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	HAL047011	A. BUILDING: _____ B. WING _____	R 05/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT WAYSIDE	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/19/16 - 05/20/16 and 05/23/16.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to administer medications as ordered for 2 of 7 residents (#7, #8) observed during the medication passes, including errors with medication for diabetic neuropathy, high cholesterol, depression, low magnesium, prevention of heart disease, a folic acid supplement (#7) and a topical gel for pain and inflammation (#8) and 3 of 5 residents (#2, #3, #4) sampled for record review including errors with insulin (#2, #4), a diuretic (#4), and an error with an oral antifungal medication (#3). The findings are:	{D 358}		

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{D 358}	Continued From page 1 1. The medication error rate was 21% as evidenced by the observation of 7 errors out of 33 opportunities during the 4:00 p.m. / 4:30 p.m. medication pass on 05/19/16 and the 8:00 a.m. / 9:00 a.m. medication pass on 05/20/16. A. Review of Resident #7's current FL-2 dated 05/18/16 revealed the resident's diagnoses included anemia, difficulty walking, muscle weakness, chronic ischemic heart disease, hyperlipidemia, enlarged prostate without lower urinary tract symptoms, hypertension, and pressure ulcer of left and right heel - unstageable. Review of Resident #7's Resident Register revealed the resident was admitted to the facility from a rehabilitation nursing center on 05/19/16. a. Review of Resident #7's current FL-2 dated 05/18/16 revealed: -There was an order for Gabapentin 300mg at bedtime. (Gabapentin may be used to treat nerve pain. Gabapentin is the generic name for Neurontin.) -There was an order for Neurontin 100mg twice daily. (Neurontin is the brand name of Gabapentin.) Review of Resident #7's handwritten May 2016 medication administration record (MAR) revealed: -There was a handwritten entry on the first page of the MAR for Gabapentin 300mg 1 capsule at bedtime and it was scheduled to be administered at 8:00 p.m. -There was a handwritten entry on the second page of the MAR for Neurontin 100mg 1 capsule twice daily and it was scheduled to be administered at 8:00 a.m. and 8:00 p.m.	{D 358}		

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{D 358}	Continued From page 2 Observation during the 8:00 a.m. medication pass on 05/20/16 revealed: -The medication aide (MA) prepared and administered Gabapentin 300mg to Resident #7 at 9:42 a.m. -Gabapentin 300mg was administered during the 8:00 a.m. medication pass instead of 8:00 p.m. as ordered. -No Gabapentin 100mg was administered to the resident. -The MA documented her initials for the 8:00 p.m. dose of Gabapentin 300mg and the 8:00 a.m. dose for Neurontin 100mg on the MAR as administered. Interview with the MA on 05/20/16 at 10:04 a.m. revealed: -Resident #7 was new and was just admitted to the facility on the previous day. -This was the first time she had administered any medications to him. -She could not find any Neurontin 100mg on hand for Resident #7. -She did not know why she initialed the Neurontin 100mg as administered. -She had not noticed the scheduled time for the Gabapentin 300mg was 8:00 p.m. -She should not have administered the Gabapentin 300mg during the morning medication pass. Refer to interview with the Resident Care Director (RCD) on 05/20/16 at 10:50 a.m. b. Review of Resident #7's current FL-2 dated 05/18/16 revealed an order for Lipitor 80mg at bedtime. (Lipitor lowers cholesterol and triglycerides.) Review of Resident #7's handwritten May 2016	{D 358}		

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{D 358}	Continued From page 3	{D 358}		

medication administration record (MAR) revealed:
-There was a handwritten entry for Lipitor 80mg 1 tablet at bedtime.
-Lipitor was scheduled to be administered at 8:00 p.m.

Observation during the 8:00 a.m. medication pass on 05/20/16 revealed:
-The medication aide (MA) prepared and administered Lipitor 80mg to Resident #7 at 9:42 a.m.
-Lipitor 80mg was administered during the 8:00 a.m. medication pass instead of 8:00 p.m. as ordered.
-The MA documented her initials for the 8:00 p.m. dose of Lipitor 80mg on the MAR as administered.

Interview with the MA on 05/20/16 at 10:04 a.m. revealed:
-Resident #7 was new and was just admitted to the facility on the previous day.
-This was the first time she had administered any medications to him.
-She had not noticed the scheduled time for the Lipitor 80mg was 8:00 p.m.
-She should not have administered the Lipitor during the morning medication pass.

Refer to interview with the Resident Care Director (RCD) on 05/20/16 at 10:50 a.m.

c. Review of Resident #7's current FL-2 dated 05/18/16 revealed an order for Zoloft 75mg once daily. (Zoloft is an antidepressant.)

Review of Resident #7's handwritten May 2016 medication administration record (MAR) revealed:
-There was a handwritten entry for Zoloft 75mg take 1 tablet once a day.

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{D 358}	Continued From page 4 -Zoloft was scheduled to be administered at 8:00 a.m. Observation during the 8:00 a.m. medication pass on 05/20/16 revealed: -The medication aide (MA) prepared and administered one Zoloft 25mg tablet to Resident #7 at 9:42 a.m. -Zoloft 25mg was administered instead of Zoloft 75mg as ordered. -The MA documented her initials for Zoloft 75mg on the MAR as administered. Review of the medication on hand for Resident #7 on 05/20/16 revealed: -There was a supply of Zoloft 25mg tablets on hand. -The instructions on the label were to take 3 tablets once daily (= 75mg). Interview with the MA on 05/20/16 at 10:04 a.m. revealed: -Resident #7 was new and was just admitted to the facility on the previous day. -This was the first time she had administered any medications to him. -She thought the handwritten entry on the MAR for Zoloft looked like 75mg when she first looked at it. -When she saw the medication label had 25mg, she just thought she misread the writing on the MAR and it actually was 25mg instead of 75mg. -She did not notice the instructions on the label for the Zoloft 25mg was to take 3 tablets. -She should have administered 3 of the Zoloft 25mg tablets. Observation of the MA on 05/20/16 at 10:04 a.m. revealed the MA did not administer 2 additional Zoloft 25mg tablets to equal 75mg after the error	{D 358}		

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{D 358}	Continued From page 5 was brought to her attention. Refer to interview with the Resident Care Director (RCD) on 05/20/16 at 10:50 a.m. d. Review of Resident #7's current FL-2 dated 05/18/16 revealed an order for Folic Acid 1mg in the afternoon once daily. (Folic Acid is a supplement used to treat low levels of folate.) Review of Resident #7's handwritten May 2016 medication administration record (MAR) revealed: -There was a handwritten entry for Folic Acid 1mg 1 tablet in the afternoon daily. -Folic Acid was scheduled to be administered at 1:00 p.m. Observation during the 8:00 a.m. medication pass on 05/20/16 revealed: -The medication aide (MA) prepared and administered Folic Acid 1mg to Resident #7 at 9:42 a.m. -Folic Acid 1mg was administered during the 8:00 a.m. medication pass instead of 1:00 p.m. as ordered. -The MA documented her initials for the 1:00 p.m. dose of Folic Acid 1mg on the MAR as administered. Interview with the MA on 05/20/16 at 10:04 a.m. revealed: -Resident #7 was new and was just admitted to the facility on the previous day. -This was the first time she had administered any medications to him. -She had not noticed the scheduled time for the Folic Acid 1mg was 1:00 p.m. -She should not have administered the Folic Acid during the morning medication pass.	{D 358}		

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{D 358}	Continued From page 6 Refer to interview with the Resident Care Director (RCD) on 05/20/16 at 10:50 a.m. e. Review of Resident #7's current FL-2 dated 05/18/16 revealed an order for Magnesium Oxide 400mg twice daily. (Magnesium Oxide is used to treat low magnesium levels.) Review of Resident #7's handwritten May 2016 medication administration record (MAR) revealed: -There was a handwritten entry for Magnesium Oxide 400mg 1 tablet twice daily. -Magnesium Oxide was scheduled to be administered at 8:00 a.m. and 8:00 p.m. Observation and interview during the 8:00 a.m. medication pass on 05/20/16 revealed: -The medication aide (MA) prepared and administered Resident #7's morning medications at 9:42 a.m. -The MA did not prepare and administer any Magnesium Oxide to the resident. -When the MA returned to the medication cart, she flipped to the MAR for the next resident. -When asked by surveyor, the MA stated she had completed administration of Resident #7's morning medications. -The MA then flipped back to Resident #7's MARs and began initialing beside the medications. -The MA documented her initials for the 8:00 a.m. Magnesium Oxide dose as administered. -When asked about the Magnesium Oxide, the MA looked at the MAR and then checked the medication cart. -She could not locate any Magnesium Oxide in the storage area for Resident #7's medications. -The MA then opened the bottom drawer of the medication cart where the oversupply medication was stored. -The MA found a bubble card with Resident #7's	{D 358}		

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{D 358}	Continued From page 7	{D 358}		

Magnesium Oxide 400mg tablets.
-None of the tablets had been punched from the card.
-The MA stated she had overlooked the Magnesium Oxide and should have administered it with the resident's other morning medications.
-The MA prepared the Magnesium Oxide 400mg and administered it to Resident #7 at 9:50 a.m.

Refer to interview with the Resident Care Director (RCD) on 05/20/16 at 10:50 a.m.

f. Review of Resident #7's current FL-2 dated 05/18/16 revealed an order for Aspirin 81mg once daily. (Aspirin is used to prevent heart disease.)

Review of Resident #7's handwritten May 2016 medication administration record (MAR) revealed:
-There was a handwritten entry for Aspirin 81mg 1 tablet once daily.
-Aspirin was scheduled to be administered at 8:00 a.m.

Observation and interview during the 8:00 a.m. medication pass on 05/20/16 revealed:
-The medication aide (MA) prepared and administered Resident #7's morning medications at 9:42 a.m.
-The MA administered Magnesium Oxide to the resident at 9:50 a.m. after being prompted by surveyor.
-The MA did not prepare and administer any Aspirin 81mg to the resident although she documented her initials for the 8:00 a.m. Aspirin 81mg dose as administered.
-When the MA returned to the medication cart for the second time, she again flipped to the MAR for the next resident.
-When asked by surveyor, the MA stated she had completed administration of Resident #7's

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{D 358}	Continued From page 8 morning medications. -When asked about the Aspirin, the MA looked at the MAR and then checked the medication cart. -She could not locate any Aspirin in the storage area for Resident #7's medications. -The MA then opened the bottom drawer of the medication cart where the oversupply medication was stored. -The MA found a card with Resident #7's Aspirin 81mg tablets. -None of the tablets had been punched from the card. -The MA stated she had overlooked the Aspirin and should have administered it with the resident's other morning medications. -The MA prepared the Aspirin 81mg and administered it to Resident #7 at 10:07 a.m. Refer to interview with the Resident Care Director (RCD) on 05/20/16 at 10:50 a.m. _____ Interview with the Resident Care Director (RCD) on 05/20/16 at 10:50 a.m. revealed: -Resident #7 was admitted to the facility yesterday on 05/19/16. -The RCC did not transcribe the orders on the current MAR for Resident #7. -Staff used the FL-2 dated 05/18/16 to transcribe the orders on the MAR. -The RCD had been working on putting Resident #7's record together but she had not reviewed the orders and the MAR yet. -Medication aides had been trained to read the MARs and the medication labels to make sure everything matched. -If something did not match, the MAs should stop and find out why it did not match. -MAs were supposed to let the RCD know if there were any discrepancies in the order, MARs, or	{D 358}		

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medication labels.
-Resident #7 was going to be seen by the facility's contracted physician today and she would have the physician to verify/clarify the medication orders.

B. Review of Resident #8's current FL-2 dated 05/18/16 revealed the resident's diagnoses included arthritis - age related, physical disability, muscle weakness, decreased coordination, unsteadiness on feet, lumbar stenosis, generalized weakness, diabetes mellitus, hypertension, and gastroesophageal reflux disease.

Review of a physician's order dated 04/29/16 for Resident #8 revealed an order for Voltaren Gel 1% apply 2 grams to knees 4 times a day. (Voltaren Gel is a topical medication used to treat pain and inflammation associated with arthritis.)

Review of the May 2016 medication administration record (MAR) revealed:
-There was an entry for Voltaren Gel 1% apply 2 grams to knees 4 times a day.
-Voltaren Gel was scheduled to be administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.

Observation of the 4:00 p.m. medication pass on 05/19/16 revealed:
-The medication aide (MA) put on gloves and a squirted a pea-sized amount of Voltaren Gel onto the tips of her fingers.
-The amount administered could not be determined.
-The MA rubbed the Voltaren Gel onto the Resident #8's right knee while the resident was sitting in her wheelchair.
-The MA did not use the plastic measuring device in the plastic bag with the tube of Voltaren Gel.

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{D 358}	Continued From page 10 -The MA did not rub any Voltaren Gel onto the resident's left knee. -The resident did not complain of any pain. Observation of medications on hand on 05/20/16 revealed: -There was a manufacturer supplied measuring device stored with Resident #8's tube of Voltaren Gel. -The flat plastic device had markings to measure 2 grams and 4 grams. Interview with the MA on 05/19/16 at 5:45 p.m. revealed: -The MA would usually apply the Voltaren Gel to both of the resident's knees when the resident was lying in bed. -The MA only applied the Voltaren Gel to the resident's right knee when the resident was sitting in the wheelchair because the resident usually complained about the right knee hurting when she was sitting in the chair. -The MA had not seen the measuring device in the bag with the tube of Voltaren. -She did not know what the measuring device was used for and she did not know how to use the device. -She had always just squirted a small amount onto her gloved hand an applied the gel. Interview with the Resident Care Director (RCD) on 05/19/16 at 6:00 p.m. revealed: -The MAs had been trained to read the MARs and administer the medications according to the orders. -The MA should use the measuring device for the Voltaren Gel and the MA should not estimate the dosage. -She would make sure all of the MAs knew how to use the measuring device for the Voltaren Gel.	{D 358}		

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{D 358}	Continued From page 11 2. Review of Resident #4's current FL-2 dated 10/23/15 revealed the resident's diagnoses included dementia, insulin dependent diabetes mellitus, hypertension, hypothyroidism, and history of urinary tract infection. A. Review of Resident #4's current FL-2 dated 10/23/15 revealed an order for Lasix 40mg 1 tablet daily. (Lasix is a diuretic used to treat swelling.) Review of a nephrology visit form for Resident #4 dated 03/03/16 revealed: -The nephrologist noted the resident had edema (swelling) and elevated blood pressure. -The nephrologist ordered to increase Lasix to 40mg twice daily. Review of an order dated 03/21/16 for Resident #4 from the primary care physician (PCP) revealed an order for Lasix 20mg once daily. Review of a form faxed to the PCP for Resident #4 revealed: -The facility notified the PCP that the nephrologist had increased the resident's Lasix dose to 40mg twice daily on 03/03/16. -The facility noted the PCP's order dated 03/21/16 for Lasix 20mg daily and requested clarification. -The PCP wrote a clarification order dated 03/22/16 to administer Lasix 40mg twice daily as ordered by the nephrologist. Review of the March 2016 medication administration record (MAR) revealed: -There was an entry for Lasix 40mg twice daily and it was documented as administered twice daily from 03/03/16 - 03/21/16.	{D 358}		

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{D 358}	Continued From page 12 -There was an entry for Lasix 20mg once daily and it was documented as administered from 03/21/16 - 03/31/16. -There was no documentation the Lasix 40mg twice daily dose was started back when clarified on 03/22/16. Review of a nephrology visit form for Resident #4 dated 03/31/16 revealed: -The nephrologist noted the resident's blood pressure was well controlled. -The nephrologist noted the resident had increased lower extremity edema but otherwise doing well overall. -There was no medication orders on the form and the resident was to follow up in 6 months. Review of the April 2016 and May 2016 MARs revealed: -There was an entry for Lasix 20mg once daily and it was documented as administered daily at 8:00 a.m. from 04/01/16 - 05/19/16. -There was no entry on the MARs for Lasix 40mg twice daily. Interview with a medication aide on 05/19/16 revealed: -She had noticed the Lasix order written by the PCP on 03/21/16 did not match the Lasix order written by the nephrologist on 03/03/16. -She faxed the PCP on 03/21/16 to get clarification. -She was not working the next day when the PCP clarified the order on 03/22/16. -She was not aware the clarification order to administer Lasix 40mg twice daily had not been implemented. -The medication aide on duty at the time an order was received was responsible for transcribing the order on the MAR and faxing it to the pharmacy.	{D 358}		

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{D 358}	Continued From page 13 -There was a tracking order sheet that should be filled out and attached to the order and put in box for the Resident Care Director. -She did not see a tracking order sheet for the clarification order for Lasix on 03/22/16. -Resident #4's were always a little swollen and the resident had to wear compression hose every day. Interview with a second medication aide on 05/20/16 at 4:10 p.m. revealed Resident #4's legs had always been swollen since she was admitted to the facility. Review of Resident #4's vital sign and weight flow sheet revealed: -The resident's blood pressure (BP) ranged from 136/70 - 166/77 in February 2016. -The resident's BP was 169/84 on 03/14/16. -The resident's BP was 138/65 on 04/03/16. -The resident's BP was 130/76 on 05/09/16. -The resident's weight was 153 pounds during first week of February 2016 (exact date not specified.) -The resident's weight was 166 pounds on 03/14/16. -The resident's weight was 173 pounds on 04/03/16. -The resident's weight was 169 pounds on 05/09/16. Interview with the Resident Care Director (RCD) on 05/19/16 at 6:28 p.m. revealed: -She had just started working at the facility about 3 weeks ago. -The medication aide on duty was responsible for faxing new orders to the pharmacy and transcribing them on the MARs. -The order then gets put in her box for review. -She was not working at the facility in March 2016	{D 358}		

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{D 358}	Continued From page 14	{D 358}		

when the order for Lasix was clarified.
-She did not recall seeing anything in her box related to the Lasix order for Resident #4.
-She was aware the resident had a kidney transplant in the past and was seeing a nephrologist.
-She would notify the PCP and the nephrologist about the Lasix error and clarify which dose the resident should be taking.

Review of a note faxed to the primary care physician for Resident #4 on 05/19/16 revealed:
-The facility notified the PCP of the medication error with the Lasix.
-The facility noted Resident #4's lower extremities still had some swelling and her blood pressure was 118/72.
-The PCP wrote an order dated 05/20/16 to change Lasix to 20mg twice daily and continue to monitor blood pressure.

Interview with the RCD on 05/23/16 at 11:10 a.m. revealed:
-She had looked at Resident #4's lower extremities today.
-Resident #4 had some bilateral lower extremity with 1+ pitting edema.

Telephone interview with a nurse at the PCP's office on 05/23/16 at 4:36 p.m. revealed:
-The facility notified the PCP office of the error with Lasix on 05/19/16.
-The PCP was unavailable for interview.
-The PCP clarified the order to give Lasix 20mg twice daily.
-The PCP ordered 20mg instead of 40mg because the resident was having swelling but her vital signs were on the lower side of normal.
-The resident's next appointment with the PCP was on 05/25/16 and the PCP would evaluate the

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{D 358}	Continued From page 15 resident at that time. Telephone interview with the nurse at the nephrologist's office on 05/23/16 at 4:45 p.m. revealed: -The facility notified the nephrologist's office of the error with Lasix on 05/19/16. -The nephrologist had been out of the office for a few days and was unavailable for interview. -She was trying to reach the nephrologist via telephone to report the medication error to him. -She would contact the facility regarding the Lasix dosage once the nephrologist had contacted her. Interview with the Resident Care Director (RCD) on 05/23/16 at 5:25 p.m. revealed: -The RCD just received a telephone order for Resident #4's Lasix. -The nephrologist gave an order to administer Lasix 40mg twice daily to the resident. B. Review of physician's orders for Resident #4 revealed: -There was an order dated 01/25/16 for Lantus insulin 4 units at bedtime. (Lantus is long-acting insulin used to lower blood sugar.) -There was an order dated 11/17/15 for Humalog 8 units with meals, if fingerstick blood sugar (FSBS) was less than 90 - hold Humalog. (Humalog is a rapid-acting insulin used to lower blood sugar.) Review of the March 2016, April 2016, and May 2016 medication administration records (MARs) revealed: -There was an entry for Lantus 4 units at bedtime and it was scheduled to be administered at 8:00 p.m. -Lantus was documented as held and not administered on 03/15/16 for a FSBS of 75.	{D 358}		

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{D 358}	Continued From page 16 -Lantus was documented as held and not administered on 03/24/16 for a FSBS of 95. -Lantus was documented as held and not administered on 04/02/16 for a FSBS of 57. -Lantus was documented as held and not administered on 04/03/16 for a FSBS of 51. -Lantus was documented as held and not administered on 04/08/16 for a FSBS of 87. -Lantus was documented as held and not administered on 04/15/16 for a FSBS of 89. -The resident's FSBS ranged from 44 - 348 in March 2016, 51 - 405 in April 2016, and 57 - 361 in May 2016. -Humalog was documented as being held as ordered from 03/2016 - 05/2016. Interview with a medication aide on 05/20/16 at 4:05 p.m. revealed: -She would sometimes hold a resident's insulin if the FSBS was running low. -She could not give a specific parameter of when she usually held the insulin. -She was afraid the resident's blood sugar would get too low if she gave the insulin and the blood sugar was already on the low side. Interview with the Resident Care Director (RCD) on 05/20/16 at 3:15 p.m. revealed: -The medication aides should not hold insulin without an order to hold the insulin. -She had just started working at the facility about 3 weeks ago and she was not aware staff was holding Resident #4's Lantus insulin without an order. -There was an order to hold Resident #4's Humalog insulin but not the Lantus insulin. -She would retrain the medication aides about insulin administration. Based on observation, interview, and record	{D 358}		

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{D 358}	Continued From page 17 review, Resident #4 was not interviewable. 3. Review of Resident #3's current FL-2 dated 08/26/15 revealed the resident's diagnoses included Alzheimer's dementia, hypertension, and scoliosis. Review of a physician's order dated 04/25/16 for Resident #3 revealed an order for Diflucan 150mg take 1 tablet weekly, 04/26/16, 05/03/16, and each week thereafter. (Diflucan is an antifungal.) Review of the April 2016 medication administration record (MAR) revealed: -There was a handwritten entry for Diflucan 150mg take 1 tablet a week for 4 weeks, start 04/26/16, 05/03/16, each week thereafter. -Diflucan was documented as administered daily on 04/26/16, 04/27/16, and 04/28/16 instead of weekly as ordered. Review of the May 2016 MAR revealed: -There was a handwritten entry for Diflucan 150mg 1 tablet by mouth weekly. -Diflucan was scheduled to be administered at 8:00 a.m. and marked as being due on 05/03/16, 05/10/16, and 05/17/16. -Diflucan was documented as administered on 05/03/16. -Diflucan was documented as not given, awaiting clarification on 05/10/16. -Diflucan was documented as refused on 05/17/16. Review of medications on hand for Resident #3 on 05/20/16 revealed there was no Diflucan on hand for the resident. Review of pharmacy dispensing records dated	{D 358}		

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{D 358}	Continued From page 18 01/01/16 - 05/23/16 for Resident #3 revealed 4 Diflucan 150mg tablets were dispensed on 04/25/16. Interview with the Resident Care Director (RCD) on 05/23/16 at 11:10 a.m. revealed: -The Diflucan was ordered for Resident #3's toenail fungus. -There was an error with the Diflucan in April 2016 when a medication aide gave the Diflucan daily from 04/26/16 - 04/28/16. -Another medication aide noticed the error on 04/30/16 and reported it to the RCD. -The RCD told the physician about the error. -She was not aware there was currently no Diflucan available to be administered to the resident. -She would contact the physician and pharmacy about the Diflucan. Based on observation, interview, and record review, Resident #3 was not interviewable. Review of a physician's order dated 05/23/16 revealed an order to discontinue Diflucan now. 4. Review of Resident #2's current FL-2 dated 03/19/16 revealed diagnoses included hyperglycemia and diabetes mellitus. Review of a prescription in Resident #2's record revealed: -There was an order dated 04/27/16 to start Novolog insulin 5 units twice a day. (Novolog is a short-acting insulin used to lower elevated blood sugar levels.) Review of Resident #2's medication administration record (MAR) for April 2016 revealed:	{D 358}		

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{D 358}	Continued From page 19 -There was an entry for Novolog sliding scale coverage four times a day. -There was no entry for Novolog insulin 5 units to be administered twice daily. Review of Resident #2's MAR for May 2016 revealed: -There was a handwritten entry for Novolog 5 units twice daily and it was dated 05/02/16. -The first dose of Novolog 5 units twice daily was documented as administered on 05/03/16 at 8:00 a.m. Review of Resident #2's blood sugar logs for April 2016 revealed: -The 8:00 a.m. blood sugars ranged from 167 to 412 . -The 12:00 p.m. blood sugars ranged from 243 to 466. -The 4:30 p.m. blood sugars ranged from 200 to 490. -The 8:00 p.m. blood sugars ranged from 247 to 464. Review of Resident#2's blood sugars logs for 05/01/16 and 05/02/16 revealed blood sugars ranged from 166 to 426. Interview with a medication aide (MA) on 05/23/16 at 3:15 p.m. revealed: -The MA could not explain the delay in implementation of the 04/27/16 order. -The Novolog insulin supply for the sliding scale was also being used to administer the scheduled dose of Novolog twice daily. Interview with the Resident Care Director on 05/23/16 at 4:20 p.m. revealed she could not explain the delay of when the order was written and when it was implemented.	{D 358}		

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{D 358}	Continued From page 20 Attempted contact with the ordering physician was unsuccessful. _____ Review of the facility's plan of protection dated 05/20/16 revealed: -Administrator and nurse immediately notified physician of medication errors with Resident #7 so the physician could assess the situation. -Resident #8's physician was notified of the medication error with the topical gel. -Facility contacted primary physician for Resident #4 to clarify Lasix dose and medication dose was corrected. -Resident #4's nephrologist will also be contacted regarding the Lasix dosage. -Medication error reports were completed. -All medication aides will be shadowed / observed by the ED, RCD, or designee biweekly for 3 months to ensure medication administration accuracy. -ED, RCD, or designee will review new order tracking daily when on-site. -Random record audits will be done biweekly for 3 months by RCD, ED, or designee and ongoing. -In-services will be done for medication aides regarding medication administration within the next week by the RCD, ED, or designee. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 7, 2016.	{D 358}		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and	D 438		

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D 438	Continued From page 21 supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report known allegations of a staff person (Staff H) dancing in an inappropriate manner with a resident (#6) with dementia within 24 hours of becoming aware of the allegations. The findings are: Review of Resident #6's current FL-2 dated 04/22/16 revealed: -The resident's diagnoses included Alzheimer's dementia. -The resident was constantly disoriented. Interview with the Administrator on 05/20/16 at 12:55 p.m. revealed: -She received a phone call from a personal care aide (PCA) /medication aide (MA) on Monday night, 05/16/16 about 8:15 p.m. -The PCA/MA reported she saw Staff H dancing around in front of Resident #6 about 2:00 p.m. that day in the secured unit of the facility. -The PCA/MA reported that Staff H was "all over" the resident. -When the Administrator returned to the facility the next day on Tuesday, 05/17/16, she shared the concerns with the Resident Care Director (RCD). -She told Staff H about the allegations against him that day on 05/17/16 and sent him home until they could investigate. -She and the RCD started an investigation that day on Tuesday, 05/17/16 and interviewed staff. -All of the staff they interviewed reported the staff	D 438		

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in the secured unit were dancing and playing music in the common living room.
-The PCA/MA reported she saw a picture of Staff H dancing.
-Another PCA reported she had a photo of Staff H dancing but it was deleted.
-She never saw a photo.
-She and the RCD did not feel like the allegation against Staff H was substantiated.
-She did the 24 hour report and faxed it to the Health Care Personnel Registry (HCPR).
-She would get a copy of the report to verify what date she sent it to the HCPR.
-The staff person who reported the allegation no longer worked at the facility but that was not related to her reporting the allegation.
-The facility's policy was to investigate any allegations of abuse and report it to the HCPR using the 24 hour report and the 5 day working report.

Interview with Staff H on 05/20/16 at 1:52 p.m. revealed:
-When he came to work on Monday, 05/16/16, he found out about the allegation about the dancing on Friday, 05/13/16.
-The Administrator stated another staff person had reported the allegation to the Administrator on Friday, 05/13/16, that Staff H was dancing and touching all over Resident #6.
-On 05/13/16, staff and residents in the secured unit were playing music and dancing.
-He and other staff danced with many residents including Resident #6.
-Staff would sometimes hold the residents' hands and they would swing their arms while moving to the music.
-Resident #6 was sitting down so he held Resident #6's hands to get her to smile and he squatted down so he would be eye to eye with

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her.
-No one voiced any concerns or complaints to him that day on 05/13/16.
-The Administrator suspended Staff H on Monday, 05/16/16, until she could complete the investigation.
-He had not seen any photos or videos related to the allegation.
-The Administrator called him on Wednesday, 05/17/16, and told him he could come back to work on 05/18/16.

Interview with a PCA on 05/20/16 at 2:15 p.m. revealed:
-She was working in the secured unit on 05/13/16 and staff was dancing with the residents including herself and Staff H.
-There was nothing inappropriate and the residents were laughing.
-She took a photo of Staff H dancing but there were no residents in the photo.
-She did not show the photo to anyone and the photo was deleted that same day.
-She thought she was interviewed by the Administrator last Friday, 05/13/16, about the incident.
-The Administrator told her not to take any photos.

Interview with a second PCA on 05/23/16 at 4:58 p.m. revealed:
-She as working on the AL side of the facility on 05/13/16.
-Another PCA assigned to the secured unit on 05/13/16 came to the AL side and showed a video to her from the PCA's cell phone.
-The video showed Staff H dancing and about 7 residents in the background.
-Resident #6 was sitting on the couch and Staff H was dancing in the common living room in front of

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the resident.
-Staff H was standing up and he was touching Resident #6.
-Staff H has a big personality and he liked to get the residents moving around.
-Staff H was dancing a dance called the "wobble" which included shaking his hips and "booty".
-She did not think the dance was offensive but she was not sure how the dance would look to the older generation.
-The residents did not seem to be concerned and Resident #6 was smiling.
-The video was shown to her and one other staff person working on the AL side of the facility that day.
-She was interviewed by the Administrator and the RCD about the incident on Tuesday, 05/17/16.
-She did not recall telling them about the video because the video was erased on 05/13/16.

Interview with a former staff person on 05/23/16 at 12:42 p.m. revealed:
-She was working on the AL side of the facility on 05/13/16 when a PCA from the secured unit came and showed her a video of Staff H dancing with Resident #6.
-Resident #6 was sitting on the couch and Staff H was standing in front of Resident #6 "pumping" his hips left and right and leaned back and "pumped" his hips back and forth.
-Staff H was "shaking his butt" in Resident #6's face and Resident #6 was just sitting and smiling.
-She told the PCA she needed to delete the video and she walked away.
-She was concerned about it so she called the Administrator that night on 05/13/16 between 7:00 p.m. and 7:30 p.m.
-She worked over the weekend but Staff H did not work.

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-When she returned to work on Tuesday, 05/17/16, the Administrator asked her about the incident and the Administrator told her not to say a word to anyone about the incident.
-She went back to the Administrator the next day, 05/18/16 and the Administrator "blew her off".

Review of the 24 hour initial report to the HCPR revealed:
-The incident date was handwritten at "Friday 13th 2016" at 1:00 p.m.
-The date of 05/13/16 had been written over and replaced with "Monday 16th 2016".
-The allegation description was a nursing assistant "danced with resident inappropriate manner".
-The Administrator signed the report and the date was handwritten and 05/17/16 appeared to have been written over with 05/18/16 or vice versa.
-The attached fax confirmation sheet noted the 24 hour report was faxed to the HCPR on 05/18/16, 5 days after the allegation was reported to the Administrator.

Interview with the Administrator on 05/20/16 at 5:00 p.m. revealed:
-She was still working on the 5 day report for the HCPR.
-When asked about the discrepancy in the date of incident on the HCPR 24 hour report, she stated the incident occurred on 05/13/16.
-She was unsure if the date she signed the 24 hour report was 05/17/16 or 05/18/16.

Interview with the Resident Care Director (RCD) on 05/23/16 at 11:20 a.m.:
-The Administrator contacted the RCD on Saturday, 05/14/16.
-The Administrator told the RCD that a staff person reported to the Administrator that Staff H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047011	A. BUILDING: _____ B. WING _____	R 05/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT WAYSIDE	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(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
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had given Resident #6 a "lap dance" on Friday, 05/13/16.
-The staff person reported the alleged incident to the Administrator on Friday night, 05/13/16.
-The Administrator told the RCD that they would have to do an investigation.
-The Administrator and the RCD began the investigation of Monday, 05/16/16.
-They interviewed Staff H who explained that everyone in the secured unit of the facility was dancing, including residents and staff.
-Staff H and the other staff were trying to get the residents up and moving and get their energy flowing.
-Staff H reported he danced with Resident #6 on 05/13/16 as well as other residents.
-Staff H stated he held hands with Resident #6 when they danced.
-The Administrator and the RCD did not feel there was any "malice intent" by Staff H.
-Staff H was suspended until they could conclude their investigation.
-The RCD was working on Friday, 05/13/16 but she did not see the alleged incident.
-She heard some loud music that afternoon and stepped out of her office to see what was going on.
-She saw residents and staff dancing including line dances and the cha cha.
-Staff H was dancing at that time but not with Resident #6.
-Everyone seemed okay and she did not see anything inappropriate.
-No one voiced any concerns to her on that day, 05/13/16.
-The Administrator and the RCD interviewed at least 4 or 5 other staff about the alleged incident during their investigation.
-The staff person who reported the allegation was working on the assisted living (AL) side of the

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	HAL047011	A. BUILDING: _____ B. WING _____	R 05/23/2016

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D 438	Continued From page 27 facility on Friday, 05/13/16. -During the investigation, staff reported a photo was taken by a personal care aide (PCA) on 05/13/16. -Staff H was reported to be in the photo "acting goofy" but no residents were reported to be in the photo. -The RCD never saw a photo because it was reported to have been deleted on that same day of the alleged incident, 05/13/16. -After the investigation was concluded, they determined there was no sexual intentions during the dancing activity in the secured unit on 05/13/16. -The RCD had worked at the facility about 3 weeks and she was not aware of the requirements for reporting allegations of abuse to the HCPR. -The Administrator handled any paperwork for the HCPR. Interview with the Administrator on 05/23/16 at 6:45 p.m. revealed: -The date of the alleged incident was Friday, 05/13/16. -She signed the 24 hour HCPR report on 05/18/16. -She was unsure when she was notified of the alleged incident but she recalled she was contacted in the evening. -She revised the 24 our reported on 05/21/16 to show the alleged incident date as 05/13/16 and faxed that to the HCPR on 05/21/16 along with the 5 day HCPR report. Based on observation, interview, and record review, Resident #6 was not interviewable.	D 438		

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{D912}	Continued From page 28	{D912}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication administration. The findings are: Based on observation, interview, and record review, the facility failed to administer medications as ordered for 2 of 7 residents (#7, #8) observed during the medication passes, including errors with medication for diabetic neuropathy, high cholesterol, depression, low magnesium, prevention of heart disease, a folic acid supplement (#7) and a topical gel for pain and inflammation (#8) and 3 of 5 residents (#2, #3, #4) sampled for record review including errors with insulin (#2, #4), a diuretic (#4), and an error with an oral antifungal medication (#3). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	{D912}		