and 12:00 midnight.

Observation during the 12:00 noon medication pass on 03/24/16 revealed:
- The medication aide (MA) put the contents of one 2.5ml Atrovent vial into the nebulizer machine at 11:49 a.m.
- The MA took the resident's oxygen off, put the nebulizer mask on the resident, and turned on the nebulizer.
- The MA walked back to the medication cart and closed the door to the resident's room.
- She did not usually stay with the resident during the nebulizer treatment because the resident was "in his right mind".
- The MA then prepared medications for

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Resident #15's roommate and went back in the room to the roommate at 11:52 a.m.
- Resident #15 was lying in bed wearing nasal cannula for oxygen.
- Resident #15's nebulizer was turned off and the mask was hanging on the side of the machine.
- There was approximately ½ of the Atrovent solution still in the nebulizer machine.
- The MA did not question Resident #15 about the nebulizer.
- The MA did not check to see if all of the Atrovent had been used.
- At 11:54 a.m., the MA was finished with medications for Resident #15 and his roommate and she was going to continue with the rest of the medication pass.

Interview with Resident #15 on 03/24/16 at 12:28 p.m. revealed:
- Resident #15 acknowledged there was still about ½ of the Atrovent solution in the nebulizer.
- He would normally use only half of the nebulizer solution because he used it when he needed it instead of constantly.
- He would save the other half and wait to use it in about ½ hour or so when he had to get up to go to the bathroom because he would get short of breath.
- The MA did not usually watch him take the nebulizer treatment.
- The MA did not usually come back to his room again until 1:00 p.m. or 2:00 p.m. when his next medications were due.

Interview with the Resident Care Director (RCD) on 03/24/16 at 1:56 p.m. revealed:
- MAs had been trained on nebulizer treatments and should instruct residents to inhale and take deep breaths.
- MAs were supposed to pour the medication into

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the nebulizer machine and if a resident was able to hold the mouthpiece and oriented, the MAs could leave the room during the treatment and check on the resident periodically throughout the treatment.
- If a resident was not oriented or able to hold the mouthpiece, the MAs were supposed to hold it and stay with the resident during the nebulizer treatment.
- All of the contents of the vial should be nebulized during the treatment.

E. Review of Resident #3's current FL-2 dated 02/24/16 revealed:
- The resident's diagnoses included vascular dementia, lung cancer, chronic obstructive pulmonary disease, hypertension, status post myocardial infarction, hyperlipidemia, gastroesophageal reflux disease, depression, osteoarthritis, gout, and tobacco abuse.
- The resident was noted to be constantly disoriented.
- There was an order for Lasix 20mg once a day. (Lasix is a diuretic.)
- There was an order for Morphine Sulfate ER (extended release) 15mg every 12 hours. (Morphine is a controlled substance used to treat moderate to severe pain.)
- There was an order for Tylenol 500mg 3 times a day. (Tylenol is for pain or fever.)

Observation and interview with the medication aide (MA) in the medication room on 03/24/16 at 1:35 p.m. revealed:
- The MA had 3 white medication soufflé cups on top of the medication cart.
- All 3 medication cups had pills inside the cups and the cups were not labeled.
- When asked about the cups, the MA hesitated and stated she knew she was not supposed to

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prepour medications.
- She had prepared medications for the 2:00 p.m. medication pass for 3 residents whose rooms were located close to each other to save time.
- The MA identified one of the cups as medications she was on her way to administer to Resident #3.
- Surveyor stopped the MA and asked her to show the surveyor the medication packages for the pills she had prepared so the medications could be identified.
- The pills in the cup for Resident #3 were identified as Morphine Sulfate ER 15mg, Tylenol 500mg, and Lasix 20mg.
- Surveyor asked the MA to compare the medications with the medication administration record (MAR).
- The MA looked at the MAR and realized she was not supposed to administer Lasix to the resident because he was only supposed to receive it at 8:00 a.m. and he already had the Lasix that morning.
- The MA could not explain why she had prepared and was going to administer the Lasix at 2:00 p.m.
- The MA removed the Lasix from the prepoured medication cup for Resident #3.
- The MA administered the Morphine and Tylenol to Resident #3 at 1:48 p.m.

Interview with the Resident Care Director (RCD) / Registered Nurse (RN) on 03/24/16 at 2:06 p.m. revealed:
- The facility's policy was no prepouring was allowed.
- The MAs know they are not supposed to prepour any medications.
- The MAs have been trained to read the MARs and should only administer medications when

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D 358	Continued From page 57 they were scheduled to be administered. 2. Review of Resident #3's current FL-2 dated 02/24/16 revealed: - The resident's diagnoses included vascular dementia, lung cancer, chronic obstructive pulmonary disease, hypertension, status post myocardial infarction, hyperlipidemia, gastroesophageal reflux disease, depression, osteoarthritis, gout, and tobacco abuse. - The resident was noted to be constantly disoriented. A. Review of Resident #3's current FL-2 dated 02/24/16 revealed: - There was an order for Aspirin EC 81mg once daily. (Aspirin EC is enteric coated and used to prevent heart attack and stroke.) - There was an order for Zoloft 15mg once daily. (Zoloft is an antidepressant.) Review of the January 2016 - March 2016 medication administration records (MARs) revealed: - There was an entry for Aspirin EC 81mg take 1 tablet once a day and it was scheduled to be administered at 8:00 a.m. - Aspirin was not administered from 01/11/16 - 03/23/16 due to the medication "not on cart". - There was an entry for Zoloft 25mg take 1 tablet once a day and it was scheduled to be administered at 8:00 a.m. - Zoloft was not administered from 01/11/16 - 03/23/16 due to the medication "not on cart". Review of progress notes for Resident #3 revealed: - On 03/23/16 at 11:00 p.m.: Hospice was contacted to get medications the resident was out	D 358		

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of and the pharmacy sent the medications this evening.
- There was no progress notes prior to 03/23/16 to indicate the facility had attempted to obtain the Aspirin or Zoloft when the medications were unavailable from 01/11/16 - 03/23/16.

Interview with the Area Director of Operations (ADO) on 03/28/16 at 5:45 p.m. revealed:
- When a survey was being conducted in one of their facilities, she usually asked the medication aides if they had all medications available.
- They audited the medication carts and did not have any Aspirin or Zoloft on hand for Resident #3 on 03/23/16.
- The medications were ordered from the primary pharmacy and delivered on 03/23/16.
- She did not know why the medications were unavailable and had not been ordered until 03/23/16.

Interview with a medication aide on 03/28/16 at 6:25 p.m. revealed:
- The facility's primary pharmacy sends cycle fills for scheduled oral medications monthly.
- For other medications, they try to reorder when there was a 5 to 7 day supply remaining.
- Resident #3's family was ordering and bringing his medications from a veteran's administration (VA) pharmacy.
- She never had any problems with the family bringing his medications on time when they family was ordering them.
- She did not know why the resident's Aspirin and Zoloft were unavailable for over two months.
- Facility management asked the medication aides to check the carts for medication availability on 03/23/16.
- When they checked the medication carts on 03/23/16, they could not find the Aspirin or Zoloft.

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- She called Resident #3's family and they told her the resident was supposed to get his medications through hospice now.
- The resident was recently started on hospice services a couple of months ago.
- The MA called hospice and hospice contacted the facility's primary pharmacy on 03/23/16 and the medications were sent to the facility that evening.

Interview with a medication aide on 03/29/16 at 2:40 p.m. revealed:
- She did not know why Resident #3 ran out of Aspirin and Zoloft.
- She thought the facility had been ordering the resident's medications from a VA pharmacy and they came through the mail until he started hospice services.
- The facility would use the primary pharmacy as a backup pharmacy for Resident #3.
- The backup pharmacy would send a few tablets at a time until the regular supply would come in.
- She did not know why the backup pharmacy was not contacted about the Aspirin and Zoloft until 03/23/16.

Review of dispensing records from the facility's primary pharmacy dated 01/01/16 - 03/29/16 revealed:
- Eight Aspirin EC 81mg tablets and eight Zoloft 25mg tablets were dispensed on 03/23/16.
- Thirty Aspirin EC 81mg tablets and thirty Zoloft 25mg tablets were dispensed on 03/27/16.

Interview with Resident #3's family member on 03/28/16 at 5:25 p.m. revealed:
- The family had been ordering the resident's medications from a VA pharmacy.
- When the resident started hospice in February 2016, the hospice nurse said hospice would order

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D 358	Continued From page 60 the medications. - The facility staff called the family member about 1 to 2 weeks ago and said the resident was about to be out of some of his medications. - He told the facility staff person that hospice was doing the resident's medications now. - He was not aware of the resident running out of any medications. Interview with the Resident Care Director (RCD) on 03/30/16 at 1:36 p.m. revealed: - If a resident used an outside pharmacy, the facility would notify the family when there was a 2 week supply remaining and the family would order the medication and bring it to the facility. - If the family could not get the medication to the facility on time, the facility would use the backup pharmacy to obtain the medication. - They would use the same system if medications were provided by a VA pharmacy or hospice. - The medication aides were supposed to notify her the first time they circle their initials and do not administer a medication no matter what the reason for not administering it. - She had not been notified that Resident #3 was not receiving Aspirin or Zoloft. - The RCD and/or the Resident Care Coordinator were responsible for reviewing MARs monthly. - She had reviewed Resident #3's MAR at some point and noticed staff had documented the Aspirin and Zoloft were unavailable for Resident #3. - She had told a medication aide to call the family. - The medication aide told the RCD that the family was called and it had been taken care of. - The RCD did not check behind the medication aide to make sure it had been done. - She could not recall when she discovered the	D 358		

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problem or which medication aide she had told to take care of it.

B. Review of Resident #3's current FL-2 dated 02/24/16 revealed there was an order for Duoneb, inhale 1 vial via nebulizer 3 times a day for shortness of breath. (Duoneb contains Albuterol and Atrovent and is used to treat breathing problems.)

Review of hospital admission forms for Resident #3 dated 01/26/16 revealed:
- The resident presented with increasing shortness of breath, hypoxia and cough.
- The resident has a history of oxygen dependent chronic obstructive pulmonary disease and a history of left upper lobe cancer.
- The chest x-ray showed extensive pulmonary fibrosis and left upper lobe mass.
- The resident was treated for pneumonia and was discharged on 02/02/16 on 4 to 5 liters of oxygen.

Review of hospital discharge form dated 02/02/16 revealed:
- Resident #3 had a history of lung cancer.
- The resident had a recurrent left upper lung mass.

Review of hospice notes for Resident #3 revealed:
- 02/06/16: The resident was admitted to hospice services.
- 02/11/16: A skilled nursing visit (SNV) assessment was completed. The resident was in wheelchair in dining room and complained that he could not breathe. The resident's oxygen level was 90% on 5 liters of oxygen.
- 02/24/16: SNV - resident was noted to have diminished breath sounds. Resident is lying in

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bed more often and struggles to breathe at rest.
- 03/07/16: SNV - resident was noted to have expiratory wheeze and oxygen at 5 liters.
- 03/15/16: SNV - resident had increased coughing.
- 03/20/16: Hospice nurse present due to call received about resident's increased shortness of breath. Lung sounds were noted in bilateral upper lobes. There was thick green mucous with blood in a cup. The resident's oxygen level was 69% on 4 liters of oxygen. A nebulizer treatment was given and the levels went to 70 - 71%. Order was received for Albuterol nebulizer as needed in addition to scheduled treatment and an antibiotic was ordered.
- 03/21/16: Follow-up visit by SN. Oxygen level at 91% with no acute respiratory distress during visit.

Review of a physician's order dated 03/20/16 revealed an order for Albuterol 1 vial via nebulizer every 2 hours as needed for shortness of breath. (Albuterol is used to treat breathing problems.)

Review of progress notes for Resident #3 revealed:
- On 03/27/16 at 5:45 a.m.: The resident was lying in bed on back resting and he stated he felt okay. The resident's oxygen level was 90%.
- On 03/27/16: The resident's oxygen level was 84% at 8:45 a.m., 90% at 12:00 p.m., 88% at 2:00 p.m., and 85% at 11:00 p.m. on 4 liters of oxygen.

Interview with Resident #3's family member on 03/28/16 at 5:25 p.m. revealed:
- The resident was in the hospital recently and it is possible his lung cancer has come back.
- The resident had been getting weaker over the last few days and his oxygen level was running

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around 85%.
- The resident was not able to feed himself anymore because he was weak and got too short of breath.
- The resident has also been coughing up blood and hospice nurse was aware of this.

Interview with a hospice registered nurse (HRN) on 03/29/16 at 3:45 p.m. revealed:
- She had checked Resident #3's oxygen level this afternoon and it was 78%.
- She went to the medication desk after she checked the oxygen level to have the medication aide give a nebulizer treatment to the resident.
- The medication aides were counting the controlled substances so she did not interrupt them and went back in about 20 minutes.
- The first shift medication aide told the HRN she was busy and she would have to do the nebulizer treatment for Resident #3 later.
- The HRN explained to the medication aide that the resident needed the nebulizer treatment now but the medication aide continued to tell the HRN that she would have to do it later.
- The HRN reported she asked several times and finally told the MA to give the nebulizer medication to the HRN and the HRN would do the treatment.
- The MA gave the nebulizer vial to the HRN and the HRN administered it to the resident.
- The resident had gotten weaker over the last few days and was not longer able to feed himself and he was too weak to hold the nebulizer mouthpiece device.

Interview with the Area Director of Operations on 03/29/16 at 4:10 p.m. revealed:
- The medication aide was responsible for administering the nebulizer treatment to the resident.
- The nebulizer treatment should have been

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administered when the HRN initially asked the medication aide to give it.
- The facility already has training with the hospice agency set up for next week.

Observation of Resident #3 on 03/30/16 at 2:03 p.m. revealed:
- The resident was lying in bed on his back with his eyes closed and both arms lying by his side on the bed.
- The resident's nebulizer machine was running and the mouthpiece was hanging down partially out toward the left side of his mouth.
- The resident was not taking deep breaths.
- There was no one in the room with the resident.

Observation on 03/30/16 at 2:04 p.m. revealed:
- The medication aide was near the end of the hall (2 to 3 doors down from Resident #3's room).
- The medication aide was preparing and administering medications to other residents.
- The MA could not see inside Resident #3's room from where she was working.

Observation with both the Administrator and the Area Director of Operations (ADO) on 03/30/16 at 2:06 p.m. revealed:
- Surveyor asked both the Administrator and ADO to go to Resident #3's room.
- When both the Administrator and the ADO got to Resident #3's door, the MA was coming out of the room.
- Resident #3 was lying in bed awake holding the nebulizer mouthpiece.
- The resident was not taking deep breaths.
- The MA stated the resident could do the treatment himself and she had been checking on him every couple of minutes.
- The ADO and the Administrator asked the medication aide to stay in the room, hold the

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nebulizer mouthpiece for the resident and instruct him to take deep breaths.

3. Review of Resident #2's FL2 dated 6/25/15 revealed:
-Resident #2 ' s diagnoses included diabetes type 2, hypothyroidism, depression, chronic renal insufficiency, cognitive impairment, osteoarthritis, and diabetic neuropathy.
-Finger stick blood sugars before meals.

Medication orders included on the FL2 dated 6/25/15 revealed:
-Levemir (a long acting insulin used to lower blood glucose) Flextouch 100units/ml, 28 units every am and 8 units at bedtime.

Review of subsequent physician orders revealed:
-There was an order dated 12/04/15 for Levemir 18 units twice daily.
-There was an order dated 12/10/15 for Levemir 29 units in the morning and 12 units at bedtime.
-There was an order dated 12/29/15 for Levemir 31 units in the morning and 12 units at bedtime.

Review of Resident #2's Resident Register revealed an admission date of 10/10/13.

Review of the Admission/Discharge Report provided by the facility on 3/23/16 revealed that Resident #2 was discharged to a Skilled Nursing Facility on 3/1/16.

Review of the January 2016 MAR for Resident #2 revealed:
-There was an entry for Levemir, inject 31 units subcutaneously every morning.
-There was a second entry for Levemir, inject 12 units subcutaneously at bedtime.
-On 01/03/16, the Levemir was documented as

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not administered for the morning dose and the MAR notes documented, "B/S 98. Refused to eat. Not Adm."
On 01/08/16, the Levemir was documented as not administered for the morning dose and the MAR notes documented, "Sugar was 74. Not given."
-01/18/16, the Levemir was documented as not administered for the morning dose and the MAR notes documented, "Blood sugar was 74. Not given."
-On 01/20/16, the Levemir was documented as not administered for the morning dose and the MAR notes documented, "Blood sugar was 79. Not given."
-On 01/29/16, the Levemir was documented as not administered for the morning dose and the MAR notes documented, "BS is 73. Held insulin."
-There was no documentation that the physician was notified that the insulin was not administered as ordered due to blood sugar levels.

Review of the February 2016 MAR for Resident #2 revealed:
-There was an entry for Levemir, inject 31 units subcutaneously every morning and 12 units at bedtime.
-On 02/01/16, the Levemir was documented as not administered for the morning dose and the MAR notes documented, "Pt [sic] refused."
-On 02/09/16, the Levemir was documented as not administered for the morning dose and the Medication Aide had written in "Ref" on the MAR in the space for the administration time for 02/09/16.
-There was no documentation that the physician was notified that the insulin was not administered as ordered because Resident #2 refused.

Review of the Progress Notes in Resident #2's

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D 358	Continued From page 67 record revealed there was no documentation that the physician was notified that the Levemir was not given due to Resident #2's blood sugar levels. Interview with the Physician Assistant (PA) on 3/28/16 at 11:00am revealed: -The PA recalled Resident #2 and remembered the blood sugars being elevated, but could not recall being contacted about low blood sugar readings. -The PA knew that changes were made in Resident #2's Levemir insulin orders. Interview with the Resident Care Director (RCD) on 3/28/16 at 12:30pm revealed: -The RCD provided the Medication Aide (MA) trainings for the facility. -The RCD had taught the MAs to call her if they ever had a question or were not sure about what to do in a situation. -The MAs had also been taught to document their interventions and any contact made with the physicians should be documented in the progress notes or on the MAR notes on the back of the MAR. Interview with a MA on 3/28/16 at 5:50pm revealed: -If the MA had a question about insulin or a resident's blood sugar, she would call the RCD for her input. -Usually, the RCD would tell the MA to call the physician. -The MA would documented what she did on the MAR and in the log book at the nurse's station so the RCD and the next shift would know what had happened. 4. Review of Resident #9's current FL2 dated	D 358		

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D 358	Continued From page 68 5/19/15 revealed diagnoses included Hypertension, Dementia, and Type 2 Diabetes. Review of a physician order for Resident #9 dated 12/3/15, revealed an order for Digoxin 0125mg per day on Monday, Wednesday and Friday. Check pulse, hold for pulse less than 60. Review of Resident #9's medication administration record (MAR) dated December 2015 revealed: -The Digoxin 125mcg (used to treat congestive heart failure) daily Monday, Wednesday and Friday order was printed on the MAR, with hold for pulse less than 60 written in. -On 5 occasions in December the Digoxin had been administered to Resident #9 and no pulse was documented on the MAR. Review of Resident #9's medication administration record (MAR) dated January 2016 revealed: -The digoxin 125mcg 1 tablet per day Monday, Wednesday and Friday, check pulse and hold if pulse less than 60 was printed on the MAR. -On 8 occasions in January the Digoxin had been administered to Resident #9 and no pulse was documented on the MAR. Review of Resident #9's medication administration record (MAR) dated February 2016 revealed: -The digoxin 125mcg 1 tablet per day Monday, Wednesday and Friday, check pulse and hold if pulse less than 60 was printed on the MAR. -On 4 occasions in February the Digoxin had been administered to Resident #9 and no pulse was documented on the MAR. Interview with a medication aide on 3/30/16 at	D 358		

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D 358	Continued From page 69 2:05pm revealed: -The heart rate for Resident #9 should be taken before her Digoxin is administered. -When the heart rate is taken it is documented on the MAR and the medication is administered. -If the heart rate is not written on the MAR it probably was not taken. Interview with the Resident Care Director (RCD) on 3/30/16 at 1:30pm revealed: -The pulse for Resident #9 should have been taken prior to administering Digoxin. -The pulse should have been documented on the MAR, by the medication aide administering the medication. -The Resident Care Coordinator (RCC) and RCD should be monitoring the MAR monthly to ensure compliance with the pulse and medication administration. -She had noticed the signatures on the MARs indicating the Digoxin had been administered. -She did not realize the documentation for the pulse was missing for Resident #9, on multiple days on the December 2015, January 2016, and the February 2016 MARs. The RCC was not available for interview. The physician was not available for interview. _____ The facility provided the following Plan of Protection on 3/24/16: -Med Tech removed from duties until re-education. -Place a list of all diabetics in front of each hall's MAR. -Review with all Med Techs prior to their next shift: proper diabetic medication administration, nebulizer administration, and the 6 rights of medication administration.	D 358		

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D 358	Continued From page 70 -Placed crackers on carts to ensure food given in case of time constraint. -RCC, RCD, ED or designee will ensure all Med Techs receive review prior to shift. -RCC, RCD, ED or designee will ensure food available on carts for meds/insulin requiring food. -Review medication and insulin times that are with meal to be in an appropriate window to meal times. -Pharmacy will be here April 7th to continue Medication Overview Education to include diabetes, nebulizers, and 6 rights of Medication Administration. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 14, 2016.	D 358		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and	D 363		

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D 363	Continued From page 71 labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 3 of 3 residents (#3, #15, #18) during the 2:00 p.m. medication pass on 03/24/16. The findings are: Observation and interview with the medication aide (MA) in the medication room on 03/24/16 at 1:35 p.m. revealed: - The MA had 3 white medication soufflé cups on top of the medication cart. - All 3 medication cups had pills inside the cups and the cups were not labeled with any information and the cups were not covered or sealed. - When asked about the cups, the MA hesitated and stated she knew she was not supposed to prepour medications. - She had prepared medications for the 2:00 p.m. medication pass for 3 residents whose rooms were located close to each other to save	D 363		

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time.
- The 3 cups contained medications for Residents #3, #15, and #18.
- Surveyor stopped the MA and asked her to show the surveyor the medication packages for the pills she had prepared so the medications could be identified.

A. Review of Resident #18's current FL-2 dated 09/28/15 revealed:
- The resident's diagnoses included chronic non-malignant back pain, chronic obstructive pulmonary disease, hypertension, congestive heart failure, diabetes mellitus, osteoarthritis, conjunctivitis, history of cerebrovascular accident, colitis, insomnia, obstructive sleep apnea, reflux, depression, anxiety, and seizure.
- There was an order for Morphine Sulfate ER (extended release) 15mg every 12 hours. (Morphine is a controlled substance used to treat moderate to severe pain.)
- There was an order for Clonazepam 1mg twice daily. (Clonazepam is a controlled substance for anxiety.)

Observation and interview with the MA on 03/24/16 at 1:35 p.m. revealed:
- The pills in the cup for Resident #18 were identified as Morphine Sulfate ER 15mg and Clonazepam 1mg.
- Surveyor asked the MA to compare the medications with the medication administration record (MAR).
- The MA looked at the MAR and realized the Morphine was scheduled at 2:00 p.m. but the Clonazepam was not scheduled until 3:00 p.m.
- The MA stated she was going to wait to administer those 2 medications until at least 2:00 p.m. so both medications would be given within the 1 hour time frame of the scheduled times.

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D 363	Continued From page 73 - The MA took the unlabeled cup with Resident #18's medication and put the cup in the top left drawer of the medication cart and locked the cart. Refer to interview with the Resident Care Director (RCD) on 03/24/16 at 2:06 p.m. B. Review of Resident #3's current FL-2 dated 02/24/16 revealed: - The resident's diagnoses included vascular dementia, lung cancer, chronic obstructive pulmonary disease, hypertension, status post myocardial infarction, hyperlipidemia, gastroesophageal reflux disease, depression, osteoarthritis, gout, and tobacco abuse. - The resident was noted to be constantly disoriented. - There was an order for Lasix 20mg once a day. (Lasix is a diuretic.) - There was an order for Morphine Sulfate ER (extended release) 15mg every 12 hours. (Morphine is a controlled substance used to treat moderate to severe pain.) - There was an order for Tylenol 500mg 3 times a day. (Tylenol is for pain or fever.) Observation and interview with the MA on 03/24/16 at 1:35 p.m. revealed: - The pills in the cup for Resident #3 were identified as Morphine Sulfate ER 15mg, Tylenol 500mg, and Lasix 20mg. - Surveyor asked the MA to compare the medications with the medication administration record (MAR). - The MA looked at the MAR and realized she was not supposed to administer Lasix to the resident because he was only supposed to receive it at 8:00 a.m. and he already had the Lasix that morning. - The MA could not explain why she had	D 363		

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prepared and was going to administer the Lasix at 2:00 p.m.
- The MA removed the Lasix from the prepoured medication cup for Resident #3.
- The MA then stacked Resident #3's unlabeled medication cup on top of the other unlabeled medication cup and walked down the hall to Resident #3's room.
- The MA administered the Morphine and Tylenol to Resident #3 at 1:48 p.m.

Refer to interview with the Resident Care Director (RCD) on 03/24/16 at 2:06 p.m.

C. Review of Resident #15's current FL-2 dated 03/23/16 revealed:
- The resident's diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, hypertension, anemia, anxiety, depression, and schizophrenia.
- There was an order for Norco 10/325mg 1 tablet 3 times a day. (Norco is a controlled substance used to treat moderate to severe pain.)

Observation and interview with the MA on 03/24/16 at 1:35 p.m. revealed:
- The pill in the cup for Resident #15 was identified as a Norco 10/325mg tablet.
- Surveyor asked the MA to compare the medications with the medication administration record (MAR).
- The MA looked at the MAR and stated the Norco was scheduled to be administered at 2:00 p.m.
- The MA then stacked Resident #3's unlabeled medication cup on top of Resident #15's unlabeled medication cup and walked down the hall to Resident #3's room.
- The MA administered medications to Resident

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D 363	Continued From page 75 #3 at 1:48 p.m. - The MA administered the Norco to Resident #15 at 1:50 pm. Refer to interview with the Resident Care Director (RCD) on 03/24/16 at 2:06 p.m. _____ Interview with the Resident Care Director (RCD) on 03/24/16 at 2:06 p.m. revealed: - The facility's policy was no prepouring was allowed. - The MAs know they are not supposed to prepour any medications. - The MAs have been trained to read the MARs and should only administer medications when they were scheduled to be administered.	D 363		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a record of the receipt and administration of controlled substances was maintained, accurate and reconciled for 3 of 6 residents (#1, #3, #4) sampled who were prescribed controlled substances including Tramadol, Xanax, and Ativan. The findings are:	D 392		

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1. Review of Resident #3's current FL-2 dated 02/24/16 revealed:
- The resident's diagnoses included vascular dementia, lung cancer, chronic obstructive pulmonary disease, hypertension, status post myocardial infarction, hyperlipidemia, gastroesophageal reflux disease, depression, osteoarthritis, gout, and tobacco abuse.
- The resident was noted to be constantly disoriented.
- There was an order for Ativan 1mg twice daily. (Ativan is a controlled substance used to treat anxiety.)

Review of a physician's order revealed an order dated 02/09/16 for Ativan 1mg twice daily.

Review of pharmacy dispensing records revealed:
- Thirty Ativan 1mg tablets were dispensed on 02/09/16.
- Thirty Ativan 1mg tablets were dispensed on 02/24/16.
- Thirty Ativan 1mg tablets were dispensed on 03/12/16.
- Sixty Ativan 1mg tablets were dispensed on 03/28/16.

Review of the controlled substance (CS) logs for Resident #3's Ativan revealed:
- There was a morning and evening CS log for 2 bubble cards of 15 Ativan tablets each dispensed on 02/09/16.
- The morning doses were documented from 02/10/16 - 02/24/16 leaving a balance of zero.
- The evening doses were documented from 02/09/16 - 02/24/16 leaving a balance of zero.
- There was an evening CS log for a bubble card of 15 tablets dispensed on 02/24/16 with administration from 02/25/16 - 03/10/16 leaving a

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balance of zero.
- There was not a morning CS log for the other 15 tablets dispensed on 02/24/16.
- There was not a CS log to account for the administration 15 of 30 tablets of Ativan 1mg dispensed on 02/24/16.
- There was a morning and evening CS log for 2 bubble cards of 15 tablets each dispensed on 03/12/16.
- Staff documented the first dose used from the morning card was on 03/13/16 at 8:00 a.m. - 03/27/16 leaving a balance of zero.
- The evening doses were documented from 03/13/16 - 03/26/16 leaving a balance of zero.
- There was a morning and evening CS log for 2 bubble cards of 15 Ativan tablets each dispensed on 03/28/16 noting a total of 58 Ativan 1mg tablets were remaining.

Review of medication delivery sheets revealed 30 Ativan 1mg tablets were delivered to the facility on 02/24/16.

Review of medications on hand on 03/29/16 revealed:
- There was 58 of 60 Ativan 1mg tablets remaining from the supply dispensed on 03/28/16.
- There was no Ativan on hand from the supply dispensed on 02/24/16.

Review of the February 2016 and March 2016 medication administration records (MARs) revealed:
- Ativan 1mg was documented as administered daily from 02/09/16 at 8:00 p.m. - 02/29/16 at 8:00 p.m.
- Ativan 1mg was documented as administered daily from 03/01/16 at 8:00 a.m. - 03/29/16 at 8:00 a.m. except for 1 dose.

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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 392	Continued From page 78 - The 8:00 a.m. dose for 03/12/16 was not administered due to the medication being on order. Interview with the Interim Executive Director / Administrator-in-Training on 03/30/16 at 3:35 p.m. revealed: - There should be a CS log for the morning dose of 15 tablets dispensed on 02/24/16. - The Ativan was administered as documented on the MAR. - She had not been able to locate the CS log sheet for that morning dose but she was going through the file cabinets. - She thought it may have been misfiled. - She did not know why it was not stored with the other CS log sheets for Resident #3. - None of Resident #3's Ativan had been returned to the pharmacy to her knowledge. - She would find the missing CL log. The CS log sheet for 15 of 30 Ativan 1mg tablets dispensed on 02/24/16 was not provided. 2. Review of Resident #1's current FL2 dated 2/10/16 revealed: -Resident #1's diagnoses included muscle weakness, diaphragmatic obstruction, dysphagia, and headache. -There was an order for Tramadol 50 mg four times daily. (Tramadol is a controlled substance used to treat moderate to severe pain.) Review of pharmacy dispensing records revealed: -One hundred sixteen Tramadol 50 mg tablets were dispensed on 01/25/16. -One hundred twenty four Tramadol 50 mg tablets were dispensed on 02/26/16. -One hundred twenty Tramadol 50 mg tablets	D 392		

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	HAL043027	A. BUILDING: _____ B. WING _____	C 03/30/2016

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D 392	Continued From page 79 were dispensed on 03/27/16. Review of medication delivery sheets revealed 124 Tramadol 50 mg tablets were delivered to the facility on 02/25/16 and 12/24/15. Review of the controlled substance (CS) logs for Resident #1's Tramadol dated 12/26/15 revealed: -There was a morning, afternoon, evening, and bedtime CS log for the 124 tablets delivered to the facility on 12/24/15. -The amount the staff signed in as received for each CS log was thirty one Tramadol 50 mg tablets and each CS log was dated 12/26/15. -The morning doses were documented from 12/29/15-01/26/15 leaving a balance of two tablets left. -The afternoon doses were documented from 12/29/15-01/26/16 leaving a balance of four tablets left. -The evening doses were documented from 12/28/15-01/25/16 leaving a balance of two tablets left. -The bedtime doses were documented from 12/29/15-01/26/16 leaving a balance of two tablets left. -There was no documentation on the CS log to account for the total of 10 tablets noted as remaining balance on the four pages of the CS log. Review of the January 2016 MAR revealed: -Tramadol 50 mg was documented as administered four times daily from 01/01/16-01/31/16 except for two doses. -The 1:00pm dose for 01/05/16 and 01/18 16 was documented as not administered due to Resident #1 being out of the facility. Observation of medications on hand on 03/28/16	D 392		

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D 392	Continued From page 80 revealed there was no Tramadol on hand from the supply delivered on 12/24/16. Review of the controlled substance (CS) logs for Resident #1's Tramadol dated 01/27/16 revealed: -There was a morning, afternoon, evening, and bedtime CS log Tramadol 50 mg tablets dispensed on 01/25/16. -The amount the staff signed in as received for each CS log was thirty one Tramadol 50 mg tablets and each CS log was dated 01/27/16. -The morning doses were documented from 01/27/16-02/26/16 leaving a balance of one tablet left. -The afternoon doses were documented from 01/26/16-02/26/16 leaving a balance of two tablets left. -The evening doses were documented from 01/27/16-02/26/16 leaving a balance of zero. -The bedtime doses were documented from 01/27/16-02/26/16 leaving a balance of one tablet remaining. -There was no documentation on the CS log to account for the total of 4 tablets noted as remaining balance on the four pages of the CS log. Review of the February 2016 MAR revealed: -Tramadol 50 mg was documented as administered four times daily from 02/01/16-02/29/16 except for two doses. -The 1:00pm dose for 02/16/16 and 02/17/16 was documented as not administered due to Resident #1 being out of the facility on 02/16/16 and at therapy on 02/17/16. Observation of medications on hand on 03/28/16 revealed there was no Tramadol on hand from the supply dispensed on 01/25/16.	D 392		

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D 392	Continued From page 81 Review of the controlled substance (CS) logs for Resident #1's Tramadol dated 02/27/16 revealed: -There was a morning, afternoon, evening, and bedtime CS log for Tramadol 50 mg tablets dispensed on 02/26/16. -The amount the staff signed in as received for each CS log was thirty one Tramadol 50 mg tablets and each CS log was dated 02/27/16. -The morning doses were documented from 02/27/16-03/28/16 leaving a balance of zero. -The afternoon doses were documented from 02/27/16-03/27/16 leaving a balance of three tablets left. -The evening doses were documented from 02/27/16-03/27/16 leaving a balance of two tablets left. -The bedtime doses were documented from 02/27/16-03/27/16 leaving a balance of one tablet left. Review of the March 2016 MAR revealed: -Tramadol 50 mg was documented as administered four times daily from 03/01/16-03/22/16 except for two doses. -The 9:00am and 1:00pm doses on 03/07/16 were documented as not administered due to "meds held" for the 9:00am dose and Resident #1 was out of the facility for the 1:00pm dose. Observation of medications on hand on 03/28/16 revealed: -There were four Tramadol 50 mg tablets remaining from the supply dispensed on 03/01/16 which was the date on the medication label on the bubble pack. Interview with Resident #1 on 3/23/16 at 11:36am revealed: -Resident #1 did not have any concerns about her medications.	D 392		

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-Resident #1 received medications on time.
-Resident #1 did not have an issue with pain control and knew she took a "pain pill" four times a day.

Interview with the Executive Director on 3/30/16 at 10:25am revealed:
-She did not understand why the same RX# was assigned to different CS logs that were signed in at different times.
-The Tramadol was administered as documented on the MAR for Resident #1.
-There was no record of any Tramadol being returned to the pharmacy.
-She did not know why there were any Tramadol tablets remaining.

3. Review of Resident #4's current FL-2 dated 2/29/16 revealed:
-The resident's diagnoses included Alzheimer's dementia with psychosis, osteoarthritis, high blood pressure, hypothyroidism and gastroesophageal reflux disease.
-There was an order for Xanax 0.5 mg, take one tablet daily at bedtime (used to help treat anxiety and panic disorders).
-The resident was constantly disoriented.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 03/03/04.

Review of a subsequent physician's order dated 2/29/16 revealed an order for Xanax 1 mg, take 1/2 tablet every monring on Mondays, Wednesdays and Fridays (shower days).

Review of pharmacy dispensing records revealed:
-Twenty nine Xanax 0.5 mg tablets were

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dispensed on 01/25/16.
-Thirty Xanax 0.5 mg tablets were dispensed on 02/26/16.
-Seven Xanax 1 mg tablets were dispensed on 02/29/16.
-Seven Xanax 1 mg tablets were dispensed on 03/27/16.
-Thirty Xanax 0.5 mg tablets were also dispensed on 03/27/16.

Review of the controlled substance (CS) logs for Resident 4's Xanax 0.5 mg revealed:
-There was a "bedtime" CS log with documentation that 31 tablets of Xanax 0.5 mg were received on 01/27/16.
-The bedtime doses were documented from 01/27/16-02/26/16 leaving a balance of zero.
-There was another CS log with documentation that 31 tablets of Xanax 0.5 mg were received on 02/27/16.
-The bedtime doses were documented from 02/27/16-03/28/16 leaving a balance of zero.
-There was a third CS log with documentation that 31 tablets of Xanax 0.5 mg were received on 03/28/16.
-There was one documented dose administered on 3/29/16 leaving a balance of 30 tablets.
-The quantities received did not match the quantities documented as dispensed.

Review of the January 2016 MAR revealed that Xanax 0.5 mg was documented as administered at bedtime from 01/01/16-01/31/16.

Review of the February 2016 MAR revealed that Xanax 0.5 mg was documented as administered at bedtime from 02/01/16-02/29/16.

Review of the CS logs for Resident #4's Xanax 1 mg revealed:

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D 392	Continued From page 84 -There was a CS log with documentation that 13 one half tablets were received on 02/29/16. -The documentation revealed that the doses were administered from 03/02/16-03/25/16 leaving a balance of 2 one half tablets. -There was no documentation on the CS log to account for the 2 one half tablets noted as remaining balance on the CS log. -There was another CS log with documentation that 13 one half tablets were received on 03/28/16. -There was one documented dose administered on 03/30/16 leaving a balance of 12 one half tablets. Observation of medications on hand on 03/30/16 revealed: -There was no Xanax 1mg on hand from the supply dispensed on 02/29/16. -There were twelve half tablets of Xanax 1 mg dispensed on 03/28/16 as noted on the CS log. -There were 30 tablets of Xanax 0.5 mg dispensed on 03/28/16 as noted on the CS log. Review of the March 2016 MAR revealed: -Xanax 0.5 mg was documented as administered at bedtime from 03/01/16-03/23/16. -Xanax 1 mg was documented as administered on Monday, Wednesday, and Friday from 03/01/16-03/23/16. Interview with the Executive Director on 3/30/16 at 10:25am revealed: -She did not understand why the information on the CS logs did not match information on the pharmacy dispensing records and/or delivery sheets. -The Xanax was administered as documented on the MAR for Resident #4.	D 392		

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D 392	Continued From page 85 -There were no other control logs for Resident #4's Xanax.	D 392		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on interview and observation, the facility failed to ensure that staff treated residents with respect, consideration and dignity. The findings are: Based on interview and observation, the facility failed to maintain the rights of all residents as it relates to residents being treated with respect and dignity by staff including a named staff person, Staff A, Personal Care Aide (PCA). [Refer to Tag D0338, 10A NCAC 13F.0909 Resident Rights (Type B Violation)].	D911		
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:	D912		

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D912	Continued From page 86 Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care and medication administration. The findings are: 1. Based on observation, interview, and record review, for 4 of 10 residents sampled, the facility failed to measure and document urinary output as ordered for Resident #10 who had a history of urinary retention and the facility failed to obtain urinalysis as ordered by the licensed provider for Residents #2, #7, and #8. [Refer to Tag D276, 10A NCAC 13F.0902(c)(3)(4) Health Care (Type B Violation)]. 2. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 4 of 10 residents (#3, #15, #16, #17) observed during the medication passes, including errors with insulin (#16), medications for nebulizer treatments (#15, #17), and a diuretic (#3) and 3 of 10 residents (#2, #3, #9) sampled for record review including errors with insulin (#2), errors with medications for depression and heart disease prevention (#3), and errors with a medication for congestive heart failure and atrial fibrillation(#9). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		