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	HAL074033	A. BUILDING: _____ B. WING _____	R 04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON HOUSE	716 WALL STREET GRIFTON, NC 28530

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, followup survey and a complaint investigation on April 4-5,2016.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the walls and floors in good repair in all common resident bathrooms and a resident's room #109. The findings are: Observations of the facility's women's wing common bathrooms #1 and #2 on 4/4/16 at from 10:30am to 10:45am revealed: -There were 3 exposed pipes and residual caulking bathroom #1 where a sink was previous located. -There were 2 of 6 missing stall doors in bathroom #1. -There were rusted support brackets for each sink in bathroom #1 and #2. -The baseboard radiator located on the far wall at the floor had a broken rusted casing in bathroom #1. Observations of the facility's men's wing common bathrooms #1 and #2 on 4/4/16 at from 10:45am to 11:00am revealed: -There was a missing cover plate for the exhaust fan switch by the entry door in bathroom #1 and	D 074		

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D 074	Continued From page 1	D 074		

#2.
-There was a sink on the wall with cracking ceramic paint in bathroom #1.
-There was an area around the paper-towel dispenser wall which was unpainted and patched in the men's wing common bathroom #1.
-There was peeling paint on the support bars on each side of the toilets in bathroom #1 and #2.
-There were rusted support brackets for each sink in bathroom #1 and #2.
-The was a baseboard radiator located on the far wall at the floor had a broken rusted casing in bathroom #1.

Observation of resident room #109 on 4/4/16 at 11:00am revealed:
-There was a baseboard radiator that was partially detached from the wall.
-There was wall plate with an exposed television cable hanging 2 feet below the wall opening on the left wall by the closet door.

Attempted interview with resident in room #109 unsuccessful.

Confidential interviews with three residents revealed:
-The bathrooms needed painting.
-"Everything worked in the bathrooms but its just an old facility."
-No resident was bothered by the missing bathroom doors as it made for easier access for wheelchairs.
-The facility did not have a maintenance person.
-Various facility staff, including medication aides and dietary aides, assisted in facility repairs when needed.

Confidential interview with a staff member revealed:

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D 074	Continued From page 2 -The facility needed "a good paint job." -The bathrooms were in need of repair but everything worked. -There were no repair needs that were relayed by a resident to the staff member. -The facility was old and needed a full-time maintenance person. -The facility had no maintenance person on staff. -The facility called outside contractors for repairs when needed. -Staff members were sometimes asked by the Operations Manager to perform minor repairs such as painting. -Staff member did not mind assisting in repairs. Interview with Resident Care Coordinator (RCC) and Operations Manager (OM) on 4/5/16 at 9:00am revealed: -The facility did not have a maintenance person. -Repairs were performed by housekeeping and dietary staff. -The OM had purchased paint and supplies for repairs last month. -They had not been able to begin painting the walls. -No reason was given for not having begun the painting process. -They were aware of the broken baseboard heating units and unpainted bathroom walls. -The missing stall doors in the women's common bathroom were included in the repairs. -They admitted to being behind schedule for all repairs in the facility. -The OM was aware of the repairs needing to be performed.	D 074		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident	D 164		

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D 164	Continued From page 3 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 3 sampled medication aides (Staff A and C) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: A. Review of Staff A personnel record on 4/5/16 revealed: -She was hired on 6/4/1998. -Her current position was listed as a medication aide.	D 164		

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D 164	Continued From page 4 -She passed her Medication Aide exam on 6/2/2000. -She was administering medication independently. -She had completed the Medication Clinical Skills validation prior to resident care. Interivew with Staff A at 3:15pm on 4/5/16 revealed: -She had performed finger stick blood sugar testing (FSBS) daily on residents for 16 years. -She had administered insulin to residents daily for 16 years. -She did not recall having received a "separate diabetic training certification." -She was unware that a diabetic care training certificate was required. B. Review of Staff C's personnel record on 4/5/16 revealed: -She was hired on10/15/2012. -Her current position was listed as a medication aide. -She passed her Medication Aide exam on 11/15/2007. -She was administering medication independently. -She had completed the Medication Clinical Skills validation prior to resident care. Attempted interview with Staff C was unsuccessful. Observation of the residents' medication administration records (MARs) for the month of April 2016 revealed that both Staff A and C had performed FSBS and administered insulin Confidential interview with a staff member	D 164		

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D 164	Continued From page 5 revealed: -Staff member administered insulin. -There was no specific training on diabetic care. -The skills checklist was the only requirement needed to have to administer insulin. -There was no recollection of a specific class or study guide on care of the diabetic resident. -Staff member did not recall having a nurse educator for teaching diabetic care. Interview with Resident Care Coordinator (RCC) on 4/5/16 at 1:00pm revealed: -The staff always were trained on everything they needed prior to resident care. -The RCC did not know who taught the diabetic care course. -The RCC was responsible for employee training. -The RCC was responsible for keeping employee records. -The documentation was unavailable and he would look for the training certifications if they existed. -The RCC would review all Medication Aide personnel records to make sure that they have had the required training on the care of residents with diabetes. -The RCC was under the impression it was part of the medication aide training that they could administer insulin and nothing further was needed. -No policy exists to ensure specific diabetic training to employees prior to insulin administration. -The RCC would ensure all staff requiring diabetic care training would receive it as soon as possible.	D 164		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 6 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure thickened liquids were prepared and served as ordered by the physician for 2 of 2 sampled residents (#2 and #6) with orders for thickened liquids. The findings are: 1. Review of Resident #2's current FL2 dated 09/01/15 revealed diagnosis included of history of right laparoscopic hemicolectomy, mental retardation, seizure, emphazyma, cerebral vascular accident, asthma, cecal polyp, hypertension, and family history of Huntington's chorea. Review of Resident #2's record revealed: -An order for nectar thickened liquids dated for 02/25/16. -Resident #2 was prescribed 3 ½ teaspoons of Thick It (a powder used to thicken liquids) per 4oz of beverage including water, apply juice, cranberry juice, tea, and coffee. -The Resident was prescribed 4 teaspoons of Thick It per 4oz of milk or mighty milk supplement. Observation of the lunch meal on 04/04/16 at 12:35 PM revealed: -The Medication Aide was preparing thickened	D 310		

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liquids for Resident #2.
-She followed the directions that were listed on the order
-She used a large glass of tea and water and added 3 tablespoons of thickener to the beverages.
-Once the thickener was added she stirred the beverages with a straw and continued to check for consistency.
-The beverages did not appear to be nectar thick consistency.
-The Resident drank both the water and tea with no coughing or choking.

Interview with a Medication Aide on 04/05/16 at 08:35 AM revealed:
-There were 2 residents that get thickened liquids at the facility.
-The Medication Aides were responsible for mixing thickened liquids for the residents at meals and medication passes.
-She was trained on use of thickeners by the facility's Nurse Practitioner about 1-2 years ago.
-She was taught that the big end of the scoop was 1 whole teaspoon and the little end was a half of teaspoon.
-The Medication Aides were the only ones allowed to put the thickener in the resident's beverages.

Telephone interview with a second Medication Aide on 04/05/16 at 12:22 PM revealed:
-There are 2 resident's that are currently receiving thickened liquids.
-The Medication Aides are responsible for mixing the thickened liquids.
-She did get training on how to properly prepare thickened liquids.
-She was unaware of when and how long ago that training was done.

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D 310	Continued From page 8 -She had mixed thickened liquids before for the two resident's receiving thickened liquids. Attempted phone interview with the Family Nurse Practitioner on 04/05/16 at 9:35 AM was unsucessful. Interview with the Resident Care Coordinator on 04/05/16 at 9:00 AM revealed: -There were two residents at the facility receiving thickened liquids. -The Medication Aides were responsible for mixing and preparing thickened liquids for the residents. -The facility's Nurse Practitioner did an in-service a few months ago to train the medication aides on how to properly prepare thickened liquids. -He was not sure of the exact date the in-service was done. -He did not attend the training himself on preparing thickened liquids. Interview with the Operations Manager on 04/05/16 at 10:15 AM revealed: -There were currently two residents receiving thickened liquids. -The Medication Aides were responsible for administering thickened liquids. -The facility's Nurse Practitioner did an in-service training to all medication aides a couple of years ago; she die not specify a specific date. -She attended that training herself to learn how to prepare thickened liquids. 2. Review of Resident #6's current FL2 dated for 09/23/15 revealed diagnoses of hypoglycemia, Diabetes Mellitus Type 2, hypertension, anemia, gastroesophageal reflux disease, cerebral vascular accident, hyperlipidemia, and chronic constipation.	D 310		

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D 310	Continued From page 9 Review of Resident #6's record revealed: -An order for nectar thickened liquids dated for 02/09/16. -Resident #2 was to get 3 ½ teaspoons of Thick It (a powder used to thicken liquids) per 4oz of beverage including water, apple juice, cranberry juice, tea, and coffee. -The Resident was to get 4 teaspoons of Thick It per 4oz of milk or a mighty milk supplement. Observation of the lunch meal on 04/04/16 at 12:15 PM revealed: -The Medication Aide offered to put thickener in Resident #6's tea and water and both glasses contained chunks of ice. -Resident #6 refused to have the thickener added to her beverages. -The Medication Aide left and Resident #6 drank the tea and water without having any thickener added to them. Interview with a Medication Aide on 04/05/16 at 08:35 AM revealed: -There were 2 residents that get thickened liquids at the facility. -The Medication Aides were responsible for mixing thickened liquids for the residents at meals and medication passes. -She was trained by the facility's Nurse Practitioner about 1-2 years ago. -She was taught that the big end of the scoop was 1 whole teaspoon and the little end was a half of teaspoon. -The Medication Aides are the only ones allowed to put the thickener in the resident's beverages. -The Medication Aide said that Resident #6 had been refusing to take the thickener for several months. -There was no documentation that MD had been	D 310		

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made aware that Resident #6 was refusing thickener in her beverages.

Telephone interview with a second Medication Aide on 04/05/16 at 12:22 PM revealed:
-There were 2 resident's that are currently receiving thickened liquids.
-The Medication Aides were responsible for mixing the thickened liquids.
-She did get training on how to properly prepare thickened liquids.
-She was unaware of when and how long ago that training was taught.
-She had mixed thickened liquids before for the two resident's receiving thickened liquids.
-Resident #6 had been refusing her thickened liquids for a few months now.
-She had never contacted the MD and made them aware that Resident #6 was refusing the thickened liquids.

Attempted phone interview with Family Nurse Practitioner on 04/05/16 at 9:35 AM was unsuccessful.

Interview with the Resident Care Coordinator on 04/05/16 at 9:00 AM revealed:
-There are two residents at the facility receiving thickened liquids.
-The Medication Aides are responsible for mixing and preparing thickened liquids for the residents.
-The facility Nurse Practitioner did an in-service a few months ago to train the medication aides on how to properly prepare thickened liquids.
-He did not attend the training himself on preparing thickened liquids.
-Resident #6 did not like taking the thickened liquids.
-He had contacted Resident #6 primary medical doctor on 04/04/16 in regards to her not taking

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D 310	Continued From page 11 the thickened liquids. -He was going to request a speech therapy consult for Resident #6. -He had not gotten a returned call from the MD office at this time. Interview with the Operations Manager on 04/05/16 at 10:15 AM revealed: -There were currently two residents receiving thickened liquids. -The Medication Aides were responsible for administering thickened liquids. -The facility's Nurse Practitioner did an in-service training to all medication aides a couple of years ago; she die not specify a specific date. -She attended that training herself to learn how to prepare thickened liquids.	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.	D 317		

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D 317	Continued From page 12 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to offer the residents 14 hours of weekly activities. The findings are: Observation of the activity calendar posted on the lobby wall to the right of the reception window revealed activities and events for each day for the month of April 2016. Review of the activity calendar on 4/4/16 at 9:45am revealed: -There were only 11 hours scheduled for the week of 4/3/16 to 4/9/16. -There were 7 hours of activities for the week of 4/10/16 to 4/16/16. -There were 7 hours of activities for the week of 4/17/16 to 4/23/16. -There were 4 hours of activities for the week of 4/24/16 to 4/30/16. -There were no beginning and end times for two scheduled worship services on April 3 and April 10, 2016. -There were two entries on April 18 and April 25, 2016 which had "TBD" (to be determined). -There were three entries "1-3pm" with no activity listed. -There were three "Free Day" entries with no time ranges listed. -There was a "Resident Meeting & Cultural Events" activity posted on the activities calendar from 9am to 11am on April 5, 2016. Observation of activities room at 10:30an on 4/5/2016 revealed that there was a "Resident Meeting & Cultural Events" activity being held with 5 residents in attendance was being held with 5 residents in attendance.	D 317		

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D 317	Continued From page 13 Three confidential resident interviews revealed: -Activities were not being consistently offered in the facility. -They don't have activities daily. -Bingo used to be offered every week. -The Activities Director had not visited the facility in months. -There was a new volunteer activities volunteer person since January 2016. -Residents were bored and wished for more things to occupy their time. -They did not want to "get anyone in trouble" by reporting a lack of activities. -No staff member in the facility had ever asked if they had any activity preferences. Interview with the volunteer activity coordinator at 10:35am on 4/4/16 revealed: -She had been volunteering at the facility since January 2016. -She made out the activities calendar. -She was unable to list specific times for events due to her personal scheduling. -She was unaware that a minimum of 14 hours per week was required. Interview with the Operations Manager (OC) at 11:00am on 4/5/16 revealed: -The Activities Director was on medical leave and still employed by the facility. -The Activities Director had her certification. -The Activities Director was her mother. -She would be getting her certification and replace the current Activities Director. -She was not currently certified as an Activities Director. -They facility staff tried to provide activities to the residents until the activities director returned.	D 317		

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D 317	Continued From page 14 -The facility had a volunteer activities coordinator who takes care of the calendar. -She could not provide details of how many hours a week of activities were being offered. -She would ensure that the 14 hours of activities were met.	D 317		
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 control log was maintainted to record of the receipt and administration of Tramadol, a controlled substance, for 1 of 7 residents (#7). The findings are: 1. Review of Resident #7's current FL-2 dated 01/14/16 revealed: -The resident's diagnoses included hypertension, diabetes, psychosis, schizophrenia and chronic kidney disease stage III. -The resident was noted to be intermittently disoriented. -There was an order for Tramadol 50 mg four times daily. (Tramadol is a controlled substance used to treat pain.) Interview with Resident #7 at 12:00pm on 4/5/16 revealed:	D 392		

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D 392	Continued From page 15 -She was prescribed Tramadol 50mg four times daily "for about a year." -She never missed a dose of Tramadol. Review of a physician's order revealed an order dated June 1, 2015 for Tramadol 50 mg four times daily. Interview with the facility's pharmacist on 4//5/16 at 11:00am revealed: - There was an order filled on June 1, 2015 for Tramadol 50 mg to be taken four times daily. - The pharmacy had filled the prescription monthly since June 1, 2015. - The resident had been on Tramadol previously 3 times daily prior to June 1, 2015. - The pharmacy sent control log sheets with each Tramadol refill. - The refills were processed on the first of each month with 120 tablets for 30-day months, and 124 tablets for 31-day months. - The last refill was sent to the facility on 3/1/16 with 124 tablets. - The pharmacist could not say if the quarterly resident pharmacy reviews conducted at the facility included verification of controlled medication counts. Review of the controlled substance (CS) log book revealed no control sheet for Tramadol for Resident #7. Review of Resident #7's medication adminstration records (MARs) for February, March and April, 2016 revealed: - The resident received Tramadol 50 mg four times daily. - There were no refusals documented. - Administration times of Tramadol 50mg were listed at 8am, 12pm, 4pm and 8pm.	D 392		

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D 392	Continued From page 16 Review of medication delivery sheets revealed 124 Tramadol 50 mg tablets were delivered to the facility on 3/1/16. Review of medications on hand on 4/4/16 revealed: - There were 38 Tramadol 50 mg tablets remaining from the 124 tablet supply dispensed on 3/01/16. - The Tramadol was stored with the non-controlled medications. - The count was correct according to dispensing and administration records. Interview with a Medication Aide (MA) on 4/4/16 at 11:15am revealed: - The MA thought that Tramadol was a non-controlled drug. - There were no control log records kept for Tramadol. - The facility had always treated Tramadol as a "regular medication." Interview with the Resident Care Coordinator (RCC) and Operations Manager (OM) on 4/5/16 at 11:00am revealed: - They did not know Tramadol was considered a controlled medication. - They did received control sheets with each delivery of Tramadol. - They assumed the control sheets were delivered in error. - They did not call the pharmacy to question why they were receiving control sheets for Tramadol. - They would immediately begin using the control log sheets for Tramadol. - Tramadol would be locked up with the other control medications immediately. - They saw "a big red C" on the Tramadol	D 392		

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D 392	Continued From page 17 medication cards but did not question the stamp.	D 392		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews, employee record reviews, the facility failed to assure 3 of 3 sampled medication aides (A,B and C) had completed the annual state mandated infection control course. The findings are: 1. Review of Staff A's personnel records revealed: -A hire date of 6/4/98. -Job title was Medication Aide -No documentaton of the state-mandated annual infection control course had been completed. Interview with Staff A on 4/4/16 at 2:00pm revealed:	D934		

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D934	Continued From page 18 -She had infection control training by the pharmacy. -She could not remember when the most recent infection control training was provided. Refer to Operations Manager and RCC interivew at 1:00pm on 4/5/16. 2. Review of Staff B's personnel records revealed: -A hire date of 4/27/01. -Job title was Medication Aide --No documentaton of the state-mandated annual infection control course had been completed. Attempted interivew with Staff B was unscuccessful. Refer to Operations Manager and RCC interivew at 1:00pm on 4/5/16. 3. Review of Staff C's personnel records revealed: -A hire date of 10/15/12. -Job title was Medication Aide -No documentaton of the state-mandated annual infection control course had been completed. Attempted interivew with Staff C was unscuccessful. Refer to Operations Manager and RCC interivew at 1:00pm on 4/5/16. Interview with the Operations Manager (OM) and Resident Care Coordinator (RCC) on 4/5/16 at 1:00pm revealed: -The OM and RCC were unaware of the specific state mandated course and certificate. -The OM and RCC did not know how the	D934		

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D934	Continued From page 19 certificates were obtained. -The OM and RCC thought the pharmacy had provided them. -Staff had taken the infection control course sometimes with the pharmacy. -The RCC was responsible for employee training and maintaining records. -The OM and RCC were not aware that the infection control course required an appropriate licensed health professional to teach the course. -The OM and RCC were not aware that the infection control training was supposed to be done annually. -The OM and RCC would ensure all staff get the mandated infection control training as required per state rules.	D934		