STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R-C 05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow up survey and complaint investigation on 5/4/16, 5/5/16, 5/6/16 , 5/9/16 and 5/10/16.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview and record review, the facility failed to assure each exit door accessible by residents had a functioning alarm or alert system device activated when the door was opened for 2 of 2 sampled residents (#5, and #6) with dementia and disorientation. The findings are: 1. Review of the current FL2 for Resident #6 dated 6/18/15 revealed:	D 067		

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D 067	Continued From page 1 -Diagnoses included depression and hypertension. -She was constantly disoriented. Review of Resident #6's resident register revealed she was admitted to the facility 8/30/12. Review of Resident #6's Care Plan dated 12/18/15 revealed: -Resident was constantly disoriented. -Resident had started to wander throughout the facility, and required close monitoring by staff. Confidential interviews with 6 staff members revealed: -Resident #6 went out the back door in the south hall and no one knew she left; the door did not alarm. -Resident #6 was eventually found in the back of the building about 11:30pm lying face down in a mud puddle, " it was cold out that night " . -The staff could not come up with a time frame of how long Resident #6 had been missing, but they found her around 11:30pm. -The resident went out of the door leading to the driveway. -Nothing really changed after the resident got out and was found in the back parking lot, there was still nothing to stop another resident from getting out. -The doors still malfunctioned sometimes, "I think the battery goes bad or something". -Those exit doors are not secure; they are battery operated. -Those batteries can go bad at any time. Interview with the Resident Care Coordinator (RCC) on 5/5/16 at 10:40am revealed: -Last year Resident #6 eloped out of the south hall door.	D 067		

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-Maintenance and the night shift supervisors started checking the alarms on the exit doors after that.
-The off-going evening shift and on-coming night shift supervisors checked the alarms on the exit doors every night, to ensure the alarms were functioning.
-If the alarm did not function properly they were instructed to call the maintenance director and sit a staff member at the exit door until the door was fixed.
-If the door was just in need of a battery change, there were 9 volt batteries on the medication cart so they could change the battery.
-The supervisors both documented on the Door Alarms Daily Inspections- 3rd Shift logs checking the alarms on the doors.
-The supervisors should make a notation on the sheet to document when the batteries were changed.
-The maintenance director and business office manager (BOM) monitored the sheets to assess the door alarm checks.
-The BOM should alert the RCC if staff were not doing the checks as instructed.

Review of the Door Alarms Daily Inspection logs for 3rd shift revealed:
-The logs were started 12/18/15.
-Two initials were on the lines documented next to the date and time.
-The logs were done daily 12/18/16 through 4/29/16.
-There was no documentation on the back of the forms to indicate there had been any battery changes.

Interview with a night shift supervisor on 5/5/16 at 11:10pm revealed:
-He checked all of the exit door alarms every

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D 067	Continued From page 3	D 067		

night he worked and signed off on the log.
-The supervisors had to start checking the doors after the resident got out last year.
-Back in November of last year he found one of the exit doors not functioning.
-He notified the maintenance director, and pulled a staff member to sit at the door until the maintenance director arrived, and fixed the door.
-He had never had to change a battery on any of the doors.

Interview with the BOM on 5/5/16 at 11:30pm revealed:
-She did not monitor the Door Alarm Daily Inspections- 3rd shift logs.
-The logs were in the book with the time census so she had seen them, but she did not do anything with them.

Interview with the Maintenance Director on 5/5/16 at 10:00am revealed:
-All of the exit doors with the exception of the front door were alarmed.
-The front door was alarmed for the wander guard system.
-The alarmed exit doors were operated by a 9 volt battery. The other alarmed doors were not connected to the wander guard system.
-A little over 4 months ago, a resident got out of the door exit #4, and the alarm did not sound.
-The alarms on the exit doors were not being checked when Resident #6 eloped.
-He and the night shift staff were instructed to check the door every Monday, Wednesday and Friday, to ensure the alarms sounded after the resident eloped from the facility.
-Prior to the resident getting out of the facility, he was checking the alarms once a week and the night shift were not checking the alarms at all.
-He checked the alarms on all of the exit doors

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each day during the day shift and replaced the batteries as needed.
-To test the alarm, he would open the door and the alarm would sound, he would then take the key to turn off the alarm.
-If the battery was bad the alarm would shut off by itself.
-It had been a few months since the batteries had been changed by him. He did not remember the date.
-He documented the door checks, but did not document when the batteries were replaced.

2. Review of the current FL2 for Resident #5 dated 3/1/16 revealed:
-Diagnoses included dementia, traumatic brain injury, and a history of urinary tract infections.
-She was intermittently disoriented.
-Resident #5 required total care, non-ambulatory, and used a wheelchair.

Review of Resident #5's Resident Register revealed she was admitted to the facility on 12/1/15.

Review of Resident #5's Care Plan dated 1/1/16 revealed:
-Due to cognitive deficits, resident was not able to perform activities of daily living without assistance.
-She was not able to dress herself at all.
-She was wheelchair bound and required hands on assistance for ambulation.

Review of 2 Accident Incident reports for Resident #5 dated 4/26/16 revealed:
-Resident #5 eloped from the facility without alerting staff.
-She was found down the street from the facility

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D 067	Continued From page 5	D 067		

at 3:00am.
-Later the same night around 9:35pm Resident #5 exited the same front door and was attempting to open visitor car doors in the parking lot.

Interview with the Maintenance Director on 5/5/16 at 10:00am revealed:
-The front door did not have an alarm that sounds when the door was opened.
-The front door was wired to sound with the wander guard.
-If a resident with a wander guard got close to the door the alarm would sound.

Confidential interviews with 7 staff revealed:
-All of the residents knew how to turn the lock on the front door, even the confused residents.
-You just turn the lock to unlock the door, it was like a house lock.
-Most nights they did not lock the door at all.
-The door did not lock from the outside either; anyone could just walk in the facility at any time of the day or night.
-If someone came in the building to do something to a resident at night, you wouldn't even know they were in the building.
-The front door did not make any kind of sound when it opens.
-There was an enclosed smoking area in the back, so "I don't know why the front door needs to be left open for residents to go out to smoke all night".
-Management was aware that front door was unsecured.

Interview with the Administrator on 5/5/16 at 11:55pm revealed:
-She was new to the community.
-The front door was not alarmed.
-Nothing had been put in place since Resident #5

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D 067	Continued From page 6 eloped from the facility to stop another resident from eloping. -There was nothing on the door to stop anyone from coming in or going out of the door. -The only alarm system that was currently on the door was a wander guard alarm, for the residents that had a wander guard. -Starting tonight she would "start 30 minute checks on every resident until the door situation is fixed". _____ Review of the Plan of Correction received from the Administrator on 5/6/16 revealed: -A staff member was designated to monitor the front door until completion of a door alarm installation. -An alarm was installed on the front entrance door. -All supervisors were designated and to monitor the alarm and to document that the door is alarmed and operable after hours. -The shift supervisor will report to front entrance immediately when hearing the alarm sound and redirect the resident back into the facility. -The Administrator will perform random, unannounced visits to the facility after hours to assure the door is locked and alarmed to protect from outsiders/visitors entering the building unnoticed and unannounced. -The maintenance director /or designee in his absence will perform exit door checks 3 times per week to ensure maglocks and doors are operable. -The supervisor will check and document each night that exit doors are locked and secure. -The supervisor will document nightly that doors have been checked. CORRECTION DATE FOR THE TYPE A2	D 067		

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D 067	Continued From page 7 VIOLATION SHALL NOT EXCEED JUNE 09, 2016.	D 067		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: The facility failed to assure walls, ceilings, and floors were kept in good repair for 1 of 2 common men's restrooms, 1 of 2 common men's shower rooms, the flooring leading into the dining area, the bathroom ceiling in room 328, and the ceiling in the dining area. The findings are: Observation of the first common men's restroom on the East Hall on 05/04/16 during the facility tour between 10:30am and 11:30am revealed: -There was a strip of black tape at the entrance that joined the carpet and the restroom tile. - The lower third of the entrance door had worn, scuffed marks. - The lower third of the door frame entrance had worn missing paint. Observation of the first common men's shower room on the East Hall on 05/04/16 during the facility tour between 10:30am and 11:30am revealed: -There was a strip of black tape at the entrance that joined the carpet and shower room tile.	D 074		

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D 074	Continued From page 8 -The carpet leading into the shower room had a dark stain. Interview with Resident #3 in room 328 on 05/04/16 at 11:50am revealed: -The bathroom ceiling had been leaking water when it rained for about 6 months. -The hole in the bathroom ceiling just occurred on 05/03/16. -She had been using 2 trashcans to catch the water under the leaking ceiling. -She was afraid she would forget about the possibility of a wet floor one night and fall in the bathroom. -She was in the process of moving but did not want to move from this room. -Administration had asked her to move in order for the bathroom ceiling to be repaired. Observation of the bathroom in room 328 on 05/04/16 at 11:55am revealed: - There was a large yellow stain in the center of the ceiling. -There was missing, dangling popcorn ceiling material that exposed the under layer of the ceiling. -There was a hole that was the size of a softball in the middle of the yellow stain that left the outer edges of the surface ceiling dangling downward. -The administrator and owner of the facility came in the bathroom to observe the ceiling. Observations on the East Hall on 05/10/16 revealed there was an area of black tape that had been applied over a section of the carpet that was the approximate size of a large book located close to the entrance of the dining room; the area underneath the black tape was uneven.	D 074		

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D 074	Continued From page 9 Interview with the Administrator on 5/4/16 at 9:55am revealed: -The facility was currently under reconstruction. -Six restrooms had been remodeled, 4 were under reconstruction. -One restroom in room 328 had an issue with the ceiling leaking due to the recent storms. -A new roof would be installed in 2 weeks, the roof would be installed in stages. Interview with the Administrator on 5/6/16 at 10:25am revealed: -The maintenance director wrote down a housekeeping list of the resident rooms to be deep cleaned each week. -He did not keep up with the list which outlined which rooms were to be deep cleaned each week. -The maintenance director was supposed to monitor weekly to see if those rooms were cleaned, he had stopped doing that. -There currently no system in place to monitor what rooms were deep cleaned. Observation of the dining room on 5/10/16 revealed: -The dining room ceiling had 3 yellow water stains on the right side of the dining room. -One of the water spots was near the air conditioning unit in the window. -Another water spot was in the back of the dining room near the kitchen. -The one near the kitchen was about the size of a hub cap or larger, with peeling paint and the dry wall exposed. Interview with the Administrator on 5/10/16 at 7:54pm revealed: -The damage to the ceiling in the dining room was old damage.	D 074		

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D 074	Continued From page 10 -Her first day in the building was 4/4/16. -One of the owners was made aware of the leaks in the dining room ceiling. -She had taken pictures of the dining room ceiling and sent them to the owner on 5/3/16 after the storm damage. -The ceiling had been leaking before, but the leak had been fixed. -She has not seen the dining room ceiling leaking in the 3 weeks since she had been at the facility. -The owner walked around the facility on 5/4/16 and they discussed the ceilings and the duct tape on the carpeted floors and doorways. -Patchwork was done on the roof, the leaks had been fixed, and they were getting ready to repair the roof. -They just obtained ownership of the building on 5/6/16. -They were not able to make structured changes to the building before, because they did not own the building. -They will be starting to repair the roof in the south hall sometime next week.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 1 of 2 common men's shower room, 1 of 2 common men's restroom,	D 075		

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D 075	Continued From page 11	D 075		

and the hallway at the first common men's restroom and first common men's shower room of the East Hall of the facility did not smell like urine and sewage.

The findings are:

Observations of the East Hall during the facility tour on 05/04/16 from 10:30am-11:30am revealed:
-Upon entering the East Hall, there was a strong smell of sewage and urine in the first common men's restroom, first common men's shower room and into the hallway adjacent to resident rooms.
-There was a stronger sewage odor in the first common men's shower room; there were flies in this room as well as gnats coming from the floor drain when the water was turned on.
-There were two housekeeping staff members on the floor, one was collecting trash in the residents' bedrooms.
- In the first common men's restroom, there were 2 toilets covered with a black plastic cover.
- In the first common men's shower room, the glass window was up with a window screen in place that allowed outside air in.
-There was a second common men's restroom and second common men's shower room.
-The second common men's restroom and second common men's shower room had been remodeled with new flooring, walls, toilets and shower.
-There were no odors of urine or sewage in the second common men's restroom and second common men's shower room.

Interview with Housekeeping staff on 05/04/16 at 10:40am revealed:
-The Housekeeping staff cleaned the floors and

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bathrooms daily.
-They would also clean rooms and mop floors as needed when there was an accident or spill.
-They had some residents that urinated on the floor in the bathroom at times.
- He had noticed an odor in the first common men's restroom and first common men's shower room for some time off and on and related the smell to residents soiling the restroom after the cleaning had been done.

Observation on the East Hall on 5/04/16 at 1:30pm revealed:
-There was a sewage odor noted in the first common men's restroom, first common men's shower room and in the hallway around the entrance of the restroom and shower room.
-The remainder of the hallway smelled of air freshener.
-The second common men's restroom and second common men's shower room had no foul odors detected.

Observations and interview on the East Hall on 05/05/16 at 8:20am revealed:
-The sewage odor remained in the first common men's restroom and in the first common men's shower room.
-The odor was not quite as strong as the previous day on 05/04/16.
-A Personal Care Aide (PCA) was in the first common men's shower room swatting at a fly.
- The PCA had noticed a sewage smell in the first common men's shower room.
-The PCA had noticed this smell in both the first common men's restroom and first common men's shower room before.
- The PCA never noticed a smell in the second common men's restroom and second common men's shower room.

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D 075	Continued From page 13 Observations on the East Hall on 05/05/16 at 6:50pm revealed: -There was a strong sewage odor noted in the first common men's restroom, first common men's shower room and in the hallway around the restroom and shower room. -The remainder of the hallway had no smell of sewage. -The second common men's restroom and second common men's shower room had no foul odors detected. -There were flies seen in the first common men's shower room and gnats noted coming from floor drain when the floor was tapped at the drain. Interview with the Administrator on 05/05/16 at 6:50pm revealed pest control would spray the facility. Observations on the East Hall on 05/06/16 at 9:00am revealed: -The sewage odor remained in the first common men's restroom, first common men's shower room, and down the hallway toward resident bedrooms. -There was a stronger sewage odor in the first common men's shower room. -The Housekeeping staff member was at the door of the first common men's restroom with a cleaning cart. --The second common men's restroom and second common men's shower room had no foul odor detected. Interview with a Housekeeping staff member on 05/06/16 at 9:00am revealed: -The Housekeeping staff member was getting ready to clean the restroom. -He had noticed a bad odor at times but wished	D 075		

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D 075	Continued From page 14 the resident's would tell him if they had an accident so he could clean it up. A confidential interview with staff revealed: -The two toilets in the first common men's restroom formed a crack in the bowl; the crack occurred in the first toilet (toilet closet to the restroom entrance) about a year ago, and in the other toilet about 3 months ago. -The facility would not replace the cracked toilets since a different style toilet would be needed when the planned remodeling was done. -In the first common men's restroom and first common men's shower room, the odors were coming from a lack of water in the pipes that lead from the cracked toilets which would cause a backflow of odor from the septic tank. -The odors could have been coming from old urine stains on the walls as well. Interview with the Administrator on the East Hall on 05/10/16 at 1:45pm revealed: -The Administrator was advised by a provider of pest control services who treated the facility the week prior, that the odor in the first common men's restroom and first common men's shower room could have been related to a broken pipe that drained the toilets located under the foundation; if this was the cause of the odors, there would not be anything they could immediately do for the odors, except to "snake the pipes". - A plumber had been contacted.	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings	D 079		

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D 079	Continued From page 15 (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain areas used by residents free from obstructions and hazards in the first common men's shower room and failed to keep room 328 clean and free from obstructions on the East Hall. The findings are: Observations of the first common men's shower room on the East Hall on 05/04/16 revealed: -There were multiple cracks and missing edges of the vanity, some were covered with white tape and others were exposed with uneven, jagged edges. -The doors on the vanity were not flush with the vanity base and stayed in a partially opened position. Interview with Resident #3 on 05/04/16 at 11:50am revealed: - The toilet in her bathroom was installed in the wrong position; the toilet base was slanted toward the wall which made it difficult for her to transfer on and off of that toilet. -The toilet in her bathroom had been that way for a very long time. -There was a hole in her bathroom ceiling that appeared on 05/03/16. -The bathroom ceiling had been leaking for about	D 079		

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6 months.
-She was afraid she would forget about the possibility of a wet floor one night and fall in the bathroom.
-She had been using 2 trashcans to catch the water under the leaking bathroom ceiling.
-She was in the process of moving but did not want to move from this room.
-She wanted to move her personal items herself so she could purge items she no longer needed.
-Administration had asked her to move in order for the bathroom ceiling to be repaired.
-At that point she did not want staff to assist her with moving, but would need help later on to move larger items.

Observation of room 328 on 05/04/16 at 11:55am revealed there was scattered dirt, dust, and debris on the furniture and floor.

Observation of the bathroom in room 328 on 05/04/16 at 11:55am revealed:
-There was a large yellow stain in the center of the ceiling.
-There was missing, dangling, popcorn ceiling material that exposed the under layer of the ceiling.
-There was a hole that was the size of a softball in the middle of the yelllow stain that left the outer edges of the ceiling dangling downward.
-The bathroom toilet was installed in a slanted position that caused the bowl to angle closely toward the bathroom wall.
-The administrator and owner of the facility came into the bathroom to observe the ceiling.

Observation of room 328 on 05/05/16 at 6:40pm revealed:
-The resident had moved to another room.
-There was an area on the floor with a thick,

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D 079	Continued From page 17 sticky, build-up of dirt, debris and paper that had adhered to the floor. -There was an insect crawling on the floor around the debris on the floor. Interview with the Administrator on 05/05/16 at 6:40pm revealed: -Resident #3 was asked to move in order for the repairs to begin for the bathroom ceiling. -She made rounds on 05/04/16 with one of the owner's in this room and bathroom and other areas of the facility to show him areas that needed to be repaired. -There were plans to remodel the first common restroom and bathroom on the East Hall. -Pest control would spray the facility. -The resident did not like staff members in her room. -The build up of the thick, sticky debris on the floor was in an area where the Resident had a piece of furniture. Interview with the Administrator on 05/06/16 at 10:25am revealed: -The maintenance director wrote down a housekeeping list of the resident rooms to be deep cleaned each week. -He did not keep up with the list which outlined which rooms were to be deep cleaned each week. -The maintenance director was supposed to monitor weekly to see if those rooms were cleaned, he stopped doing that. -There currently was no system in place to monitor what rooms were deep cleaned.	D 079		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio	D 234		

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D 234	Continued From page 18 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 7 residents (#4) sampled was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #4's current FL-2 dated 04/15/2016 revealed diagnoses included status post right below knee amputation, hypertension, diabetes mellitus type II, coronary artery disease, chronic obstructive pulmonary disease, peripheral artery disease, depression, and chronic kidney disease. Review of Resident #4's Resident Register revealed an admission date of 04/03/2015. Review of an immunization report for Resident #4 revealed: -The printed Immunization Report was from a skilled nursing facility dated 04/02/2015. -There was documentation for a tuberculosis (TB) skin test administered 03/07/2015. -There was documentation of negative results. -There was no date documented to indicate the	D 234		

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date the TB skin test was read as negative.
-There was no documentation of any other TB skin tests.

Review of Resident #4's record revealed:
-A hospital history and physical report dated 03/28/2016 documented "PPD status: neg in 2013, will plant annual PPD".
-There was no documentation for the 03/28/2016 TB skin test being placed.
-There was no documentation for the 03/28/2016 TB skin test being read.
-There was no documentation of any other TB skin tests.

Interview with the Administrator on 05/05/2015 at 5:10pm revealed:
-The Administrator would be responsible to verify TB skin testing was done prior to admission.
-She was not working at the facility when Resident #4 was admitted.
-She would look in a file kept in the business office for any documentation on TB skin testing for Resident #4.
-If a resident was admitted from another facility with one TB skin test completed in the past 12 months, that TB skin test would be accepted.
-The second TB skin test would be done upon admission to the facility.
-The facility got the PPD serum from the pharmacy and the RN came to the facility to place the PPD.

Interview with the Resident Care Coordinator (RCC) on 05/05/2016 at 5:25pm revealed:
-She was responsible to file information in the resident records.
-TB skin test results would be filed in the record in the lab result section.

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D 234	Continued From page 20 Interview with the Administrator on 05/05/2016 at 5:40pm revealed: -She could not find any documentation in the admission packet information kept in the business office on TB skin testing for Resident #4. -She did not know if TB skin testing results were received prior to admission or not. Interview with the RCC on 05/09/2016 at 3:00pm revealed she did not have any additional information on 2-step TB skin testing for Resident #4.	D 234		
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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview and record review, the facility failed to ensure supervision of residents was provided in accordance with each resident's assessed need, resulting in elopement for 2 of the 7 sampled (#5, and #6) residents. The findings are: 1. Review of the current FL2 for Resident #5 dated 3/1/16 revealed: -Diagnoses included dementia, traumatic brain injury, and a history of urinary tract infections.	D 270		

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D 270	Continued From page 21 -She was described as being intermittently disoriented. -Resident #5 required total care, non-ambulatory, and used a wheelchair. Review of Resident #5's Resident Register revealed she was admitted to the facility on 12/1/15. Review of Resident #5's Care Plan, dated 1/1/16 revealed: -Due to cognitive deficits, resident was not able to perform activities of daily life without assistance. -She was not able to dress herself at all. -She was wheelchair bound and required hands on assistance for ambulation. Review of 1 of 2 an Accident Incident reports for Resident #5 dated 4/26/16 revealed: -At 3:00am Resident #5 rolled herself in her wheelchair, down the parking lot onto the sidewalk along a Main [named] road. -Staff were looking for the resident, went into the parking lot and noticed blue lights flashing. -The staff went toward the flashing lights and noticed a police officer with Resident #5. -The staff assisted the resident back to the facility. -The staff asked the resident where she was planning to go and she replied [a named location] in the direction she was headed toward. -The supervisor completed a full body assessment and no injury was noted. -One to one supervision was provided for the resident and a wander-guard bracelet was placed on the resident. -Resident #5 was involuntary committed on 4/26/16 due to ongoing behavior problems. Review of a second accident/incident report for	D 270		

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D 270	Continued From page 22 Resident #5 dated 4/226/16 at 9:35pm revealed: -Resident was combative toward staff and other residents. -Resident was sliding down and out of her wheelchair. -Resident was having impulsive, loud outbursts, at times using profanity, kicking and biting staff when approached. -Resident was attempting to open a visitor's car doors in the parking lot. -Emergency medical systems (EMS) was contacted along with the Magistrate's office. -Resident #5 was visually assessed for injury, and there was no injury noted. -Resident #5 and others were kept safe until emergency personnel arrived. -The resident's physician and family was notified. Review of the Care Notes for Resident #5 written by 5 staff working the 3rd shift on 4/26/16 revealed: -On 4/26/16, around 2:30am the aide assigned to the South hallway where Resident #5 resided noticed Resident #5 was not in the hall. -She looked on the adjoining hallway and was not able to find Resident #5. -She alerted 2 other staff and they were all unable to locate the resident. -The entire 3rd shift including the shift supervisor was alerted and began searching the facility for the resident. -The supervisor went outside, walked around the building, and directed the other staff members to continue to search the inside of the facility. -"The supervisor walked down the driveway and to the street, where down the street a little ways he saw Resident #5 talking to a police officer." -When he approached the police officer the resident started being combative yelling and screaming that she did not want to go back to the	D 270		

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facility.
-The supervisor went back to the facility and asked another staff whom Resident #5 responded to better, to go and bring the resident back to the facility.
-When the other staff went to get Resident #5, she returned to the facility with him.

Confidential interviews with 6 staff members revealed:
-Resident #5 was fully dressed in her clothes and shoes when she eloped on 4/26/16.
-Resident #5 had been missing for about 2 hours, before they found her.
-It had to take Resident #5 a while to get all the way down the street.
-Resident #5 was about a quarter of a mile down the road.
-Resident #5 did not sleep in bed clothes, she would not let anyone put her in pajamas.
-The resident did not sleep in her room, she slept on the couch in the day room every night (the physician was not aware of this).
-Resident #5 had tried to elope from the facility before.
-Resident #5 was in need of 1:1 supervision.
-The staff could not do rounds and do laundry and keep watch on Resident #5 at the same time.
-Resident #5 had tried to go out of the south hall door one night in mid- March about 4:00am.
-The alarm was on and sounded and staff was able to pull her back in before she got anywhere.
-The shift supervisor was aware of the time she tried to elope the first time.
-The night shift often had to do other duties such as laundry and counting linen in the front of the building, which took them away from the resident area they were assigned to monitor.
-There was supposed to be staff in the back hall at all times, but that did not always happen.

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D 270	Continued From page 24 Sometimes night shift staff had left the building and no one knew they had left. -Staff were not always where they were supposed to be, the night staff sometimes congregated in the dining room leaving the resident hallways unsupervised. -There had been a previous incident with a resident exiting the building unnoticed on the night shift. Interview with the Resident Care Coordinator (RCC) on 5/5/16 at 10:40am revealed: -Resident #5 eloped out the front door on 4/26/16, during the 3rd shift. -The front door was not alarmed. -Residents are able to go out of the front door to smoke throughout the night. -The 3rd shift staff generally locked the door. The door was supposed to be locked on the 3rd shift. -From her understanding, the door was not locked that night. -Resident #5 kept saying she was going to go down the street near the place she was found that night. -A wander guard was placed on Resident #5 later in the day on 4/26/16. -The resident smashed the bracelet into pieces prior to exiting out of the front door again later the same day. -Resident #5 was sent to the hospital on the evening of 4/26/16 and discharged due to her behaviors. Interview with a family member of Resident #5 on 5/5/16 at 5:00pm revealed: -Resident #5 had a previous traumatic brain injury, due to a motor vehicle accident. -She had no use of the right side of her body, and was unable to put herself in a wheelchair.	D 270		

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D 270	Continued From page 25 -She was unable to stand up or walk without a person on each side of her, and her speech was impaired, to the point it could be difficult for some people to understand her. She (the family member) was always able to understand her. -She received a call on 4/26/16 at 5:00pm from the facility and was informed Resident #5 had exited the building and went down the street, in the early morning hours around 3:00am. -When they contacted her, they were talking about Resident #5's behaviors instead of explaining how she managed to get out of the facility -She was not aware how long Resident #5 had been missing. -She did not understand how Resident #5 could be completely dressed at 3:00am. -Since Resident #5 could not walk, she did not understand how she left the facility in a wheelchair, without staff knowing she was gone. -They said they put a wander guard on her the same day she exited the building after they got her back inside. -She had been told Resident #5 had tried to exit the facility in March. -One day, about a month prior, she visited Resident #5 at the facility and she was sitting out on the front porch by herself. -She was told they had an open door policy. -They said they could lock the door from the outside, but could not lock the door from the inside, so the residents could go out to smoke anytime day or night. -Later the same night on 4/26/16 Resident #5 "was transported to the hospital they said, due to her behaviors". -Resident was still in the hospital and the family member was no longer able to understand what Resident #5 was saying.	D 270		

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D 270	Continued From page 26 Interview with a Nurse Aide (NA) on 5/5/16 at 10:20pm reveled: -She had been assigned the south hall on the night of 4/25/16. -At about 2:00am, Resident #5 had been laying on the couch in the TV room. -The resident asked her to put her (the resident) in her wheelchair. -She put Resident #5 in her wheelchair and left the south hall to go and do laundry in the front of the building. -She came back to the south hall a little after 2:00am to put away another resident's laundry, Resident #5 was still sitting in the hallway. -The other resident asked the NA to change her bed sheets while she was in her room putting away laundry. -The NA changed the bed sheets for the other resident. While she was changing the bed linens Resident #5 took off. -She did not hear Resident #5 take off , she thought Resident #5 went to the west hall (adjoining hall connected to the front hallway). -When she finished changing the linens, she realized she did not hear Resident #5, so she checked the west hallway and was not able to find Resident #5. -She asked other staff to help her locate Resident #5 and they both checked the west hall, and the east hall, although Resident #5 rarely went to the east hall. -Three NAs were searching the building and could not find the resident, she alerted the supervisor. -He went outside and checked around the building when he went down the driveway onto the street, he saw police lights and noticed that Resident #5 was down the street talking to a police officer. -He was not able to get the resident back in the	D 270		

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building because she began yelling and fighting.
-The supervisor came back to the building and another NA had to go down the street to get Resident #5 to come back to the facility.
-By the time they got the resident back in the building, it was about 3:00am.
-Resident #5 had walked right out of the front door.
-The front door was unlocked the majority of the time, so residents that smoke could go in and out to smoke.

Interview with the Business Office Manager (BOM) on 5/6/16 at 11:30pm revealed:
-She was on call on the 4/26/16, and received a call from the 3rd shift supervisor at 3:52am.
-She was informed that Resident #5 had eloped from the facility at about 3:00am.
-The supervisor said he went outside to look for the resident and found the resident down the street talking to a police officer.
-She notified the RCC, the Administrator, and the Regional Director by group text.
-The Regional Director called her back for more detail.
-The NA had been doing laundry when she noticed Resident #5 was missing, between 2:30am and 3:00am.
-Staff did not know when Resident #5 was last seen.
-The Regional Director requested Resident #5 receive one to one supervision for the remainder of the shift.

Interview with the Administrator on 5/5/16 at 11:55pm revealed:
-She was new to the community.
-She had been the Administrator at the facility for 3 weeks.
-There had been a discussion on 2 hour staff

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checks on residents and more frequently on residents with behaviors.
-She did not have an answer for how frequently residents were to be monitored.
-Resident #5 had displayed verbally and physically abusive behavior, the resident had not displayed any wandering behaviors that she was aware of.
-There was a video system on the front door, but the lock on the door was a turn lock. It could be turned by anyone and the door would open.
-The front door was not alarmed.
-Nothing had been put in place since Resident #5 eloped from the facility to stop another resident from eloping.
-There was nothing on the door to stop anyone from coming in or going out the door.
-The only alarm system that was currently on the door was a wander guard alarm for the residents that had a wander guard.
-Starting 5/6/16, she would "start 30 minute checks on every resident until the door situation is fixed".

2 Review of the current FL2 for Resident #6 dated 6/18/15 revealed:
-Diagnoses included depression and hypertension.
-She was documented constantly disoriented.

Review of Resident #6's Resident Register revealed she was admitted to the facility 8/30/12.

Review of Resident #6's Care Plan dated 12/18/15 revealed:
-Resident was constantly disoriented.
-Resident had started to wander throughout the facility, and required close monitoring by staff.

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Review of an Accident Incident report for Resident #6 dated 11/12/2015 revealed:
-At 11:15pm, Resident #6 was observed (outside) on the ground.
-The resident was assessed by the NA, and assisted back into the building.
-Resident #6 did not complain of any pains; however Resident #6 did have skin abrasions on her face and one skin abrasion on each of her knees.
-Vital signs were taken and EMS were called.
-The family and physician were both notified and the resident was to follow up with her physician in 2 days.

Review of Care Notes for Resident #6 dated 11/13/15 at 7:00am revealed:
-Staff was doing rounds, and the resident was not in her normal area, so staff started a search inside of the facility.
-The search moved outside where Resident #6 was observed on the ground.
-Staff was unsure how Resident #6 ended up in the area.
-There were no visible signs of injuries at this time, 11:50pm.
-The resident was assisted inside the facility for personal hygiene and further assessment.
-Injuries were noted on her face and legs; EMS was called, and the Resident Care Coordinator, the Administrator, and family were notified.

Confidential interviews with 6 staff members revealed:
-On a cold night in November 2015, Resident #6 eloped from the building.
-The 4 NAs working were in the front hall in the laundry room counting linen.
-Resident #6 went out of the back door on the south hall and no one knew she left, the door did

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not alarm.
-Resident #6 was eventually found in the back of the building about 11:30pm lying face down in a mud puddle, "it was cold out that night".
-The staff could not come up with a time frame of how long Resident #6 had been missing, but they found her around 11:30pm.
-The resident went out of the (south hall) door leading to the driveway.
-No staff was on the south hall, east hall or west hall that night. The supervisor was in the medication room and all of the other staff were in the laundry room counting linen.
-That was not the first time Resident #6 tried to get out before staff would usually catch her before she got too far.
-Resident #6 was someone you needed to keep an eye on.
-After that incident a wander guard device was placed on Resident #6.
-She has not tried to get out of the facility again.
-The only door that was connected to the wander guard was the front door.
-The front door was not the door Resident #6 went out that night, so if she went out the south hall door again and the alarm was not working, it could happen again.

Review of hospital discharge paperwork dated 11/13/16 revealed, Resident #6 was treated for a facial contusion and abrasion.

Interview with the RCC on 5/5/16 at 10:40am revealed:
-Around the holidays last year Resident #6 eloped out of the south hall door.
-The resident was found on the ground at the back of the building she was notified along with the Administrator at that time, the Co-Administrator, Regional Director, the

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D 270	Continued From page 31 resident's physician and family. -A wander guard was placed on Resident #6 and she had not tried to go out again. Observation of Resident #6's room on 5/5/16 at 11:30am revealed she still resided on the south hallway (located in the back of the building). Attempts to contact the family of Resident #6 was not successful. _____ Review of the Plan of Protection received from the Administrator on 5/6/16 revealed: -Fifteen minute checks will be implemented if increased supervision is deemed necessary upon resident assessments. -If it is determined that there is a potential for wandering, resident will be assessed for the need of a wander guard bracelet, bracelet will be used if deemed necessary. -The Administrator/RCC will perform random record reviews and interviews to determine if level of supervision/personal care being provided meets the needs of the residents weekly times 4 weeks, than monthly thereafter. -Resident's family will be contacted to determine if this is a new behavior. If new behavior, a physician appointment will be scheduled and resident will be seen by the physician. -Resident's physician will be contacted and reported to regarding the current symptoms, to determine if new orders are needed. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 09, 2016.	D 270		

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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, record review and interviews, the facility failed to assure 1 of 7 residents (#3) sampled was rescheduled for a mammogram appointment and failed to assure referrals were coordinated for physical therapy services and for an ankle/foot orthotic. The Findings are: Review of Resident #3's current FL-2 dated 11/18/15 revealed: -Diagnoses included gastric ulcer, hypotension, bipolar, Ehlers- Danlos syndrome, otitis externa, fibromyalgia, depression, vitamin D deficiency, and status post cerebral vascular accident. -Resident #3 was intermittently confused. -Resident #3 was ambulatory with a rollator. Review of the Resident #3's Resident Register revealed an admission date of 10/13/12. a. Interview with Resident #3 on 05/05/16 at 1:35pm revealed: -There had been 2 mammogram appointments that were missed, one was in February 2016 that was cancelled due to weather "she thought", and the other appointment was around the first of the year and was cancelled due to no facility transportation. -She had not had a mammogram in over 10	D 273		

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years.
-She had located a lump in her breast recently, and reported the lump to her Primary Care Physician (PCP) on 05/05/16.
-The PCP was going to schedule another mammogram and would let her know on his next visit when the upcoming mammogram would be.

Review of Resident #3's Care Notes and the Physician's verbal/telephone orders did not reveal any notation of a scheduled or cancelled mammogram.

Interview with the Administrator on 5/06/16 at 9:40am revealed they would attempt to locate the information missing from Resident #3's chart.

Interview with the Resident Care Coordinator (RCC) on 05/09/16 at 1:55pm revealed:
-There was an appointment book that logged all residents' upcoming appointments.
-The prior administrator had the resident appointment book and then the transportation person kept the book who was later terminated. Then, she "inherited" this resident appointment book just a few weeks ago.
-She could not determine if there were any missed appointments for a mammogram in February 2016 or any other time around the beginning of year.
-The PCP had not provided any information/paperwork regarding an upcoming mammogram appointment but she would follow up with him.
- She had no additional information related to Resident #3's mammogram needs or appointments.

Telephone interview with the Clinical Organizer for Resident #3's PCP on 05/10/16 at 11:55am

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revealed:
-The most recent documentation in the resident's chart was from 05/05/16 that a mammogram appointment had been scheduled for later this month.
-Prior documentation was on 01/27/16 that a mammogram was scheduled for 02/26/16 however, there was no proceeding documentation that this mammogram appointment was cancelled.
-The Clinical Organizer would send a message to the PCP to return the call.

On 05/10/16 at 4:08pm a return telephone call was made to the Clinical Organizer to follow up on a requested return call from the PCP; however, at that time he was unavailable but would return the call.

Telephone interview with the Radiology/Diagnostic Center on 05/10/12 at 4:44pm revealed:
-There was an appointment in February 2016 that was cancelled by phone.
-There was no information available to identify who the caller was that cancelled the appointment.
-There was no information available to determine why the appointment was cancelled.
-Resident #3 had been scheduled for an upcoming appointment in May 2016.
-There was no information in the systems history of another missed or cancelled appointment at that practice.

No return call was received from the primary care provider before the survey exit.

b. Interview with Resident #3 on 05/05/16 at 1:35pm revealed:

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D 273	Continued From page 35 -She had a brace that was used to treat foot drop however the brace was worn out and needed replacement. -She was seen by an orthopedic clinic on 04/01/16; the orthopedic clinic gave a prescription for a replacement brace to treat her foot drop and a prescription for physical therapy for strengthening. - There had not been any follow up. Review of Resident #3's Care Notes revealed no documentation of any follow up from an orthopedic clinic for a brace or a referral to physical therapy from the orthopedic visit on 04/01/16. Interview with the Administrator on 5/06/16 at 9:40am revealed they would attempt to locate the missing information. Review of subsequent physician orders and prescriptions for Resident #3 revealed: -An order and a prescription dated on 04/01/16 for a new AFO (ankle and foot orthotic) for the left lower extremity. -There was a prescription dated 04/01/16 for physical therapy to evaluate for passive/active range of motion, strengthening, and functional activities. Observation of the RCC on 05/09/16 at 1:55pm revealed: -The RCC called the home health agency that was used by the facility. -The RCC called the facility's medical equipment supplier. Interview with the RCC on 05/09/16 at 1:55pm revealed: -There was no referral received by the home	D 273		

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D 273	Continued From page 36 health agency for physical therapy services for Resident #3 from the facility. -There was no referral received by the medical equipment supplier for the AFO for Resident #3 from the facility. -The referral for physical therapy services and an AFO for Resident #3 were overlooked. -The RCC would forward the referral for the new AFO to the medical equipment provider and the referral for physical therapy to the facility's home health agency.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure physician orders for lab testing were implemented for 3 of 7 residents (Residents #1, #2, #8)sampled. The findings are: 1. Review of Resident #8's current FL-2 dated 10/07/2015 revealed diagnoses included altered mental status, acute renal failure, chronic kidney disease III, dementia, hypertension,	D 276		

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gastro-esophageal reflux disease, hyperlipidemia (HLD), and schizophrenia.

Review of the consulting pharmacy review for Resident #8 revealed:
-On 06/09/2015, the pharmacist review noted Valproic Acid labs every month: "vpa 4/15, 3/15".
-On 12/03/2015, the pharmacist review noted Valproic Acid labs every month: "vpa 7/15".
-On 03/08/2016, the pharmacist review noted Valproic Acid labs every month: "vpa 7/15".

Review of a psychiatry visit report dated 02/08/2016 revealed the Physician Assistant (PAC) documented "no new labs in chart since VPA 7/22/15.

Review of a psychiatry visit report dated 08/19/2015 revealed the PAC documented "no new labs in chart since 7/22/15."

Review of a Physician's order dated 03/16/2016 revealed an order for Valproic Acid level to be checked every month.

Review of Resident #8's lab results revealed:
-There were lab results for a Valproic Acid level (Depakene) performed 07/22/2015, 06/03/2015, 04/08/2015, 03/27/2015, 02/18/2015, and 01/14/2015.
-There was a lab result for a Valproic Acid (Depakene) performed 03/23/2016.
-There was no lab result for Valproic Acid for January 2016, February 2016, and April 2016.

Interview with the Resident Care Coordinator (RCC) on 05/05/2016 at 10:20am revealed:
-She was responsible for placing lab orders in the lab requisition book kept in the medication room.
-The lab representative came to the facility every

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Wednesday to draw labs for those residents with lab requisitions.
-If labs were ordered in March 2016, the labs should have been done.
-Once the labs were completed, the lab faxed a copy of the lab results back to the facility.
-She had been the RCC for 7 months.
-She had recently began to identify those residents who needed routine lab draws.

Interview with the RCC on 05/09/2016 at 11:25am revealed:
-The RCC contacted the lab provider on 05/09/2016 about Resident #8's April 2016 lab draw.
-Resident #8 did not get lab drawn in April 2016.
-She had overlooked preparing a lab requisition for Resident #8's April 2016 Valproic Acid lab draw.
-The physician had not been notified about the missed lab draw.
-She would need to talk to the physician about the lab.

Interview with the Primary Care Provider (PCP) on 05/10/2016 at 12:30pm revealed:
-She had recently become the PCP for Resident #8.
-She did not manage the Valproic Acid, but it was important to get a Valproic Acid level drawn every 3 months.
-She communicated with the RCC through email to refer a recent Valproic Acid level for Resident #8 to the psychiatrist that was low.
-She did not know why labs at the facility were being missed.

2. Review of Resident #2's current FL-2 dated 09/28/2015 revealed diagnoses included history of cerebrovascular accidents x's 8, recurrent falls

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D 276	Continued From page 39 8/4/15, and seizure disorder. Review of a Physician's order dated 03/08/2016 revealed an order to have Dilantin level, complete blood count (CBC), and comprehensive metabolic panel (CMP) obtained. Review of Resident #2's lab results revealed: -There was a lab result for a Dilantin level collected on 03/09/2016. -There were no lab results for a CBC found in the record. -There were no lab results for a CMP found in the record. Interview with the Resident Care Coordinator (RCC) on 05/05/2016 at 10:20am revealed: -She was responsible for placing lab orders in the lab requisition book kept in the medication room. -The lab representative came to the facility every Wednesday to draw labs for those residents with lab requisitions in the lab book kept in the medication room. -If labs were ordered in March 2016, the labs should have been done. -Once the labs were completed, the lab faxed a copy of the lab results back to the facility. -She had been the RCC for 7 months. -She had recently began to identify those residents who needed routine lab draws. Interview with the RCC on 05/05/2016 at 5:00pm revealed: -She had contacted the lab provider. -The lab provider had only drawn bloodwork for a Dilantin level on 03/09/2016. -The lab provider did not know why bloodwork for a Dilantin level was the only lab work performed. -She would contact the lab for a copy of the lab requisition prepared for the 03/09/2016 lab draw.	D 276		

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D 276	Continued From page 40 Review of the lab requisition provided by the RCC that was prepared for Resident #2's lab work revealed: -There was no checkmark next to the CMP lab procedure. -There was no checkmark next to the CBC lab procedure. -"Dilantin level" had been handwritten in the section of the lab requisition for "Other Tests". Interview with the RCC on 05/05/2016 at 5:35pm revealed: -She had only requested a Dilantin level be drawn and not the CBC and CMP. -She had to have overlooked the request for the CBC and CMP. -She would have to call the physician. Review of an email received from the RCC on 05/08/2016 at 6:30pm that was sent from the PCP revealed: -The Dilantin level was the most important lab. -The other labs would be drawn on the normal every 3 month schedule. Interview with the Primary Care Provider (PCP) on 05/10/2016 at 12:30pm revealed: -She had clarified the lab orders through communication with the RCC. -The CBC and CMP lab was used to monitor the resident's baseline. -She did not know why labs at the facility were being missed. 3. Review of Resident #1's current FL-2 dated 01/08/16 revealed: -Diagnoses included dementia (multi infarct), hypertension, arthritis, hip replacement,	D 276		

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hyperlipidemia, atypical psychosis, left ventricular hypertrophy, cellulitis of right leg, history of left calf deep vein thrombosis.
-There was a physician's order for Warfarin, generic name for Coumadin (an oral, blood thinner medication used to treat and prevent blood clots) 12 mg take daily at bedtime.

Review of subsequent Physician orders for Resident #1 revealed an order dated 03/22/16 for an International Normalized Ratio blood test (INR) (an International Normalized Ratio is a blood serum test to measure how long it takes for the blood to clot) to be done every week.

Review of Resident #1's lab results revealed:
-There were no lab results for an INR level for the week beginning 04/03/16.
-There were no lab results for an INR level for the week beginning 04/17/16.
-There were no lab results for an INR level for the week beginning 04/24/16.

Interview with Resident Care Coordinator (RCC) on 05/09/16 at 2:35pm Revealed:
-Resident #1 had current orders for an INR to be done weekly.
-All of the weekly INR results should be filed in Resident #1's chart.
-She would double check to make sure there were no additional lab results for Resident #1 that needed to be filed.
-She communicated with the Primary Care Provider (PCP) mostly via emails concerning Resident #1's lab test needs or medication adjustments, and would provide any additional information if found.

Interview with the PCP on 05/10/16 at 12:20pm revealed:

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D 276	Continued From page 42 -She could verify that most orders are handled via email. -She was aware that there was one weekly INR that was missed recently when the RCC was off but could not verify what week it was. -She would typically base the need for obtaining the INR levels on the result of the therapeutic range level. -If there were any order changes for obtaining the INR levels it would be in the form of an order documented within the chart or via email correspondences with the RCC. Review of email correspondents between the RCC and the PCP for Resident #1 revealed: -An email dated 02/18/16 at 3:51pm from the RCC to the PCP that Resident #1 was on Coumadin 12mg -An email dated 02/18/16 at 3:55pm from the PCP to the RCC to change Resident #1's Coumadin to 11mg daily. -An email dated 03/23/16 at 6:00pm from the PCP for Resident #1's Coumadin to be increased to 12mg daily. -There was no documentation to reflect a change to the previous ordered weekly INR lab order. Interview with the RCC on 05/10/16 at 5:30pm revealed: -The facility had a lab requisition book that was used for the lab provider. -The lab provider must have a lab requisition each time and on each resident prior to any lab being obtained. -There was one missed lab the week of 04/13/16; she was off that day and the Supervisor must not have filled out the lab requisition. -She was not aware that there were no INR levels for the week of 04/17/16 and 04/24/16.	D 276		

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D 276	Continued From page 43 Observation of the RCC on 05/10/16 at 5:30pm revealed: -The RCC called the lab provider and confirmed there were no INR labs drawn the week of 04/17/16 and 04/24/16. -The RCC called the PCP to report that Resident #1 had no INR labs performed as ordered for the week of 04/17/16 and 04/24/16. Review of the Plan of Protection received from the Administrator on 5/10/16 revealed: -The facility will contact physicians for clarification of lab orders. -The facility will have labs drawn per physician orders, -A lab order notebook will be implemented for the tracking and monitoring of ordered labs. -The Administrator/Regional Director will review lab orders and the lab notebook weekly to ensure compliance. CORRECTION DAT FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 24, 2016.	D 276		
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.	D 358		

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D 358	Continued From page 44 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 3 of 6 residents (Residents #4, #9, #10) observed during the medication passes, including errors with Novolin R insulin (Resident #4) and Humalog Insulin (Resident #10) and Flonase nasal spray (Resident #9), and 3 of 7 residents (Residents #1, #3, #4) sampled for record review including errors with Novolin R Insulin (Resident #4), Hydralazine (Resident #4), Abilify and Coumadin (Resident #1), and Clonazepam (Resident #3). The findings are: 1. The medication error rate was 9% as evidenced by 3 errors out of 33 opportunities observed during the 12:00pm and 5:00pm medication passes on 05/04/2016, and the 8:00am medication pass on 05/05/2016. A. Observation of the Medication Aide (MA) on 05/04/2016 at 11:50am revealed: -The MA performed a finger stick blood sugar (FSBS) for Resident #4. -The blood sugar result was 192. Interview with the MA on 05/04/2016 at 11:55am revealed: -She would administer Resident #4's insulin in the medication room when the resident went to the dining room for lunch. -Resident #4 was on a sliding scale insulin. -Resident #4 would be administered 2 units of Novolin R insulin (a short acting injectable medication used to lower the blood sugar) for a	D 358		

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D 358	Continued From page 45 FSBS of 192. Observation of the MA on 05/04/2016 at 12:33pm revealed: -The MA prepared and administered Novolin R Insulin 2 units to Resident #4's left upper arm. -The MA documented administration of the Novolin R Insulin 2 units on the May 2016 Blood Sugar Monitoring Sliding Scale flow sheet. Review of Resident #4's current FL-2 dated 04/15/2016 revealed: -The resident's diagnoses included status post right below knee amputation, hypertension, diabetes mellitus type II, coronary artery disease, chronic obstructive pulmonary disease, peripheral artery disease, depression, and chronic kidney disease. -There was a physician's order for accuchecks before meals and at bedtime (ac&hs). -There was no physician's order for sliding scale insulin (SSI). Review of Resident #4's May 2016 Medication Administration Records (MARs) revealed: -Printed instructions for Novolin R Insulin were check FSBS before meals and at bedtime sliding scale insulin: less than 150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, greater than 351=10 units and call physician. -The FSBS checks were scheduled for 7:30am, 11:30am, 4:30pm, and 8pm. -"See sheet" was written in the section of the MAR for documenting administration of medication. Review of a May 2016 Blood Sugar Monitoring Sliding Scale flowsheet for Resident #4 revealed: -There were handwritten instructions on the flow	D 358		

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D 358	Continued From page 46 sheet for Novolin R sliding scale less than 150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, greater than 351=10 units and call physician. -There was documentation for accuchecks at 7:30am, 11:30am, 4:30pm, and 8pm daily for Resident #4. -There was documentation of administration for sliding scale insulin 10 times when Resident #4's FSBS results were greater than 150. Interview with the Resident Care Coordinator (RCC) on 05/06/2016 at 4:15pm revealed: -Resident #4 had been readmitted to the facility on 04/14/2016 with a new FL-2 and discharge orders from the hospital. -The RCC did not see orders for sliding scale insulin on the new FL-2 or hospital discharge orders. -Resident #4 was on a sliding scale insulin before hospitalization. -The RCC did not know why someone attached the sliding scale flow sheet to the MAR's because Resident #4 did not have an order for sliding scale insulin. -The RCC had transcribed the orders from the discharge summary to the MAR when Resident #4 was readmitted and there was no sliding scale order. Interview with the RCC on 05/06/2016 at 4:30pm revealed: -The RCC had just contacted the physician and the physician stated the resident should be on a sliding scale insulin. -The sliding scale insulin order had been overlooked and the physician would write an order for the sliding scale insulin. -A medication aide had attached an old sliding scale flow sheet because Resident #4 had	D 358		

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D 358	Continued From page 47 previously been on the sliding scale. B. Observation of the MA on 05/04/2016 at 5:00pm revealed: -The MA performed a finger stick blood sugar (FSBS) for Resident #2. -The blood sugar result was 172. -The MA informed Resident #2 he would "get 2 units for 172" finger stick blood sugar. -The MA used a Humalog Kwik Pen labeled for Resident #2 to administer the insulin. -The MA did not prime the insulin pen after changing the needle prior to injecting Resident #2 with the insulin pen. -The MA documented the FSBS result and administration for Humalog insulin 2 units on the blood sugar monitoring flow sheet for Resident #10. Interview with the MA on 05/04/2016 at 5:10pm revealed: -She was trained to only prime the insulin pen each time a new insulin pen was opened and not when the needle was changed. -She did not know she needed to prime the insulin pen every time the needle was changed. -She would check with her supervisor about using the insulin pen. Review of Resident #10's current FL-2 dated 04/25/2016 revealed: -The resident's diagnoses were listed as atherosclerotic heart disease, hypertensive heart and chronic kidney disease, enlarged prostate, and obstructive sleep apnea. -There was a physician's order for "accucheck s/s [sliding scale] coverage Humalog ([Humalog is an injectable medication used to lower blood sugars in diabetics])100u/ml subq". -There was no frequency for the accuchecks.	D 358		

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D 358	Continued From page 48 -There were no sliding scale parameters provided. Review of a physician's orders for Resident #10 revealed: -There was a Physician's Order copy of the April 2016 MARs which included a signature for the Nurse Practitioner dated 04/04/2016. -The orders included an order for accuchecks ac&hs with sliding scale coverage using Humalog insulin. -The orders included the sliding scale parameters for a blood sugar of 150 - 199 = 2 units. -There were no subsequent orders after the FL-2 date for the Humalog sliding scale parameters. Review of the May 2016 MARs for Resident #10 revealed: -FSBS checks before meals and at bedtime was handwritten on the MAR and scheduled for 7:30am, 12:30pm, 5:30pm, and 8pm. -There were handwritten instructions on the MAR for Humalog sliding scale 150-199=2 units, 200-249=4 units, 250-299=6 units, 300-350=8 units, 351-400=10 units, greater than 400=12 units and contact physician. -"See sheet" was written in the section of the MAR for documenting administration of medication. Review of a May 2016 Blood Sugar Monitoring Sliding Scale flowsheet for Resident #10 revealed: -There were handwritten instructions on the flow sheet for Humalog sliding scale 150-199=2 units, 200-249=4 units, 250-299=6 units, 300-350=8 units, 351-400=10 units, greater than 400=12 units and contact physician. -There was documentation for accuchecks at 7:30am, 11:30am, 4:30pm, and 8pm daily when	D 358		

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D 358	Continued From page 49 Resident #10 was in the facility. -There was documentation of administration for sliding scale insulin 30 times when Resident #10's FSBS results were greater than 150. Interview with the Administrator on 05/09/2016 at 2:05pm revealed: -Resident #10 was admitted to the facility on 04/27/2016. -The Administrator received Resident #10's FL-2 for review on 04/25/2016 -The Administrator did not review all information sent prior to admission but gave information to the RCC for review. -The Administrator did not know whether the physician orders were complete or not because the RCC was responsible to review the physician orders. -Any additional information received in the facility regarding physician orders may have been requested from the referring facility by the RCC or Medication Aide. -She would contact the referring facility regarding any additional sliding scale insulin orders for Resident #10. Interview with the RCC on 05/10/2016 at 11:10am revealed: -The RCC had received a fax from the referring facility with a physician's order dated 04/27/2016 that documented Resident #10 "may take insulin pens (Lantus and Humalog) with resident". -There were no orders subsequent to the 04/04/2016 orders for the Humalog sliding scale. -The RCC had requested orders for sliding scale parameters on 04/27/2016 when she realized the FL-2 did not include sliding scale parameters. -The referring facility faxed over the 04/04/2016 signed orders.	D 358		

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D 358	Continued From page 50 Interview with the RCC on 05/10/2016 at 4:40pm revealed: -Resident #10 was seen by the facility PCP on 05/10/2016 and a new FL-2 had been completed. -Resident #10 had not selected a physician on 04/27/2016, so the RCC used the 04/04/2016 orders for sliding scale parameters. Review of an FL-2 dated 05/10/2016 provided by the RCC on 05/10/2016 at 4:40pm revealed the FL-2 included an order for Humalog sliding scale 150-199=2 units, 200-249=4 units, 250-299=6 units, 300-350=8 units, 351-400=10 units, greater than 400=12 units and call physician. C. Review of Resident #9's current FL-2 dated 02/08/2016 revealed: -The resident's diagnoses included chronic obstructive pulmonary disease exacerbation, and methicillin resistant staph aureus bronchitis. -There were written instructions in the section for medications to see discharge summary. Review of the hospital discharge summary dated 02/09/2016 revealed a physician's order for Fluticasone (generic for Flonase used to treat upper respiratory conditions) 50mcg nasal spray one spray into each nostril two times a day. Observation of the MA on 05/05/2016 at 8:54am revealed: -The MA administered two puffs of the Flonase nasal spray to each of Resident #9's nostrils. -The MA documented administration of the Flonase after she finished administering medications to Resident #9. Review of the May 2016 Medication Administration Record (MAR) for Resident #9 revealed:	D 358		

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-Fluticasone (Flonase) Spray 50 mcg inhale one spray into each nostril twice a day was printed on the MAR.
-The Flonase was scheduled for administration at 8am and 8pm daily.

Interview with Resident #9 on 05/10/2016 at 2:30pm revealed:
-She used Flonase for her sinuses.
-She administered two sprays to each nostril two times a day.
-She had always used two sprays of Flonase.
-The Flonase helped a lot.
-The MA kept the Flonase on the medication cart and would usually pass the Flonase to the resident when time for administration.

Interview with a Pharmacy Representative on 05/10/2016 at 5:30pm revealed the most current order for Resident #9's Flonase was for one spray each nostril twice daily.

2. Review of Resident #4's current FL-2 dated 04/15/2016 revealed the resident's diagnoses included status post right below knee amputation, hypertension, diabetes mellitus type II, coronary artery disease, chronic obstructive pulmonary disease, peripheral artery disease, depression, and chronic kidney disease.

Review of Resident #4's Resident Register revealed an admission date of 04/03/2015.

Record review of physician orders on the current FL-2 dated 04/15/2016 for Resident #4 revealed:
-There was a physician's order for accuchecks before meals and at bedtime (ac&hs).
-There was no physician's order for sliding scale insulin (SSI).
-There was no physician's order for Hydralazine.

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D 358	Continued From page 52 a. Review of Resident #4's April 2016 Medication Administration Records (MAR) revealed: -Handwritten instructions were for "accuchecks - ac & hs". -The accuchecks were scheduled for 7:30am, 12:30pm, 5:30pm, and 8pm. -"See sheet" was written in the section of the MAR for documenting administration of medication. Review of the April 2016 Blood Sugar Monitoring Sliding Scale flowsheet for Resident #4 revealed: -There were printed instructions on the flow sheet for Novolin R sliding scale less than 150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, greater than 351=10 units and call physician. -There was documentation for accuchecks at 7:30am, 11:30am, 4:30pm, and 8pm daily for Resident #4 beginning on 04/15/2016 at 7:30am through 04/30/2016 at 8pm. -There was documentation of administration for sliding scale insulin 38 times when Resident #4's FSBS results were greater than 150. Review of Resident #4's May 2016 MAR revealed: -Printed instructions were for Novolin R Insulin check FSBS before meals and at bedtime sliding scale insulin: less than 150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, greater than 351=10 units and call physician. -The FSBS checks were scheduled for 7:30am, 11:30am, 4:30pm, and 8pm. -"See sheet" was written in the section of the MAR for documenting administration of medication.	D 358		

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D 358	Continued From page 53 Review of the May 2016 Blood Sugar Monitoring Sliding Scale flowsheet for Resident #4 revealed: -There were handwritten instructions on the flow sheet for Novolin R sliding scale less than 150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, greater than 351=10 units and call physician. -There was documentation for accuchecks at 7:30am, 11:30am, 4:30pm, and 8pm daily for Resident #4. -There was documentation of administration for sliding scale insulin 10 times when Resident #4's FSBS results were greater than 150. Interview with the Resident Care Coordinator (RCC) on 05/06/2016 at 4:15pm revealed: -Resident #4 had been readmitted to the facility on 04/14/2016 with a new FL-2 and discharge orders from the hospital. -The RCC did not see orders for sliding scale insulin on the new FL-2 or hospital discharge orders. -Resident #4 was on a sliding scale insulin before hospitalization. -The RCC did not know why someone attached the sliding scale flow sheet to the MAR's because Resident #4 did not have an order for sliding scale insulin. -The RCC had transcribed the orders from the discharge summary to the MAR in when Resident #4 was readmitted and there was no sliding scale order. Interview with the RCC on 05/06/2016 at 4:30pm revealed: -The RCC had just contacted the physician and the physician stated the resident should be on a sliding scale insulin. -The sliding scale insulin order had been overlooked and the physician would write an	D 358		

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order for the sliding scale insulin.
-A medication aide had attached an old sliding scale flow sheet because Resident #4 had previously been on the sliding scale.

Telephone interview with the Primary Care Provider (PCP) on 05/09/2016 at 11:40am revealed:
-The PCP had "maintained the old sliding scale dosage" for Resident #4.
-The PCP had "probably" talked to the RCC on the day Resident #4 was discharged from the hospital and gave the RCC a verbal order for the sliding scale.
-The PCP had given the RCC a verbal order on 04/15/2016 for a regular insulin sliding scale for blood sugar less than 150=0 units, 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, greater than 351 give 10 units and call physician.
-The PCP had not signed a verbal order prior to 05/06/2016 because no one had asked her to sign a verbal order.

-She did not recall receiving a verbal order from the PCP on 04/15/2016.
-When she received a verbal order, she documented the verbal order on the order form sheet, checked the box at the bottom of the form indicating verbal order, faxed the order to any physician other than the inhouse doctor which the RCC kept a folder in her office for any type of paperwork the inhouse doctor needed to see.
-The RCC knew she had 15 days to get the verbal order signed and filed.

Interview with Resident #4 on 05/05/2016 at 12:00pm revealed:
-Staff checked his FSBS four times a day.
-Staff administered insulin to him.

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D 358	Continued From page 55 b. Review of the April 2016 MAR's for Resident #4 revealed: -Instructions for administration of medications were handwritten to the MARs. -Hydralazine 10mg was not transcibed to the MAR. Review of the May 2016 MAR's for Resident #4 revealed: -Hydralzaine (used to treat high blood pressure) 10mg take one tablet twice a day was printed on the MAR. -The Hydralazine was scheduled for 9am and 9pm daily. -There was documentation for administration of the Hydralazine 10mg tablet twice daily at 9am and 9pm from 05/01/2016 at 9am through 05/09/206 at 9am. Review of medications on hand for Resident #4 on 05/09/2016 at 1:30pm revealed Hydralazine 10mg tablets take one tablet twice daily was on hand. Interview with the Medication Aide (MA) on 05/09/2016 at 2:15pm revealed: -The physician's order for Hydralazine should be in Resident #4's record. -The RCC usually notified the MA's when a new order was received by telling them or by writing on the board in the medication room "new orders, check MAR". -If a medication was discontinued, the RCC would write on the MAR "order d/c'ed". -Medications discontinued were removed from the medication cart and placed in the medication room to be returned to the pharmacy. -The MA's were responsible for removing discontinued medications from the medication	D 358		

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D 358	Continued From page 56 cart. Interview with the RCC on 05/09/2016 at 2:25pm revealed: -She did not see a current order on the 04/14/2016 FL-2 or hospital discharge orders for Hydralazine for Resident #4. -She had transcribed the medication orders to the MAR for Resident #4 when Resident #4 returned to the facility on 04/14/2016. -Hydralazine 10mg take one tablet twice daily was not transcribed to the April 2016 MAR when the resident returned to the facility. -The MA who was assisting with reviewing the MARs for May 2016 missed discontinuing the Hydralazine off the May 2016 MAR and the medication was administered in May 2016. -New medication orders were faxed to the pharmacy. -New admit FL-2's were faxed to the pharmacy. -Resident #4's FL-2's were sent to the pharmacy for the pharmacy to print the MARs. -The 05/2016 MARs could have already been printed when the new FL-2 for Resident #4 was faxed to the pharmacy. -When reviewing the MARs, the MA's needed to have the new order book to verify any new orders or any discontinued orders. -The RCC would contact the physician about the Hydralazine and complete a medication error. Review of daily blood pressure readings for Resident #4 from 05/01/2016 through 05/09/2016 revaled the resident's systolic blood pressure ranged from 128-134, and the diastolic blood pressure ranged from 71-82. Interview with a Pharmacy Representative on 05/10/2016 at 5:30pm revealed: -The pharmacy printed the MARs for the	D 358		

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residents at the facility.
-The FL-2's should be sent to the pharmacy.
-New medication orders should be sent to the pharmacy.
-In general, orders may come in to the pharmacy the next day since residents returned to the facility with medications from the hospital as opposed to the pharmacy having to fill the prescription.

3. Review of Resident #1's current FL-2 dated 01/08/16 revealed:
-Diagnoses included dementia (multi infarct), hypertension, arthritis, hip replacement, hyperlipidemia, atypical psychosis, left ventricular hypertrophy, cellulitis of right leg, history of left calf deep vein thrombosis.
-There was a physician's order for Warfarin, generic name for Coumadin (an oral, blood thinner medication used to treat and prevent blood clots) 12 mg take daily at bedtime.
-There was no order for Aripiprazole generic name for Abilify (an antipsychotic medication used to treat the symptoms of psychotic conditions) 15mg daily at bedtime.

Review of Resident #1's Resident Register revealed an admission date of 09/25/07.

a. Review of subsequent orders for Resident #1 revealed:
-There was an order dated 03/29/16 for Coumadin 12mg daily.
-There were no other subsequent orders in the record related to Coumadin.

Review of the March 2016 Medication Administration Records (MARs) for Resident #1 revealed:

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D 358	Continued From page 58 -A computerized entry for Coumadin 6mg, take 2 tablets daily at 8pm; there was a handwritten entry in large print across the administration row that the order had changed 02/18/16. -There was a handwritten entry dated 02/18/16 for Coumadin 11mg, take daily at 5pm; an entry that the order had stopped 03/29/16 with one line drawn thru the administration rows from 03/29/16 through 03/31/16. -The Medication Aides (MAs) documented administration of Coumadin 11mg from 03/01/16 through 03/28/16. -There was a handwritten entry dated 03/29/16 for Coumadin 12mg, take daily at 5pm. -The MAs documented administration of Coumadin 12 mg from 03/29/16 through 03/31/16. Review of the April 2016 MARs for Resident #1 revealed: - A computerized entry for Coumadin 6mg, take 2 tablets daily at 8pm; there was a handwritten entry in large print across the administration row that the order had changed. -A handwritten entry dated 03/29/16 for Coumadin 12mg, take daily at 5pm. -The MAs documented the administration of Coumadin 12mg from 04/01/16 through 04/29/16. Review of the May 2016 MAR for Resident #1 revealed: - A computerized entry for Coumadin 6mg, take 2 tablets daily at 8pm; there was a handwritten entry in large print across the administration row that the order was "rewritten". -A handwritten entry for Coumadin 6mg, 2 tablets by mouth daily at 5pm. -The MAs documented administration of Coumadin 6mg, 2 tabs daily at 5pm from 05/01/16 through 05/04/16.	D 358		

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D 358	Continued From page 59 Interview with the Resident Care Coordinator (RCC) on 05/09/16 at 2:20pm revealed: - There should have been order changes for Coumadin in Resident #1's record. - Most orders were received via email with the primary care provider in regards to Coumadin. -She would review her emails and provide a copy. Interview with the Primary Care Provider (PCP) on 05/10/16 at 12:20pm revealed: -Most communication related to Coumadin was done through email. - The email communications were considered an order. -Any order changes in Coumadin would be in the form of an order documented in the resident's record or via email correspondences with the RCC. Review of email correspondents between the RCC and the PCP for Resident #1 regarding Coumadin revealed: -An email dated 02/18/16 at 3:51pm from the RCC to the primary provider that Resident #1 was on Coumadin 12mg. -An email dated 02/18/16 at 3:55pm from the PCP to the RCC to change Resident #1's Coumadin to 11mg daily. -An email dated 03/23/16 at 6:00pm from the PCP for Resident #1's Coumadin to be increased to 12mg daily. Interview with the RCC on 05/10/16 at 5:30pm revealed: -There "must had been an oversight" for the Coumadin order given on 03/23/16 to increase to 12 mg daily. -The PCP was not aware that Resident #1 received the wrong dose of ordered Coumadin	D 358		

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D 358	Continued From page 60 from 03/24/16 through 03/28/16. Observation of the RCC on 05/10/16 at 5:30pm revealed the PCP was contacted and advised that Resident #1 received Coumadin 11mg from 03/24/16 through 03/28/16 instead of the ordered dose of Coumadin 12mg. b. Review of the March 2016 Medication Administration Records (MARs) for Resident #1 revealed: -There was a computerized entry for Aripiprazole 15 mg take at 9pm. -The MAs documented administration of Aripiprazole 15 mg from 03/01/16 through 03/31/16. Review of the April 2016 MARs for Resident #1 revealed: -There was a computerized entry for Aripiprazole 15 mg take at 9pm. -The MAs documented administration of Aripiprazole 15 mg from 04/01/16 through 04/30/16. Review of the May 2016 MAR for Resident #1 revealed: -There was a computerized entry for Aripiprazole 15 mg take at 9pm. -The MAs documented administration of Aripiprazole 15 mg from 05/01/16 through 05/04/16. Interview with the Administrator on 5/06/16 at 9:40am revealed they would attempt to locate information missing from Resident #1's chart regarding any missing information. Interview with the RCC on 05/10/16 at 5:30pm revealed:	D 358		

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D 358	Continued From page 61 -The RCC could not locate a current order for Aripiprazole and also attempted to call Resident #1's pharmacy provider, however, they were closed. -The RCC would clarify if Resident #1 should continue Aripiprazole. 4. Review of Resident #3's current FL-2 dated 11/18/15 revealed: -Diagnoses included gastric ulcer, hypotension, bipolar, Ehlers Danlos syndrome, otitis externa, fibromyalgia, depression, vitamin D deficiency, and status post cerebral vascular accident. -Resident #3 was intermittently confused. -Resident #3 was ambulatory with a rollator. -Review of the Resident #3's Resident Register revealed an admission date of 10/13/12. Review of physician orders for Resident #3 revealed: -There was an order dated 03/23/16 for Clonazepam (used to treat anxiety) 0.5mg take one tablet daily as needed for anxiety. -There was an order dated 03/31/16 for Clonazepam 0.5mg take one daily in am as needed for anxiety. Review of Resident #3's April 2016 Medication Administration Record (MAR) revealed: -A computerized entry for Clonazepam 0.5mg take one tablet once a day as needed for acute anxiety. -The Medication Aides (MAs) documented administration of Clonazepam 0.5mg outside of the ordered times on 04/12/16 at 8:10pm, 04/14/16 at 1:00pm, 04/15/16 at 8:00pm, 04/17/16 at 1:00pm, 04/18/16 at 1:00pm,	D 358		

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D 358	Continued From page 62 04/19/16 at 12:00pm, 04/20/16 at 12:30pm, 04/21/16 at 12:00pm and 04/22/16 at 1:00pm. Review of Resident #3's May 2016 MAR revealed: -A computerized entry for Clonazepam 0.5mg take one tablet once a day as needed for acute anxiety. -There was no documented administration of Clonazepam 0.5mg from 05/01/16 through 05/05/16. Interview with the Resident Care Coordinator (RCC) and Administrator on 05/10/16 at 6:45pm revealed: -The RCC was unaware of the order. -The Administrator had concerns the resident would frequently leave the facility in the am hours with her boyfriend and may not be at facility to take this medication as needed in the morning hours. -There would be contact made with the primary care provider to possibly change the order. _____ The facility submitted the following Plan of Protection on 05/06/2016: -The physician had been contacted to obtain order. -Medication would be administered as ordered. -The RCC/Administrator/Designee would immediately begin auditing MAR's to ensure medications were being administered as ordered. -The RCC would monitor MAR's weekly to review new orders that have been added to MAR. -The ED/RCC would perform random chart audits to assure medications were being administered as ordered weekly times one month, then monthly thereafter. -Any staff found not following policies and	D 358		

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D 358	Continued From page 63 procedures would receive additional training and disciplined up to and including termination. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 09, 2016.	D 358		
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 reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with the rules and regulations as related to Personal Care and Supervision, Medication Administration, Health Care and Physical Environment. The findings are: 1. Based on observation, interview and record review, the facility failed to ensure supervision of residents was provided in accordance with each resident's assessed need, resulting in elopement for 2 of the 7 sampled (#5, and #6) residents. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record	D912		

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D912	Continued From page 64 reviews, the facility failed to assure medications were administered as ordered for 3 of 6 residents (Residents #4, #9, #10) observed during the medication passes, including errors with Novolin R insulin (Resident #4) and Humalog Insulin (Resident #10) and Flonase nasal spray (Resident #9), and 3 of 7 residents (Residents #1, #3, #4) sampled for record review including errors with Novolin R Insulin (Resident #4), Hydralazine (Resident #4), Abilify and Coumadin (Resident #1), and Clonazepam (Resident #3). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on record review and interview, the facility failed to assure physician orders for lab testing were implemented for 3 of 7 residents (Residents #1, #2, #8)sampled. [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]. 4. Based on observation, interview and record review, the facility failed to assure each exit door accessible by residents had a functioning alarm or alert system device activated when the door was opened for 2 of 2 sampled residents (#5, and #6) with dementia and disorientation. [Refer to Tag 067, 10A NCAC 13F .0305(h (4)Physical Environment (Type A2 Violation)].	D912		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is	D992		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D992	Continued From page 65 conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 3 sampled employees (Staff B) hired after 10/1/13. The findings are: Review of Staff B's employment record revealed:	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R-C 05/10/2016

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D992	Continued From page 66 -Staff B was hired on 1/16/14 as a medication aide. -There was no documentation of completion of controlled substance examination and screening found in the record. Interview with the Administrator on 5/10/16 at 2:35pm revealed: -She was unable to locate controlled substance screening for Staff B ,"it was not done". -The Administrator was responsible for controlled substance screening for new staff. -Staff B had been working at the facility for 2 years; the previous Administrator apparently did not do a screening on Staff B.	D992		