STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	C 02/01/2016

RECEIVED MAR 22 2016 ADULT CARE LICENSURE SECTION RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Currituck County Department of Social Services conducted an annual survey and complaint investigation on January 27, 2016-January 29, 2016 and on February 1, 2016.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident *10A NCAC 13F .0505 Training On Care Of* Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 7 of 7 sampled medication aides	D 164	It is the policy of The Currituck House to assure that each Medication Aide, who is responsible for administering medications to the residents, has received "Training On Care Of Diabetic Residents" 100% review of all Medication Aide Personnel files were completed to identify any other staff who was missing the required Diabetic Training so that it can be scheduled and completed. All future Medication Aides, as a part of their orientation will receive the required Diabetic Training. This will be properly documented in their personnel file.	2/22/16 3/18/16 2/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lauren Duncan-Marcil TITLE: Executive Director (X5) DATE: 3/14/2016

"Approved + accepted"
3/10/16 JLP + addendum

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D 164	Continued From page 1 (Staff A,B,C,D,E,F and G) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: Review of Staff A,B,C,D,E,F and G's personnel records on 1/29/16 revealed: -All were medication aides. -All are currently administering medication independently. -All had completed the Medication Clinical Skills validation prior to resident care. -There was no documentation of training on the care of residents with diabetes. -All had passed the Medication Aide exam. -All had administered insulin based on verification of resident medication administration records. Confidential interview with staff revealed: -There was no specific training on diabetic care. -The skills checklist was all they needed to have to administer insulin. -There was no recollection of a specific class or study guide on care of the diabetic resident. -They did not recall having a nurse educator for teaching diabetic care. Interview with Administrator on 1/29/16 at 3:00pm revealed: -The staff always get trained on everything they need prior to resident care. -She did not know who taught the diabetic care course. -The diabetic training must have been performed upon hire. -The documentation was unavailable and she would look for the training certifications. -She would review all Medication Aide personnel records to make sure that they have had the required training on the care of residents with	D 164	The Executive Director, or her designee, will conduct a 100% audit of the Personnel Files for all newly hired or promoted Medication Aides. Audits will be performed every month and documentation will be kept in the BOM's office.	2/22/16 and ongoing

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D 164	Continued From page 2 diabetes. -She was under the impression it was part of the medication aide training that they could administer insulin and nothing further was needed. -No policy exists to ensure specific diabetic training to employees prior to insulin administration. A second review of Staff A,B,C,D,E,F and G's personnel records on 2/1/16 revealed: -All had diabetic training certificates signed by the corporate nurse consultant on 1/31/16. -No response from the Administrator was received when asked if diabetic training had been performed over the weekend on Sunday 1/31/16 after discovery of the lack of documentation on 1/29/16.	D 164		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building,	D 219	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of The Currituck House to Staff the facility, at all times, in accordance with 10A NCAC 13F .0606 Staffing chart.	2/1/16

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D 219	Continued From page 3 or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 71-80 Aide 32 32 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 81-90 Aide 36 36 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 91-100 Aide 40 40 32 Supervisor 8 8 8** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 101-110 Aide 44 44 32 Supervisor 8 8 8** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 111-120 Aide 48 48 32 Supervisor 8 8 8** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.	D 219	It is the policy of The Currituck House to assure that required staffing ratios are adhered to on the weekends on the Assisted Living Unit or Special Care Unit. A review of the regulatory staffing requirements was held with the weekend "Manager on Duty"staff, by the Executive Director, to assure that there was full understanding of required staffing patterns based on current census. This training will be added to the orientation process for all managers who will have "Manager On Duty"responsibilities. Sign up sheets will be posted at the time clock on the Assisted Living Care Station every Wednesday that will allow staff to sign up for any available shift. Staff were educated on the policy that they may not leave the facility at the end of their shift until their relief has arrived or until a manager has relieved him/her of their shift. Documentation was received by each staff and placed in their personnel file.	2/1/16 2/1/16 and ongoing 2/10/16 2/8/16

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D 219	Continued From page 4 121-130 Aide 52 52 40 Supervisor 8 8 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 131-140 Aide 56 56 40 Supervisor 8 8 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call 141-150 Aide 60 60 40 Supervisor 8 8 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 151-160 Aide 64 64 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 161-170 Aide 68 68 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 171-180 Aide 72 72 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 181-190 Aide 76 76 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 191-200 Aide 80 80 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 201-210 Aide 84 84 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 211-220 Aide 88 88 64 Supervisor 16 16 16	D 219	The Care Managers and/or the Executive Director, in their absence, will review the Daily Schedules every Wednesday to assure that proper staffing is in place for the upcoming weekend and that the sign-up sheets are posted, as indicated. Those sheets will be initialed and dated, at the bottom, to signify that they were reviewed. The Manager on Duty for each weekend will communicate any staffing needs to the appropriate Care Manager, who will, in turn, communicate those needs to the Executive Director should a solution need to be found that will satisfy the staffing requirements. Weekly audits of the time clock reports will be conducted by the Executive Director to assure that the corrective action is affective and that staffing requirements are being met.	2/24/16 and ongoing. 2/27/16 and ongoing. 2/22/16 and ongoing.

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

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D 270	Continued From page 9 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure supervision for 1 of 7 sampled residents with continued falls that resulted in injuries (#5). The findings are: Review of Resident #5's current FL2 dated 1/13/16 revealed the resident's diagnoses included Alzheimer's type dementia, diabetes type II, hypertension, hypothyroidism, and asthma. Review of the Resident's Register revealed Resident #5 was admitted to the facility on 11/12/12. Review of the FL2 dated 1/13/16 for Resident #5 revealed the resident was "ambulatory." Review of Incident Reports revealed: -On 8/19/15 with a closed head injury and was sent to local emergency department for assessment. The resident was found by staff in her bathroom in front of the mirror located in the AL unit. -On 10/22/15 with her right ankle sprained and the resident was sent to the local emergency department. The resident was found sitting on the floor, in the hallway of the AL unit, beside the dining room area -On 11/04/15 there were two separate falls documented with no visible injuries noted that occurred in the AL unit. -On 1/11/16 a head injury due to hitting her head	D 270	It is the policy of The Currituck House to assure that all residents receive proper supervision based on their identified needs, condition, care plan and current symptoms. All residents will receive visual checks every 2 hours that will be prompted and documented electronically on the MAR. All residents identified as a "Fall Risk" will receive visual checks every 30 minutes that will be prompted and documented electronically on the MAR. All Care Staff to be in-serviced on appropriate Fall Interventions and the Fall Management Program to include proper documentation and interventions. Two hour and 30 minute visual checks to be monitored and reviewed weekly by the Care Managers and reviewed with the Executive Director. Monthly Fall Team Meetings to be conducted by the Executive Director.	2/1/16 2/1/16 3/31/16

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D 270	Continued From page 10 and was went to the local emergency department. The resident fell twice in the AL unit reported by staff. Confidential Interview with a staff member on 1/28/16 at 8:41 a.m. revealed: -The residents were unsupervised on many occasions by facility staff due to staff shortages for 2 - 3 hours or more at times. -The staff member was unable to specify the number of times the residents were unsupervised due to being short staffed. -Facility staff were unable to successfully monitor residents who had falls on the Assisted Living and Special Care Units. -Resident #5 was found with falls and injuries as a result of being short staffed on a "few occasions" but mostly on the evening and night shifts. No specific number of these falls were given. -The Residential Care Coordinator (RCC) and the Administrator were made aware on the next working day of the residents being unsupervised for extended periods of time due to limited staffing but no changes were made to correct this issue. No specific dates given. -She was only required by the facility to check on all the residents, including Resident #5, at least every two hours. -The majority of the residents, including Resident #5, were not consistently checked every two hours. -The staff member was not required to perform more frequent checks than every two hours for the residents including Resident #5. Interview with the Nurse's Assistant (NA) on 1/28/16 at 10:18 a.m. revealed: -She checks on all the residents including Resident #5 in the SCU "every hour or so" but	D 270	Fall Risk Assessments were completed on all residents to identify any residents at risk for falls.	2/1/16

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D 270	Continued From page 16 Medication Administration Record. -Falls risk residents will receive 30 minute checks. -Two hour and thirty minute checks will be reviewed weekly. -A falls risk assessment will be completed for all the residents. -Nursing staff will be inserviced on fall interventions. -A monthly fall team meeting will be conducted by the Executive Director. -Scheduled staff will not be relieved until relief staff had arrived to assure coverage to the residents. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 2, 2016	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the primay care physician was notified for 1 of 5 sampled Residents (#4) with elevated blood sugars. The findings are: Review of Resident #4's current FL-2 dated 9/2/15 revealed: -The resident's diagnoses included high blood	D 273	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of The Currituck House to assure that all diabetic residents receive proper referral and follow-up with regards to blood sugars outside of the normal parameter, as ordered by the provider.	2/1/16

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D 273	Continued From page 17 pressure, hyperlipidemia and Type II Diabetes Mellitus and mental retardation. -An order for Metformin 1,000 milligrams take one tablet twice daily (used to help control high blood sugars.) Review of the Resident Register revealed Resident #4 was admitted to the facility on 12/28/11. Review of Resident #4's record revealed: -An order dated 10/9/15 for blood sugars to be taken twice daily. -An order dated 12/16/15 for blood sugars to be taken twice daily. Send results every two weeks to the primary care physician. -There was no order when to contact the physician for elevated blood sugars. Review of Resident #4's December 2015 Medication Administration Record (MAR) revealed: -The blood sugars were documented as taken twice daily at 6:00 a.m. and 5:00 p.m. from 12/1-12/31/15. -The 6:00 a.m. blood sugars ranged from 107-169. -The 5:00 p.m. blood sugars ranged from 101-474. -On 12/20/15 at 5:00 p.m., the blood sugar was 474 and on 12/24/15 the blood sugar was 420. Review of Resident #4's January 2016 MAR revealed: -The blood sugars were documented as taken at 6:00 a.m. from 1/1-1/28/16 and at 5:00 p.m. from 1/1-1/27/16. -The 6:00 a.m. blood sugars ranged from 99-150. -The 5:00 p.m. blood sugars ranged from 118-329.	D 273	All residents with a diagnosis that requires blood sugar monitoring will receive a written order, by their health care provider, clearly specifying parameters for which they are to be notified if readings fall outside of that parameter. Those parameters will be added to the electronic MAR, for notification purposes. Medication Aides will be in-serviced on revised procedure for reporting blood sugars that fall outside of the ordered parameter. Attendance documentation will be kept in the QA Binder. Diabetic Training as required by the state will be held annually and on hire for all Medication Aides. This documentation will be kept in their personnel File. Care Managers to conduct a weekly review of the electronic MAR to identify residents who's blood sugars were outside of the ordered parameters to assure that the provider was notified and to follow up, as necessary. The results of these audits will be reviewed with the Executive Director weekly. The results of these audits will be reviewed weekly by the Care Managers, documentation will be kept in the QA binder.	3/7/16 3/31/16 2/1/16 and ongoing 3/7/16 and ongoing

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

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D 276	Continued From page 20 a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 1 of 1 Resident (#9) received a physical therapy evaluation as ordered by the physician. The findings are: Review of Resident #9's current FL-2 dated 6/11/15 revealed: -The residents diagnoses included cerebellar hemorrhage (4/15), vascular dementia, A-Fib, coronary artery disease and vitamin D deficiency. -The resident was ambulatory. The Resident Register revealed Resident #9 was admitted to the facility on 6/12/15. Review of Resident #9's record revealed a physician's order dated 11/9/15 which revealed: -The resident was to have a physical therapy (PT) evaluation. -The resident had a cerebral vascular accident (CVA) April 2015. Observation of Resident #9 on 1/27/16 at 3:30 p.m. revealed the resident was sitting in a wheel chair in the living room. Interview with Resident #9 on 1/27/16 at 3:30 p.m. revealed: -He had resided at the facility for almost a year.	D 276	It is the policy of The Currituck House to assure that all Physician Orders are properly noted and implemented, as ordered. All Physician Orders are to be reviewed by the appropriate Care Manager and documented in the medical record and immediately forwarded to the appropriate provider for processing. Once the order has been acted on, the order is to be initialed as "complete" and filed in the resident's medical record. The Executive Director will conduct weekly random audits of resident records for identification of and follow through with Physician Orders. The audit tool will be maintained in the QA binder.	2/1/16 2/22/16 3/7/16

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D 276	Continued From page 22 -She was unaware the order for a PT evaluation, dated 11/9/15, had not been scheduled as of 1/29/16. Review of Resident #9's record revealed as of 1/29/16 a PT evaluation had not been scheduled for Resident #9.	D 276	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to their bedroom doors being unlocked and accessible without the need to ask for staff assistance when entering or exiting their rooms. The findings are: Observations on the Special Care Unit (SCU) on 1/26/16 at 12:30pm during the tour revealed: -Eighteen resident room doors were locked and staff was needed to open the doors as residents did not have keys. -Four of the residents were in their rooms when the doors were unlocked by staff. -Residents were observed walking up to doors trying the door handles and calling to staff to let them in the rooms.	D 338	It is the policy of The Currituck House to assure that Resident Rights are maintained and may be exercised without hindrance. All "privacy only" lock sets on the Special Care Unit resident doors were immediately unlocked. All staff were informed, in person and with a written follow up on 2-8-16, that these passive locks are to remain "unlocked" unless the room is occupied by a resident who desires to have their door secured, for privacy, while they are in the room. The Executive Director and Maintenance Director will conduct random checks for locked doors while making routine rounds on the Special Care Unit. Any findings will be communicated to the Supervisors in Charge and the appropriate Care Manager for follow through.	2/1/16 2/1/16 2/22/16 and ongoing

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D 338	Continued From page 23 Observation of a resident and resident's room door on 1/26/16 at 3:35pm revealed; -The door was locked. -Resident was unable to open the door and stated "staff lets me in my room." -The inside handle lock button was depressed in the locked position. Interview with a second shift Medication Aide (MA) on 1/26/16 at 3:45pm revealed: -We have wanderers in the building and all rooms are locked to prevent them from going into the wrong rooms. -All of the staff had room keys to open the door. -None of the residents had room keys. -The residents knew to ask the staff to unlock their own rooms if they wanted entry. -Resident #2 had the ability to unlock her door from the inside, but had to ask staff for entry. Interview with another second shift MA on 1/26/16 at 4:00pm revealed: -"We were told to keep all the doors lock to prevent wanderers from entering the wrong rooms." -Some residents took items from other rooms when they were unlocked. -The residents could open their doors from the inside but not from the outside. -If a resident needed to use her bathroom, she would use the common one in the lobby so staff could keep an eye on that resident. -None of the residents had complained about their rooms being locked. -All residents knew to ask to have their doors opened. Confidential interview with a resident on the special care unit on 1/26/16 at 4:45pm revealed:	D 338	Facility will have all staff sign Declaration of Resident Rights acknowledging their receipt and understanding. Form will be kept in each employee's personnel file. ED will attend resident council meetings monthly and ask residents to voice any concerns. Documentation will be kept in binder in Activity Room. Facility has suggestion/complaint box at front entrance that is available for resident/families to voice there concerns. ED checks daily and RDO follows up during site visit. Facility will have Ombudsman, to provide resident right training to all staff. Documentation will be kept in training folder.	3/22/16 3/18/16 12/15/15 3/31/16

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

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D 344	Continued From page 26 medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to contact the physician to clarify medication orders for Tramadol and Marinol for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 1/4/16 revealed diagnoses of Alzheimer's, Chronic Kidney Disease Stage 3, Hypertension, Anorexia, Syncope, history of hip fracture, and Coronary Atherosclerosis. Review of Resident #1's current FL2 dated 1/4/16 revealed no order for Tramadol and Marinol. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 1/4/16 and discharged on 1/21/16. Review of the January 2016 Medication Administration Record (MAR) from 1/4/16 to 1/21/16 revealed all medications ordered on the FL2 were administered as ordered.	D 344	It is the policy of The Currituck House to assure that all Medication Orders at the time of admission or re-admission or medications received by an outside source, are clarified, when indicated, and documentation of such is maintained in the resident record. All medications orders, not dated within 24 hours of admission/re-admission and/or do not match on all of the forms received, will be clarified by the appropriate Care Manager with the prescribing provider using an FL2 Clarification Form that will be maintained in the resident's medical record. A Receipt of Medication Form, signed by the family or responsible party, will be used at the time of admission to inventory all medications received and to reconcile all medications against the prescribing provider's orders The Executive Director, or her designee, will audit all medication orders received at the time of admission and conduct random audits on orders received at the time of re-admission for accuracy. This will be documented/initialed on the FL2 Clarification Form for the next 90 days and conducted monthly thereafter.	2/1/16 2/1/16 2/22/16 and ongoing

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D 344	Continued From page 31 -The facility policy is to destroy or send back medications to the pharmacy if the resident was using those medications. -The resident came from another facility and used another pharmacy, so the facility destroyed the medications. -The facility would clarify any extra medications brought in for all future residents admitted to the facility.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, record reviews and interviews, the facility failed to administer medication such as cardiovascular agents, antidepressants, seizure medications, hypnotic medications for diabetes for 2 of 5 sampled Residents (#5, #3). The findings are: 1 A. Review of Resident #5's current FL2 dated 1/13/16 included: -The resident's diagnoses included Alzheimer's type dementia, diabetes type II, hypertension,	D 358	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of The Currituck House to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with the orders of the licensed prescribing provider, are maintained in the resident's record, and are a part of the facilities policies and procedures.	2/1/16

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D 358	Continued From page 32 hypothyroidism, and asthma. -An order for Levothyroxine 25 milligrams (mg) once daily (used to help treat low thyroid hormone levels). -An order for Metformin 1,000 mg twice daily (used to help control high blood sugars). -An order for Vitamin D 5,000 cap tab once per week (used to help replenish vitamin D deficiency). -An order for Atorvastatin 20 mg once daily (used to high cholesterol). -An order for Cyanocobalamin 10,000 mg once monthly (used to treat vitamin B12 deficiency). -An order for Metoprolol Tartrate 25 mg twice daily (used to treat high blood pressure). -An order for Glimepiride 2 mg one tab twice daily (used for treating Type II Diabetes). Review of Resident's Register revealed Resident #5 was admitted to the facility on 11/12/12. Review of Resident #5 ' s record revealed: -A subsequent order for Farxiga 5 mg once daily was discontinued 1/15/16 (used to help control high blood sugars). -An order for Lantus 100 milliliters injection dated 1/25/16 (used to help control high blood sugars). -An order for Venlafaxine 37.5 mg extended release (ER) cap once daily dated 1/20/16 (used for depression and anxiety). Review of Resident #5's January 2016 Medication Administration Record (MAR) revealed: -The resident was hospitalized from 1/06/16 through 1/08/16. -On 1/06/16 at 8:00 a.m., it was documented the resident was administered Atorvastatin 20 mg tab, Farxiga 5 mg tab, Glimepiride 2 mg tab, Metformin 1,000 mg tab, and Metoprolol Tartrate	D 358	Current photos will be added to all Electronic MAR profiles, then updated yearly. All Medication Aides are to assure that all Medications are scanned into the electronic MAR, at the time of administration, to assure that the 6 Rights of Medication Administration are being followed. Starting immediately, Med Pass Observations by the Care Managers and Executive Director will commence and will be reviewed weekly for 3 months, then monthly. Medication Aides were re-validate by a licensed nurse and documented in their personnel files. The Executive Director and/or Care Managers will conduct random and monthly audits of the medication cart, physician's orders and med pass observations . This will be maintained in the QA binder.	2/1/16 and ongoing 2/1/16 2/1/16 & ongoing 2/10/16 3/1/16 ongoing

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D 358	Continued From page 33 25 mg tab. -On 1/06/16 at 6:30 a.m., Levothyroxine 25 micrograms tab was documented as administered. Review of Resident #5's Incident Report dated 1/06/16 revealed: -The resident was given another resident's morning medications at 8:28 a.m.by facility staff. -The primary care provider was notified by telephone at 11:30 a.m. by facility staff. -The guardian of the resident was notified by facility staff at 12:00 p.m. -The facility was advised to call emergency medical services to transport the resident to the emergency room for evaluation because she had received the medication of another resident. -Resident remained at the hospital for evaluation overnight. -The resident was noted to return to the facility on 1/07/16. Telephone Interview with Resident #5's guardian on 1/29/16 at 10:47 a.m. revealed: -Her guardian was made aware of the medication error by the facility Resident Care Coordinator (RCC). -The guardian was notified more than three hours later after the incident had occurred by the RCC. -The guardian would have wanted to have been informed earlier. -The guardian was told by the RCC that he had a "heavy workload to contend with due to having both sides of the facility." He said he understood to the RCC. Interview with the Medication Aide (MA) on 1/29/16 at 3:18 p.m. revealed:	D 358	Care Managers to conduct monthly Medication Aide meetings. Attendance and minutes of meeting will be kept QA binder.	3/22/16

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D 358	Continued From page 43 2016.	D 358	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure minimal weekend staffing on the special care unit was provided from 12/19/15 to 1/24/16. The findings are: Interview with the Administrator on 1/29/16 at 2:45pm revealed the census had a minimum of 32 residents on the special care unit and 34 on the assisted living side of the facility during the months of December 2015 and January 2016. Review of staff hours on time sheets for the weekends between 12/9/15 to 1/24/16 for first, second and third shift on the special are unit revealed: (Staffing rules require 1 staff per 10 residents then .8 hours per each resident, i.e. 33.6 hours for 1st and 2nd shift; 25.6 hours for 3rd shift with a 32 resident census)	D 465	It is the policy of The Currituck House to staff the facility, at all times, In accordance with 10A NCAC 13F .1309 Credentialed staff for the Special Care Unit are scheduled to meet the needs of the residents but at no time are less than 1 staff to every 8 residents on 1st and 2nd shift with 1 hour of staff time for every additional resident and 1 staff to every 10 residents on 3rd shift with .8 hours of time for each additional resident on the weekends. A review of the regulatory staffing requirements was held with the weekend "Manager on Duty" staff, by the Executive Director, to assure that there was full understanding of required staffing patterns based on current census. Documentation of this training has been placed in each managers personnel file.	2/1/16 2/22/16 2/1/16

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D 465	Continued From page 44 -12/19/15: 7.5 hours on 3rd shift -12/20/15: Zero coverage on 3rd shift. -12/26/15: Meets requirements. -12/27/15: Meets requirements. -1/2/16: 8 hours coverage on 3rd shift. -1/3/16: 3.5 hours coverage on 3rd shift. -1/9/16: 7.5 hours coverage for 3rd shift. -1/10/16: Meets requirements. -1/16/16: 16 hours on 2nd shift, 7.5 hours on 3rd shift. -1/17/16: Zero coverage on 3rd shift. -12/23/16: 8 hours coverage on 3rd shift. -12/24/16: 8 hours coverage on 3rd shift -Five out of six weekends had at least one shift or more with understaffing. -Two days had zero staffing on 3rd shift. Confidential interviews with 4 staff regarding special care unit staffing on 1st, 2nd and 3rd shift revealed: -Third shift staff members had been caught sleeping on the job. -Third shift frequently is understaffed. -There were not enough staff to bathe all the residents on posted schedules. -The weekends always seemed to be short on staff. -The residents need a lot of care on the special care unit. -If we had more staff, we could take better care of the residents. -There were "a lot" of staff members who called out of work for various reasons. -There were not any extra staff members to work in place of those who called out of work. -We had staff quit recently and are in the process of hiring and training new staff. -When staff called out, they were supposed to find their own replacement, but sometimes they	D 465	Sign up sheets will be posted at the time clock and on the Assisted Living Care Station every Wednesday that will allow staff to sign up for any available shift. Staff was educated on the policy that they may not leave the facility at the end of their shift until their relief has arrived or until a manager has relieved him/her of their shift. Signed documentation of this policy was received by each employee and placed in his/her personnel file. This will be reinforced at staff meetings and on initial hire. The Care Managers and/or the Executive Director, in their absence, will review the Daily Schedules every Wednesday to assure that proper staffing is in place for the upcoming weekend and that the sign-up sheets are posted, as indicated. Those sheets will be initialed and dated, at the bottom, to signify that they were reviewed. These sheets will be filed in a binder and kept in the ED's office.	2/24/16 2/8/16 & ongoing 2/24/16 ongoing

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D 465	Continued From page 45 could not. -When we had staff call-outs, we tried to look unsuccessfully for alternate staff to come in on several occasions. -There were activities scheduled daily but there was no one to carry out the activities due to staffing. Interview with the Administrator on 1/29/16 at 2:15pm revealed: -Staff have quit "yet its hard for me to believe that the special care unit was understaffed." -It has become increasingly difficult to find staff. -Two staff were recently suspended pending investigations which causes scheduling issues. -Our new time-keeping system was inaccurate. -The time keeping records provided must be missing certain staff names who must have been on those shifts to account for the appearance of understaffing. Confidential interviews with residents and resident's family members revealed: -The facility was frequently understaffed on the weekends. -There were insufficient staff on the third shift in the entire facility. -Residents were not getting bathed due to low staffing. -Residents on the special care unit were huddled into one area of the hallway for monitoring due to having only one staff member on several occasions. -Special care residents in their rooms no not get checked on during the night. -There were many falls at the facility due to low staffing where a 2-person assist is needed. -During the Christmas holidays, there was no staff person on the special care unit on 3rd shift. -The SIC tried to assist in both the assisted living	D 465	The Manager on Duty for each weekend will communicate any staffing needs to the appropriate Care Manager, who will, in turn, communicate those needs to the Executive Director should a solution need to be found that will satisfy the staffing requirements. A binder as a communication tool for the "Managers On Duty" will be kept to include information that the "Manager On Duty"would communicate to the the ED to review every Monday for follow up. Audits of the time clock reports will be conducted on Monday by the Executive Director, or her designee, to assure that corrective action is affective and that staffing required is being met. These reports will be initialed and kept with the Daily Sheets , in the Resident Care Manager's Office	2/27/16 ongoing 2/22/16 & ongoing 2-27-16

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D 465	Continued From page 46 side and the special care side when staffing is low but is overwhelmed due to frequent call outs. -The administrator has been told about the need for more staffing. Refer to interview with Corporate Director and Administrator on 2/1/16 at 3:00pm.	D 465	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least	D 468	It is the policy of The Currituck House for staff hired to work in the Special Care Unit will receive the required Special Care Unit training at the time of orientation as required by rule 10A NCAC 13F .1309. Documentation will be kept in each personnel file. All personnel training records for the staff assigned to work on the Special Care Unit were audited to identify any missing staff training requirements.	2/22/16 3/11/16

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D 468	Continued From page 47 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure six of seven sampled staff (Staff B, C, D, E, F and G) assigned to perform duties in the special care unit received 6 hours of training within the first week of employement in addition to the 20 hours additional training within 6 months of employment specific to the population to be served. The findings are: Review of the Staff B, C, D, E, F and G's personnel records revealed: -Each was hired with a dual roles as a medication aides and personal care assistant and worked on the special care unit. -None completed the 6 hours within the first week of employment and the 20 hour training for the special care unit within six months of hire. -Only Staff C's personnel had a dementia certificate with one continuing education credit related to bathing on the special care unit. -All had worked for the facility for greater than 6 months. Review of the facility work time logs and schedules for December 2015 and January 2106 revealed all staff had worked on the special care unit. Interview with the Administrator on 1/29/16 at 3:00pm revealed: -She was certain that Staff B, C, D, E, F and G had been certified to work the special care unit.	D 468	Any personnel assigned to work on the Special Care Unit identified as missing required training will receive the required training and will have documentation of that training maintained in their personnel training file. The Executive Director, or her designee, will utilize an audit tool to be used to quickly identify any personnel who are not in compliance with the Special Care Unit training requirements. The Executive Director, as a part of the QI process, will conduct monthly audits of the personnel training records to assure that all staff meet the minimum training requirements. These audits will be kept in the QA binder.	4/30/16 3/11/16 3/31/16

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D912	Continued From page 50 (Type A1 Violation)]	D912	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews, employee record reviews, the facility failed to assure 5 of 7 sampled medication aides (B, C, D, E and G) had completed the state mandated infection control course. The findings are: 1. Review of Staff B's employee records revealed: -A hire date of 8/6/14 -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff B was unavailable for interview.	D934	It is the policy of The Currituck House to assure that all Medication Aides receive the required Infection Control Training in accordance with G.S. 1310-4.SB ACH Infection Control Within 60 days of hire and annually, all Medication Aides will receive the required "State Approved" Infection Control Training and signed by a licensed nurse. The training documentation will be kept in a binder located in the BOM's office. All Medication Aide personnel training files were audited to identify any missing staff who had not received the training .	2/22/16 3/11/16

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D934	Continued From page 51 2. Review of Staff C's employee records revealed: -A hire date of 7/25/14 -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff C was unavailable for interview. 3. Review of Staff D's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff D was unavailable for interview. 4. Review of Staff E's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff E was unavailable for interview. 5. Review of Staff G's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff G was unavailable for interview. Interview with Staff B on 1/29/16 at 1:15pm revealed: -Staff completed in-services/trainings on the computer and then management give us forms to sign stating we completed the training. -The Administrator provided training information and updates when we have staff meetings.	D934	Any Medication Aides identified as missing the Infection Control Training will be required to receive the training and will have documentation of that training in their personnel training file. This training will be provided by a licensed nurse. Documentation will be kept in the BOM's office. The Executive Director, or her designee, will utilize an audit tool to be used to quickly identify any Medication Aides who are not in compliance with the Infection Control training requirements. The Executive Director, as a part of the QI process, will conduct routine audits of the personnel training records to assure that all Medication Aides meet the minimum training requirements with regards to Infection Control.	3/18/16 3/11/16 3/31/16 & ongoing

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D 000	Initial Comments The Adult Care Licensure Section and the Currituck County Department of Social Services conducted an annual survey and complaint investigation on January 27, 2016-January 29, 2016 and on February 1, 2016.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 7 of 7 sampled medication aides	D 164	It is the policy of The Currituck House to assure that each Medication Aide, who is responsible for administering medications to the residents, has received "Training On Care Of Diabetic Residents" 100% review of all Medication Aide Personnel files were completed to identify any other staff who was missing the required Diabetic Training so that it can be scheduled and completed. All future Medication Aides, as a part of their orientation will receive the required Diabetic Training. This will be properly documented in their personnel file.	2/22/16 3/17/16 2/22/16

Accepted as approved 5/16/16 in addendum

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D 164	Continued From page 1 (Staff A,B,C,D,E,F and G) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: Review of Staff A,B,C,D,E,F and G's personnel records on 1/29/16 revealed: -All were medication aides. -All are currently administering medication independently. -All had completed the Medication Clinical Skills validation prior to resident care. -There was no documentation of training on the care of residents with diabetes. -All had passed the Medication Aide exam. -All had administered insulin based on verification of resident medication administration records. Confidential interview with staff revealed: -There was no specific training on diabetic care. -The skills checklist was all they needed to have to administer insulin. -There was no recollection of a specific class or study guide on care of the diabetic resident. -They did not recall having a nurse educator for teaching diabetic care. Interview with Administrator on 1/29/16 at 3:00pm revealed: -The staff always get trained on everything they need prior to resident care. -She did not know who taught the diabetic care course. -The diabetic training must have been performed upon hire. -The documentation was unavailable and she would look for the training certifications. -She would review all Medication Aide personnel records to make sure that they have had the required training on the care of residents with	D 164	The Executive Director, or her designee, will conduct a 100% audit of the Personnel Files for all newly hired or promoted Medication Aides. Audits will be performed every month and documentation will be kept in the BOM's office.	2/22/16 and ongoing

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D 164	Continued From page 2 diabetes. -She was under the impression it was part of the medication aide training that they could administer insulin and nothing further was needed. -No policy exists to ensure specific diabetic training to employees prior to insulin administration. A second review of Staff A,B,C,D,E,F and G's personnel records on 2/1/16 revealed: -All had diabetic training certificates signed by the corporate nurse consultant on 1/31/16. -No response from the Administrator was received when asked if diabetic training had been performed over the weekend on Sunday 1/31/16 after discovery of the lack of documentation on 1/29/16.	D 164		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building,	D 219	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of The Currituck House to Staff the facility, at all times, in accordance with 10A NCAC 13F .0606 Staffing chart.	2/1/16

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D 219	Continued From page 3 or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 71-80 Aide 32 32 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 81-90 Aide 36 36 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 91-100 Aide 40 40 32 Supervisor 8 8 8** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 101-110 Aide 44 44 32 Supervisor 8 8 8** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 111-120 Aide 48 48 32 Supervisor 8 8 8** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.	D 219	It is the policy of The Currituck House to assure that required staffing ratios are adhered to on the weekends on the Assisted Living Unit or Special Care Unit. A review of the regulatory staffing requirements was held with the weekend "Manager on Duty"staff, by the Executive Director, to assure that there was full understanding of required staffing patterns based on current census. This training will be added to the orientation process for all managers who will have "Manager On Duty"responsibilities. Sign up sheets will be posted at the time clock on the Assisted Living Care Station every Wednesday that will allow staff to sign up for any available shift. Staff were educated on the policy that they may not leave the facility at the end of their shift until their relief has arrived or until a manager has relieved him/her of their shift. Documentation was received by each staff and placed in their personnel file.	2/1/16 2/1/16 and ongoing 2/10/16 2/8/16

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D 219	Continued From page 4 121-130 Aide 52 52 40 Supervisor 8 8 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 131-140 Aide 56 56 40 Supervisor 8 8 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call 141-150 Aide 60 60 40 Supervisor 8 8 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 151-160 Aide 64 64 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 161-170 Aide 68 68 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 171-180 Aide 72 72 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 181-190 Aide 76 76 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 191-200 Aide 80 80 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 201-210 Aide 84 84 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 211-220 Aide 88 88 64 Supervisor 16 16 16	D 219	The Care Managers and/or the Executive Director, in their absence, will review the Daily Schedules every Wednesday to assure that proper staffing is in place for the upcoming weekend and that the sign-up sheets are posted, as indicated. Those sheets will be initialed and dated, at the bottom, to signify that they were reviewed. The Manager on Duty for each weekend will communicate any staffing needs to the appropriate Care Manager, who will, in turn, communicate those needs to the Executive Director should a solution need to be found that will satisfy the staffing requirements. Weekly audits of the time clock reports will be conducted by the Executive Director to assure that the corrective action is affective and that staffing requirements are being met.	2/24/16 and ongoing. 2/27/16 and ongoing. 2/22/16 and ongoing.

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

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

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

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D 270	Continued From page 9 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure supervision for 1 of 7 sampled residents with continued falls that resulted in injuries (#5). The findings are: Review of Resident #5's current FL2 dated 1/13/16 revealed the resident's diagnoses included Alzheimer's type dementia, diabetes type II, hypertension, hypothyroidism, and asthma. Review of the Resident's Register revealed Resident #5 was admitted to the facility on 11/12/12. Review of the FL2 dated 1/13/16 for Resident #5 revealed the resident was "ambulatory." Review of Incident Reports revealed: -On 8/19/15 with a closed head injury and was sent to local emergency department for assessment. The resident was found by staff in her bathroom in front of the mirror located in the AL unit. -On 10/22/15 with her right ankle sprained and the resident was sent to the local emergency department. The resident was found sitting on the floor, in the hallway of the AL unit, beside the dining room area -On 11/04/15 there were two separate falls documented with no visible injuries noted that occurred in the AL unit. -On 1/11/16 a head injury due to hitting her head	D 270	It is the policy of The Currituck House to assure that all residents receive proper supervision based on their identified needs, condition, care plan and current symptoms. All residents will receive visual checks every 2 hours that will be prompted and documented electronically on the MAR. All residents identified as a "Fall Risk" will receive visual checks every 30 minutes that will be prompted and documented electronically on the MAR. All Care Staff to be in-serviced on appropriate Fall Interventions and the Fall Management Program to include proper documentation and interventions. Two hour and 30 minute visual checks to be monitored and reviewed weekly by the Care Managers and reviewed with the Executive Director. Monthly Fall Team Meetings to be conducted by the Executive Director.	2/1/16 2/1/16 3/2/16

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	HAL027003	A. BUILDING: _____ B. WING _____	C 02/01/2016

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D 270	Continued From page 10 and was went to the local emergency department. The resident fell twice in the AL unit reported by staff. Confidential Interview with a staff member on 1/28/16 at 8:41 a.m. revealed: -The residents were unsupervised on many occasions by facility staff due to staff shortages for 2 - 3 hours or more at times. -The staff member was unable to specify the number of times the residents were unsupervised due to being short staffed. -Facility staff were unable to successfully monitor residents who had falls on the Assisted Living and Special Care Units. -Resident #5 was found with falls and injuries as a result of being short staffed on a "few occasions" but mostly on the evening and night shifts. No specific number of these falls were given. -The Residential Care Coordinator (RCC) and the Administrator were made aware on the next working day of the residents being unsupervised for extended periods of time due to limited staffing but no changes were made to correct this issue. No specific dates given. -She was only required by the facility to check on all the residents, including Resident #5, at least every two hours. -The majority of the residents, including Resident #5, were not consistently checked every two hours. -The staff member was not required to perform more frequent checks than every two hours for the residents including Resident #5. Interview with the Nurse's Assistant (NA) on 1/28/16 at 10:18 a.m. revealed: -She checks on all the residents including Resident #5 in the SCU "every hour or so" but	D 270	Fall Risk Assessments were completed on all residents to identify any residents at risk for falls.	2/1/16

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D 270	Continued From page 16 Medication Administration Record. -Falls risk residents will receive 30 minute checks. -Two hour and thirty minute checks will be reviewed weekly. -A falls risk assessment will be completed for all the residents. -Nursing staff will be inserviced on fall interventions. -A monthly fall team meeting will be conducted by the Executive Director. -Scheduled staff will not be relieved until relief staff had arrived to assure coverage to the residents. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 2, 2016	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the primay care physician was notified for 1 of 5 sampled Residents (#4) with elevated blood sugars. The findings are: Review of Resident #4's current FL-2 dated 9/2/15 revealed: -The resident's diagnoses included high blood	D 273	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of The Currituck House to assure that all diabetic residents receive proper referral and follow-up with regards to blood sugars outside of the normal parameter, as ordered by the provider.	2/1/16

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D 273	Continued From page 17 pressure, hyperlipidemia and Type II Diabetes Mellitus and mental retardation. -An order for Metformin 1,000 milligrams take one tablet twice daily (used to help control high blood sugars.) Review of the Resident Register revealed Resident #4 was admitted to the facility on 12/28/11. Review of Resident #4's record revealed: -An order dated 10/9/15 for blood sugars to be taken twice daily. -An order dated 12/16/15 for blood sugars to be taken twice daily. Send results every two weeks to the primary care physician. -There was no order when to contact the physician for elevated blood sugars. Review of Resident #4's December 2015 Medication Administration Record (MAR) revealed: -The blood sugars were documented as taken twice daily at 6:00 a.m. and 5:00 p.m. from 12/1-12/31/15. -The 6:00 a.m. blood sugars ranged from 107-169. -The 5:00 p.m. blood sugars ranged from 101-474. -On 12/20/15 at 5:00 p.m., the blood sugar was 474 and on 12/24/15 the blood sugar was 420. Review of Resident #4's January 2016 MAR revealed: -The blood sugars were documented as taken at 6:00 a.m. from 1/1-1/28/16 and at 5:00 p.m. from 1/1-1/27/16. -The 6:00 a.m. blood sugars ranged from 99-150. -The 5:00 p.m. blood sugars ranged from 118-329.	D 273	All residents with a diagnosis that requires blood sugar monitoring will receive a written order, by their health care provider, clearly specifying parameters for which they are to be notified if readings fall outside of that parameter. Those parameters will be added to the electronic MAR, for notification purposes. Medication Aides will be in-serviced on revised procedure for reporting blood sugars that fall outside of the ordered parameter. Attendance documentation will be kept in the QA Binder. Diabetic Training as required by the state will be held annually and on hire for all Medication Aides. This documentation will be kept in their personnel File. Care Managers to conduct weekly Reviews of the electronic MAR to include but not limited to identifying residents with blood sugars outside of the ordered parameters. The Provider will be contacted with any discrepancies identified. The results of these audits will be reviewed with the Executive Director, and documentation will be kept in the QA Binder.	3/7/16 3/2/16 2/1/16 and ongoing 3/2/16 and ongoing

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

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D 276	Continued From page 20 a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 1 of 1 Resident (#9) received a physical therapy evaluation as ordered by the physician. The findings are: Review of Resident #9's current FL-2 dated 6/11/15 revealed: -The residents diagnoses included cerebellar hemorrhage (4/15), vascular dementia, A-Fib, coronary artery disease and vitamin D deficiency. -The resident was ambulatory. The Resident Register revealed Resident #9 was admitted to the facility on 6/12/15. Review of Resident #9's record revealed a physician's order dated 11/9/15 which revealed: -The resident was to have a physical therapy (PT) evaluation. -The resident had a cerebral vascular accident (CVA) April 2015. Observation of Resident #9 on 1/27/16 at 3:30 p.m. revealed the resident was sitting in a wheel chair in the living room. Interview with Resident #9 on 1/27/16 at 3:30 p.m. revealed: -He had resided at the facility for almost a year.	D 276	It is the policy of The Currituck House to assure that all Physician Orders are properly noted and implemented, as ordered. All Physician Orders are to be reviewed by the appropriate Care Manager and documented in the medical record and immediately forwarded to the appropriate provider for processing. Once the order has been acted on, the order is to be initialed as "complete" and filed in the resident's medical record. The Executive Director will conduct weekly random audits of resident records for identification of and follow through with Physician Orders. The audit tool will be maintained in the QA binder.	2/1/16 2/22/16 3/7/16

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D 276	Continued From page 22 -She was unaware the order for a PT evaluation, dated 11/9/15, had not been scheduled as of 1/29/16. Review of Resident #9's record revealed as of 1/29/16 a PT evaluation had not been scheduled for Resident #9.	D 276	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to their bedroom doors being unlocked and accessible without the need to ask for staff assistance when entering or exiting their rooms. The findings are: Observations on the Special Care Unit (SCU) on 1/26/16 at 12:30pm during the tour revealed: -Eighteen resident room doors were locked and staff was needed to open the doors as residents did not have keys. -Four of the residents were in their rooms when the doors were unlocked by staff. -Residents were observed walking up to doors trying the door handles and calling to staff to let them in the rooms.	D 338	It is the policy of The Currituck House to assure that Resident Rights are maintained and may be exercised without hindrance. All "privacy only" lock sets on the Special Care Unit resident doors were immediately unlocked. All staff were informed, in person and with a written follow up on 2-8-16, that these passive locks are to remain "unlocked" unless the room is occupied by a resident who desires to have their door secured, for privacy, while they are in the room. The Executive Director and Maintenance Director will conduct random checks for locked doors while making routine rounds on the Special Care Unit. Any findings will be communicated to the Supervisors in Charge and the appropriate Care Manager for follow through.	2/1/16 2/1/16 2/22/16 and ongoing

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D 338	Continued From page 23 Observation of a resident and resident's room door on 1/26/16 at 3:35pm revealed: -The door was locked. -Resident was unable to open the door and stated "staff lets me in my room." -The inside handle lock button was depressed in the locked position. Interview with a second shift Medication Aide (MA) on 1/26/16 at 3:45pm revealed: -We have wanderers in the building and all rooms are locked to prevent them from going into the wrong rooms. -All of the staff had room keys to open the door. -None of the residents had room keys. -The residents knew to ask the staff to unlock their own rooms if they wanted entry. -Resident #2 had the ability to unlock her door from the inside, but had to ask staff for entry. Interview with another second shift MA on 1/26/16 at 4:00pm revealed: -"We were told to keep all the doors lock to prevent wanderers from entering the wrong rooms." -Some residents took items from other rooms when they were unlocked. -The residents could open their doors from the inside but not from the outside. -If a resident needed to use her bathroom, she would use the common one in the lobby so staff could keep an eye on that resident. -None of the residents had complained about their rooms being locked. -All residents knew to ask to have their doors opened. Confidential Interview with a resident on the special care unit on 1/26/16 at 4:45pm revealed:	D 338	Facility will have all staff sign Declaration of Resident Rights acknowledging their receipt and understanding. Form will be kept in each employee's personnel file. ED will attend resident council meetings monthly and ask residents to voice any concerns. Documentation will be kept in binder in Activity Room. Facility has suggestion/complaint box at front entrance that is available for resident/families to voice there concerns. ED checks daily and RDO follows up during site visit. Facility will have Ombudsman, to provide resident right training to all staff. Documentation will be kept in training folder. Resident Rights review was conducted with all staff. Documentation will be kept in each employee's training file. In addition, the Regional Long Term Care Ombudsman has scheduled Resident Rights training on site (4/22/16).	3/17/16 3/17/16 12/15/15 3/17/16 3/17/16

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

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D 344	Continued From page 26 medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to contact the physician to clarify medication orders for Tramadol and Marinol for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 1/4/16 revealed diagnoses of Alzheimer's, Chronic Kidney Disease Stage 3, Hypertension, Anorexia, Syncope, history of hip fracture, and Coronary Atherosclerosis. Review of Resident #1's current FL2 dated 1/4/16 revealed no order for Tramadol and Marinol. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 1/4/16 and discharged on 1/21/16. Review of the January 2016 Medication Administration Record (MAR) from 1/4/16 to 1/21/16 revealed all medications ordered on the FL2 were administered as ordered.	D 344	It is the policy of The Currituck House to assure that all Medication Orders at the time of admission or re-admission or medications received by an outside source, are clarified, when indicated, and documentation of such is maintained in the resident record. All medications orders, not dated within 24 hours of admission/re-admission and/or do not match on all of the forms received, will be clarified by the appropriate Care Manager with the prescribing provider using an FL2 Clarification Form that will be maintained in the resident's medical record. A Receipt of Medication Form, signed by the family or responsible party, will be used at the time of admission to inventory all medications received and to reconcile all medications against the prescribing provider's orders. The Executive Director, or her designee, will audit all medication orders received at the time of admission and conduct random audits on orders received at the time of re-admission for accuracy. This will be documented/initialed on the FL2 Clarification Form for the next 90 days and conducted monthly thereafter.	2/1/16 2/1/16 2/22/16 and ongoing

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D 344	Continued From page 31 -The facility policy is to destroy or send back medications to the pharmacy if the resident was using those medications. -The resident came from another facility and used another pharmacy, so the facility destroyed the medications. -The facility would clarify any extra medications brought in for all future residents admitted to the facility.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, record reviews and interviews, the facility failed to administer medication such as cardiovascular agents, antidepressants, seizure medications, hypnotic medications for diabetes for 2 of 5 sampled Residents (#5, #3). The findings are: 1 A. Review of Resident #5's current FL2 dated 1/13/16 included: -The resident's diagnoses included Alzheimer's type dementia, diabetes type II, hypertension,	D 358	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of The Currituck House to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with the orders of the licensed prescribing provider, are maintained in the resident's record, and are a part of the facilities policies and procedures.	2/1/16

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D 358	Continued From page 32 hypothyroidism, and asthma. -An order for Levothyroxine 25 milligrams (mg) once daily (used to help treat low thyroid hormone levels). -An order for Metformin 1,000 mg twice daily (used to help control high blood sugars). -An order for Vitamin D 5,000 cap tab once per week (used to help replenish vitamin D deficiency). -An order for Atorvastatin 20 mg once daily (used to high cholesterol). -An order for Cyanocobalamin 10,000 mg once monthly (used to treat vitamin B12 deficiency). -An order for Metoprolol Tartrate 25 mg twice daily (used to treat high blood pressure). -An order for Glimepiride 2 mg one tab twice daily (used for treating Type II Diabetes). Review of Resident's Register revealed Resident #5 was admitted to the facility on 11/12/12. Review of Resident #5 ' s record revealed: -A subsequent order for Farxiga 5 mg once daily was discontinued 1/15/16 (used to help control high blood sugars). -An order for Lantus 100 milliliters injection dated 1/25/16 (used to help control high blood sugars). -An order for Venlafaxine 37.5 mg extended release (ER) cap once daily dated 1/20/16 (used for depression and anxiety). Review of Resident #5's January 2016 Medication Administration Record (MAR) revealed: -The resident was hospitalized from 1/06/16 through 1/08/16. -On 1/06/16 at 8:00 a.m., it was documented the resident was administered Atorvastatin 20 mg tab, Farxiga 5 mg tab, Glimepiride 2 mg tab, Metformin 1,000 mg tab, and Metoprolol Tartrate	D 358	Current photos will be added to all Electronic MAR profiles, then updated yearly. All Medication Aides are to assure that all Medications are scanned into the electronic MAR, at the time of administration, to assure that the 6 Rights of Medication Administration are being followed. Starting immediately, Med Pass Observations by the Care Managers and Executive Director will commence and will be reviewed weekly for 3 months, then monthly. Medication Aides were re-validate by a licensed nurse and documented in their personnel files. Implemented a new medication process And procedure, which includes the New Order Tracking System consisting of Designated color coded files representing stages of completion . Care Managers will be responsible for the review and approval of all orders.	2/1/16 and ongoing 2/1/16 2/1/16 & ongoing 2/10/16 3/2/16

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D 358	Continued From page 33 25 mg tab. -On 1/06/16 at 6:30 a.m., Levothyroxine 25 micrograms tab was documented as administered. Review of Resident #5's Incident Report dated 1/06/16 revealed: -The resident was given another resident's morning medications at 8:28 a.m.by facility staff. -The primary care provider was notified by telephone at 11:30 a.m. by facility staff. -The guardian of the resident was notified by facility staff at 12:00 p.m. -The facility was advised to call emergency medical services to transport the resident to the emergency room for evaluation because she had received the medication of another resident. -Resident remained at the hospital for evaluation overnight. -The resident was noted to return to the facility on 1/07/16. Telephone Interview with Resident #5's guardian on 1/29/16 at 10:47 a.m. revealed: -Her guardian was made aware of the medication error by the facility Resident Care Coordinator (RCC). -The guardian was notified more than three hours later after the incident had occurred by the RCC. -The guardian would have wanted to have been informed earlier. -The guardian was told by the RCC that he had a "heavy workload to contend with due to having both sides of the facility." He said he understood to the RCC. Interview with the Medication Aide (MA) on 1/29/16 at 3:18 p.m. revealed:	D 358	The LHPS Nurse and Resident Care Manager conducted a Medication Aide meeting that included Skills Validation, Psychotropic Drugs, Coumadin training and Diabetic training. The medication re-ordering process and steps to take when a medication is not on hand was also reviewed. Routine monthly Medication Aide meetings will be conducted thereafter. Attendance and minutes from the meeting will be kept in the QA binder. The Executive Director, and/or Care Managers will conduct random And monthly audits of the medication Cart, physician's orders and med pass Observations. This will be maintained In the QA binder.	3/2/16 3/1/16 ongoing

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D 358	Continued From page 43 2016.	D 358	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure minimal weekend staffing on the special care unit was provided from 12/19/15 to 1/24/16. The findings are: Interview with the Administrator on 1/29/16 at 2:45pm revealed the census had a minimum of 32 residents on the special care unit and 34 on the assisted living side of the facility during the months of December 2015 and January 2016. Review of staff hours on time sheets for the weekends between 12/9/15 to 1/24/16 for first, second and third shift on the special are unit revealed: (Staffing rules require 1 staff per 10 residents then .8 hours per each resident, i.e. 33.6 hours for 1st and 2nd shift; 25.6 hours for 3rd shift with a 32 resident census)	D 465	It is the policy of The Currituck House to staff the facility, at all times, In accordance with 10A NCAC 13F .1309 Credentialed staff for the Special Care Unit are scheduled to meet the needs of the residents but at no time are less than 1 staff to every 8 residents on 1st and 2nd shift with 1 hour of staff time for every additional resident and 1 staff to every 10 residents on 3rd shift with .8 hours of time for each additional resident on the weekends. A review of the regulatory staffing requirements was held with the weekend "Manager on Duty" staff, by the Executive Director, to assure that there was full understanding of required staffing patterns based on current census. Documentation of this training has been placed in each managers personnel file.	2/1/16 2/22/16 2/1/16

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D 465	Continued From page 44 -12/19/15: 7.5 hours on 3rd shift -12/20/15: Zero coverage on 3rd shift. -12/26/15: Meets requirements. -12/27/15: Meets requirements. -1/2/16: 8 hours coverage on 3rd shift. -1/3/16: 3.5 hours coverage on 3rd shift. -1/9/16: 7.5 hours coverage for 3rd shift. -1/10/16: Meets requirements. -1/16/16: 16 hours on 2nd shift, 7.5 hours on 3rd shift. -1/17/16: Zero coverage on 3rd shift. -12/23/16: 8 hours coverage on 3rd shift. -12/24/16: 8 hours coverage on 3rd shift -Five out of six weekends had at least one shift or more with understaffing. -Two days had zero staffing on 3rd shift. Confidential interviews with 4 staff regarding special care unit staffing on 1st, 2nd and 3rd shift revealed: -Third shift staff members had been caught sleeping on the job. -Third shift frequently is understaffed. -There were not enough staff to bathe all the residents on posted schedules. -The weekends always seemed to be short on staff. -The residents need a lot of care on the special care unit. -If we had more staff, we could take better care of the residents. -There were "a lot" of staff members who called out of work for various reasons. -There were not any extra staff members to work in place of those who called out of work. -We had staff quit recently and are in the process of hiring and training new staff. -When staff called out, they were supposed to find their own replacement, but sometimes they	D 465	Sign up sheets will be posted at the time clock and on the Assisted Living Care Station every Wednesday that will allow staff to sign up for any available shift. Staff was educated on the policy that they may not leave the facility at the end of their shift until their relief has arrived or until a manager has relieved him/her of their shift. Signed documentation of this policy was received by each employee and placed in his/her personnel file. This will be reinforced at staff meetings and on initial hire. The Care Managers and/or the Executive Director, in their absence, will review the Daily Schedules every Wednesday to assure that proper staffing is in place for the upcoming weekend and that the sign-up sheets are posted, as indicated. Those sheets will be initialed and dated, at the bottom, to signify that they were reviewed. These sheets will be filed in a binder and kept in the ED's office.	2/24/16 2/8/16 & ongoing 2/24/16 ongoing

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D 465	Continued From page 45 could not. -When we had staff call-outs, we tried to look unsuccessfully for alternate staff to come in on several occasions. -There were activities scheduled daily but there was no one to carry out the activities due to staffing. Interview with the Administrator on 1/29/16 at 2:15pm revealed: -Staff have quit "yet its hard for me to believe that the special care unit was understaffed." -It has become increasingly difficult to find staff. -Two staff were recently suspended pending investigations which causes scheduling issues. -Our new time-keeping system was inaccurate. -The time keeping records provided must be missing certain staff names who must have been on those shifts to account for the appearance of understaffing. Confidential interviews with residents and resident's family members revealed: -The facility was frequently understaffed on the weekends. -There were insufficient staff on the third shift in the entire facility. -Residents were not getting bathed due to low staffing. -Residents on the special care unit were huddled into one area of the hallway for monitoring due to having only one staff member on several occasions. -Special care residents in their rooms no not get checked on during the night. -There were many falls at the facility due to low staffing where a 2-person assist is needed. -During the Christmas holidays, there was no staff person on the special care unit on 3rd shift. -The SIC tried to assist in both the assisted living	D 465	The Manager on Duty for each weekend will communicate any staffing needs to the appropriate Care Manager, who will, in turn, communicate those needs to the Executive Director should a solution need to be found that will satisfy the staffing requirements. A binder as a communication tool for the "Managers On Duty" will be kept to include information that the "Manager On Duty"would communicate to the the ED to review every Monday for follow up. Audits of the time clock reports will be conducted on Monday by the Executive Director, or her designee, to assure that corrective action is affective and that staffing required is being met. These reports will be initialed and kept with the Daily Sheets , in the Resident Care Manager's Office	2/27/16 ongoing 2/22/16 & ongoing 2-27-16

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D 465	Continued From page 46 side and the special care side when staffing is low but is overwhelmed due to frequent call outs. -The administrator has been told about the need for more staffing. Refer to interview with Corporate Director and Administrator on 2/1/16 at 3:00pm.	D 465	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least	D 468	It is the policy of The Currituck House for staff hired to work in the Special Care Unit will receive the required Special Care Unit training at the time of orientation as required by rule 10A NCAC 13F .1309. Documentation will be kept in each personnel file. All personnel training records for the staff assigned to work on the Special Care Unit were audited to identify any missing staff training requirements.	2/22/16 3/11/16

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D 468	Continued From page 47 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure six of seven sampled staff (Staff B, C, D, E, F and G) assigned to perform duties in the special care unit received 6 hours of training within the first week of employement in addition to the 20 hours additional training within 6 months of employment specific to the population to be served. The findings are: Review of the Staff B, C, D, E, F and G's personnel records revealed: -Each was hired with a dual roles as a medication aides and personal care assistant and worked on the special care unit. -None completed the 6 hours within the first week of employment and the 20 hour training for the special care unit within six months of hire. -Only Staff C's personnel had a dementia certificate with one continuing education credit related to bathing on the special care unit. -All had worked for the facilty for greater than 6 months. Review of the facility work time logs and schedules for December 2015 and January 2106 revealed all staff had worked on the special care unit. Interview with the Administrator on 1/29/16 at 3:00pm revealed: -She was certain that Staff B, C, D, E, F and G had been certified to work the special care unit.	D 468	Any personnel assigned to work on the Special Care Unit identified as missing required training will receive the required training and will have documentation of that training maintained in their personnel training file. The Executive Director, or her designee, will utilize an audit tool to be used to quickly identify any personnel who are not in compliance with the Special Care Unit training requirements. The Executive Director, as a part of the QI process, will conduct monthly audits of the personnel training records to assure that all staff meet the minimum training requirements. These audits will be kept in the QA binder.	4/30/16 3/11/16 3/17/16

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D912	Continued From page 49 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, resident rights and medication administration. The findings are: 1. Based on observations, interviews, and record review, the facility failed to ensure supervision for 1 of 7 sampled residents with continued falls that resulted in injuries (#5). [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type A2 Violation)] 2. Based on observations and interviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to their bedroom doors being unlocked and accessible without the need to ask for staff assistance when entering or exiting their rooms. [Refer to Tag D338, 10A NCAC 13F .0909. (Type B Violation)] 3. Based on observation, record reviews and interviews, the facility failed to administer medication such as cardiovascular agents, antidepressants, seizure medications, hypnotic medications and medications for diabetes for 2 of 5 sampled Residents (#5, #3). [Refer to Tag D358, 10A NCAC 13F .1004(a).	D912	Resident Rights review was conducted on 2/8/16. Please refer to Tag D270 Resident Rights review was conducted on 2/8/16. Please refer to Tag D338 Resident Rights review was conducted on 2/8/16. Please refer to Tag D358	3/2/16 3/17/16 3/2/16

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D912	Continued From page 50 (Type A1 Violation)]	D912	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews, employee record reviews, the facility failed to assure 5 of 7 sampled medication aides (B, C, D, E and G) had completed the state mandated infection control course. The findings are: 1. Review of Staff B's employee records revealed: -A hire date of 8/6/14 -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff B was unavailable for interview.	D934	It is the policy of The Currituck House to assure that all Medication Aides receive the required Infection Control Training in accordance with G.S. 1310-4.SB ACH Infection Control Within 60 days of hire and annually, all Medication Aides will receive the required "State Approved" Infection Control Training and signed by a licensed nurse. The training documentation will be kept in a binder located in the BOM's office. All Medication Aide personnel training files were audited to identify any missing staff who had not received the training .	2/22/16 3/11/16

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D934	Continued From page 51 2. Review of Staff C's employee records revealed: -A hire date of 7/25/14 -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff C was unavailable for interview. 3. Review of Staff D's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff D was unavailable for interview. 4. Review of Staff E's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff E was unavailable for interview. 5. Review of Staff G's employee records revealed: -Job title was Medication Aide -No state-mandated annual infection control course was available. Staff G was unavailable for interview. Interview with Staff B on 1/29/16 at 1:15pm revealed: -Staff completed in-services/trainings on the computer and then management give us forms to sign stating we completed the training. -The Administrator provided training information and updates when we have staff meetings.	D934	Any Medication Aides identified as missing the Infection Control Training will be required to receive the training and will have documentation of that training in their personnel training file. This training will be provided by a licensed nurse. Documentation will be kept in the BOM's office. The Executive Director, or her designee, will utilize an audit tool to be used to quickly identify any Medication Aides who are not in compliance with the Infection Control training requirements. The Executive Director, as a part of the QI process, will conduct routine audits of the personnel training records to assure that all Medication Aides meet the minimum training requirements with regards to Infection Control.	3/17/16 3/11/16 3/17/16 & ongoing

Currituck House
Additional POC Changes – 5-3-16

Tag D273 (pg. 17-18)

The Primary Care Provider is to be notified of ALL areas outside of identified parameters OR any other abnormalities including any identified parameters.

Tag D338 (pg. 23)

Rounds will be made by the Executive Director/her designee and Maintenance/Housekeeping, a minimum of weekly, checking to assure that closed resident doors on the Special Care Unit, in rooms unoccupied, are not locked. This will be documented.

Tag D344 (pg . 27)

The Executive Director, or her designee, will audit all medication orders received at the time of admission or re-admission for accuracy. These will be documented/initialed. The FL2/Medication Clarification form will be utilized for this purpose.

Tag D358 (pgs. 32-34)

Care Managers and Medication Aides will be responsible for verifying, as needed, physician's orders as residents are admitted, readmitted or new orders are written by the physician, now and ongoing. This will be documented/initialed on the FL2 Clarification form. The ED or designee will conduct a random audit weekly for a month; then monthly to ensure that physician's orders for residents who are admitted, readmitted or who receive new orders are being clarified, when needed. Documentation of audits will be located in the QA binder.

Lorri Duncan-Marcil, ED 5/3/16
Currituck House

Currituck House
Additional POC Changes – 5-12-16

Tag D273 (pg. 17-18)

The Primary Care Provider is to be notified of ALL areas outside of identified parameters OR any other abnormalities including any identified parameters.

Tag D338 (pg. 23)

Rounds will be made by the Executive Director/her designee and Maintenance/Housekeeping, a minimum of weekly, checking to assure that closed resident doors on the Special Care Unit, in rooms unoccupied, are not locked. This will be documented.

Tag D344 (pg . 27)

The Executive Director, or her designee, will audit all orders received at the time of admission, re-admission, or subsequent orders a minimum of weekly, for accuracy. These will be documented/initialed. The Medication/Order Clarification form will be utilized for this purpose.

Tag D358 (pgs. 32-34)

Care Managers and Medication Aides will be responsible for verifying, as needed, physician's orders as residents are admitted, readmitted or new orders are written by the physician, now and ongoing. This will be documented/initialed on the Clarification form. The ED or designee will conduct a random audit weekly for a month; then monthly to ensure that physician's orders for residents who are admitted, readmitted or who receive new orders are being clarified, when needed. Documentation of audits will be located in the QA binder.

At the time of admission, re-admission or when subsequent orders are received from the provider, the Care Manager will write a clarification order for all medication orders requiring additional clarification. Once completed, signed and faxed to the pharmacy, the Med Tech will assure that the medication is received from the pharmacy within 24 hours and will immediately notify the Care Manager or Executive Director if not received. At that time, the Care Manager or Executive Director will contact the pharmacy regarding delivery and will utilize the designated backup pharmacy, if necessary.

The Care Managers will check the current orders against the medications upon weekly pharmacy delivery to assure that they are on hand to administer.

Accepted - approved
5/16/16 JSE

Lauri Duncan-Marsh, ED 5/12/16