STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: _____ B. WING _____	R 06/24/2016

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WINDHAM HALL	329 COOPER STREET KENANSVILLE, NC 28349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Duplin County Department of Social Services conducted a follow up survey and complaint investigation on June 23-24, 2016.	{D 000}		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (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 ensure that the resident rooms and common areas were free of all obstructions and hazards. The findings are: Observation of resident room #49 on 06/23/16 at 10:00am revealed the closet door was open and there were 5 metal door lock assemblies, 3 screws, a metal lamp rod and a 4-foot fluorescent bulb sitting a on top the inside shelf. Observation of resident rooms #46 and #47 on 06/23/16 at 10:10am revealed there was a 6-inch high metal bedrail frame with two rails sticking out in each room. Observation of the pool table in the common living area on 06/23/16 at 10:15am revealed a green felt surface covered with approximately 100	D 079		

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D 079	Continued From page 1 loose metal staples and paint chips. Observation of the men's hall housekeeping closet on 06/23/16 at 10:25am revealed: -The door was open. -There were several cans of paint, screwdrivers, cleaning supplies, a gallon of paint thinner, metal cutting shears, metal rods and various construction supplies. -The light switch plates covers for the two light switches were missing. Observation of resident room #43 on 06/23/16 at 10:35am revealed a missing closet door knob. Observation of resident room #39 on 06/23/16 at 10:35am revealed: -There were 2 bottles of furniture polish on the dresser. -There was a metal curtain rod on top of the dresser. -There was a 6-inch long nail on the dresser. Observation of resident room #41 on 6/23/16 at 10:40am revealed: -The door was open. -There were two open boxes of green curtain panels. -There were two hand soap refills on the chair by the window. -There were two curtain rods and screws on top of the dresser. Confidential interview with resident revealed: -The resident had to be moved 4 times to different rooms as the painters needed to paint. -The resident returned each time to the rooms after painting was complete, each time having to put back the personal belongings and furniture which had been placed in a pile in the middle of	D 079		

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D 079	Continued From page 2	D 079		

the room prior to painting.
-The painters often left items behind in the resident's room such as door knobs, curtain rods and screws.

Confidential interview with a second resident revealed:
-The painters left all of the resident's belongings in the center of the resident's room a week earlier and had not begun to paint.
-The resident had to "maneuver slowly around the pile of stuff to avoid tripping."
-The resident had told the Director that there were too many obstructions to walk around.
-The resident had asked the Director why the painters could not complete one room then move to the next rather than leaving several rooms incomplete for over a week.
-The resident was told by the Director that the painters are working as fast as they can but never gave a completion date for the painting of the resident's room.

Observation of the facility's Director on 06/24/16 at 1:05pm revealed she picked up a 2-foot long metal support rod from the corridor floor by entrance of resident room #22.

Observation of an empty unnumbered resident room across from resident room #22 on 06/24/16 at 1:10pm revealed:
-The door was completely open.
-The room was filled with painting supplies including brushes, poles, tools, and various metal objects.
-There was no one in the room.
-The room was not taped off to prevent entry.

Interview with the Director on 06/24/16 at 1:15pm revealed:

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D 079	Continued From page 3 -The painters had occasionally left parts and pieces around the facility. -She tried to tell the painters to pick up after they were through working in an area but they did not always do so. -She had not seen any residents taking any supplies from the painters nor areas where they were working. -The empty resident rooms were being used to store items and supplies while the painters worked. -The empty resident rooms where supplies were often left unlocked. -Several knobs from doors were removed during the painting project. -The furniture and resident belongings were moved to the center of each resident room prior to painting. -She was unaware that the items moved to the center of the resident room were left there for more than one day while they painted. -She was unaware that the painters had left various supplies in several resident rooms. -She did not check the resident rooms or corridors for hazards or cleanliness issues. -She did not know the painters had dirtied the pool table so that residents could not use it. -She had locked the housekeeping closet and reminded the painters to keep it locked when going in and out for supplies. -She would remind the painters to check the main corridor, lock the housekeeping closet and go room-to-room to secure all loose items. -She immediately would secure all items in empty resident rooms to ensure safety of the residents.	D 079		
D 112	10A NCAC 13F .0311 (c) Other Requirements 10A NCAC 13F .0311 Other requirements	D 112		

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D 112	Continued From page 4 (c) Air conditioning or at least one fan per resident bedroom and living and dining areas shall be provided when the temperature in the main center corridor exceeds 80 degrees F (26.7 degrees C). This rule apply to new and existing facilities This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide air conditioning or at least one fan per resident bedroom (Rooms #1, #2, #3, #4, #7, #11, #16, #20, #23, #24, #28, #29, #31, #38 and #45) and for one resident (Resident #5) with breathing difficulties. The findings are: Observation of the thermostat in the main hallway on 06/23/16 at 1:00pm revealed: -The thermostat was set at 75 degrees F. -The corridor temperature reading was 88 degrees F. Review of "weather.com" highest outside temperature reading on 6/23/16 at 1:00pm revealed 93 degrees F. Observation of the thermostat in the main hallway on 06/23/16 at 1:45pm revealed: -The thermostat was set at 75 degrees F. -The corridor temperature reading was 91 degrees F. Review of "weather.com" highest outside temperature reading on 6/23/16 at 1:45pm revealed 95 degrees F. Observation of the thermostat in the main hallway on 06/23/16 at 2:50pm revealed:	D 112		

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D 112	Continued From page 5 -The thermostat was set at 75 degrees F. -The corridor temperature reading was 90 degrees F. Review of "weather.com" highest outside temperature reading on 6/23/16 at 2:50pm revealed 93 degrees F. Observation of the thermostat in the main hallway on 06/23/16 at 4:30pm revealed: -The thermostat was set at 75 degrees F. -The corridor temperature reading was 89 degrees F. Review of "weather.com" highest outside temperature reading on 6/23/16 at 4:30pm revealed 93 degrees F. Observation of room #16 (Resident #5's room) on 06/23/16 at 3:00 revealed: -The temperature was 87 degrees F. -There was no fan in the resident's room. Review of "weather.com" highest outside temperature reading on 6/23/16 at 3:00pm revealed 93 degrees F. 1. Review of Resident #5's FL-2 dated 05/23/16 revealed diagnoses of chronic obstructive pulmonary disease (COPD), psychosis and bipolar disorder. Review of Resident #5's Resident Register revealed a date of admission of 05/23/16. Interview with Resident #5 in Room #16 on 06/23/16 at 3:00pm revealed: -The resident used oxygen consistently. -The resident was "feeling tight in the chest due to the heat in the room."	D 112		

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D 112	Continued From page 6 -"When the air gets hot in here, I can't breathe well and feel tight in my chest." -"It is hot in here a lot of days so I'm trying to transfer to another facility because of the heat." -The resident had previously been on oxygen prior to residing in the facility. -The resident had informed the staff that of breathing difficulties on several occasions but the temperature had not changed. -The resident was recently seen at the local emergency department due to a COPD exacerbation on 06/18/16. -The resident was not provided a fan. Interview with 8 residents on 06/23/16 revealed: -They complained of "feeling warm today." -The staff had told them that they were not "allowed" to lower the temperature. -One of the residents stated that the ceiling fan in their room does not work. -Most residents stayed in bed because of the heat. -"Complaining about the heat to the Director does no good." -They preferred that the the building be cooler than the current temperature. -It has been unusually hot indoors for the last two weeks. Interview with the Resident Care Coordinator (RCC) and Director on 06/23/16 at 1:00pm revealed: -The owner prohibited setting the thermostat below 75 degrees F. -The Maintenance Director was the only person with a key to the locked thermostat. -They would lower the temperature setting on the thermostat in the facility right away. -The residents had not complained of the temperature.	D 112		

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D 112	Continued From page 7 -It was "a little warm" in the corridor by the thermostat. Further interview with the RCC on 06/23/16 at 2:30pm revealed he would request again for the thermostat to be lowered to "a cooler temperature" via the Maintenance Director as the corridor temperature still exceeded 80 degrees F. Confidential interview with staff revealed: -The corridors were very warm and uncomfortable. -The current temperature was a common occurrence. -The residents had often stated they were hot but did not report it, because they were told the facility was not allowed to lower the temperature. -They had sweat regularly during their shift. -There was a cover over the thermostat which required a key to open which prevented anyone but the Maintenance Director from lowering the temperature. -The Maintenance Director was off today and could not unlock the thermostat to lower the temperature. Interview with Administrator on 06/24/16 at 11:00am revealed: -She was responsible for ensuring that the temperatures in the building were in compliance. -She had purchased 15 fans for resident rooms that did not already have one at 10:00am on 06/24/16. -All fans were placed in the residents rooms. -She had called the air conditioner service company which services the facility regularly and they would come to the facility today. -All rooms now had fans. Interview with facility's air conditioner repairman	D 112		

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D 112	Continued From page 8 on 06/24/16 at 2:15pm revealed: -He recorded the current temperature in the corridor as 82 degrees F. -The building's air conditioning unit needed replacement because it could no longer cool the building. -He visited the facility weekly and normally the corridor did not exceed 80 degrees F. -The building's thermostat current temperature reading of 75 degrees F did not reflect the actual temperature of 81 degrees in the corridor. -He recommended the entire air conditioner system be replaced as it was old and unable to accommodate the cooling needs of the building. -The thermostat's room temperature indicator was inaccurate and displayed a temperature reading 7 degrees below the actual room temperature. Observation of the thermostat in the main hallway on 06/23/16 at 2:30pm revealed: -The thermostat was set at 75 degrees F. -The corridor temperature reading was 82 degrees F. Review of "weather.com" highest outside temperature reading on 6/23/16 at 2:30pm revealed 91 degrees F.	D 112		
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	D 358		

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D 358	Continued From page 9 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 3 of 5 residents (#1, #2, #5) including errors with a corticosteroid (#5), a narcotic pain reliever (#1), and iron sulfate (#2). The findings are: 1. Review of Resident #5's current FL2 dated 5/23/16 revealed: -Diagnoses included psychosis unspecified, bipolar disorder and COPD. -Resident #5 was semi-ambulatory and used a walker. -The resident had an order for oxygen. -Medications included Prednisone (a corticosteroid given for exacerbations of COPD). Review of a physician's order dated 6/18/16 revealed an order for Prednisone 60mg daily for 5 days, with the last dose to be given on 6/22/16. Review of Resident #2's Medication Administration Records (MAR) for June 2016 revealed: -Prednisone 60mg was scheduled to be administered daily at 8:00am. -Prednisone 60mg administration began on 6/18/16. -The Medication Aide's initials had been documented and circled on 6/21/16 and 6/23/16. -The reason for not administering the Prednisone, documented as "Exceptions for [Resident #5's name]" on both MARs was "no meds, meds on order." -Prednisone did not need to be given after	D 358		

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D 358	Continued From page 10 6/22/16, the 5th day of the prescription. Interview with Resident #5 on 6/23/16 at 11:30am revealed: -The resident had received the first Prednisone 60mg dose at the hospital on 6/18/16. -The personal care aide (PCA) who picked the resident up from the hospital on 6/18/16 had stopped at the pharmacy to fill the remaining 4 doses of Prednisone 60mg on the way to the facility. -The resident had received the second dose at the facility on 6/19/16 at 8:00am. -The resident had received the third dose at the facility on 6/20/16 at 8:00am. -The resident did not received the fourth dose on 6/21/16 and was told by the medication aide that the Prednisone was unavailable and would be reordered. -The resident did not received the fifth dose on 6/22/16 and was told by the medication aide that the Prednisone was discontinued. -Resident #5 told the RCC that the Prednisone prescription had run out and the medication aides did not explain why. -Resident #5's felt that her COPD exacerbation which she initially went to the emergency room for was beginning to come back. Interview with Staff A on 6/23/16 at 2:00pm revealed: -Staff A reordered the Prednisone for Resident #5 upon realizing there was no supply on hand on 6/20/16 for the next day's administration. -Staff A could not recall which pharmacy the refill request was sent. -Staff A did not have the empty bottle of Prednisone for Resident #5. -Staff A could not explain why the MAR reflected a dose was documented as given on 6/22/16	D 358		

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D 358	Continued From page 11 when she had no medication on hand on 6/21/16. Attempted interview with Staff C on 6/23/16 at 3:15pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) and Director revealed: -The RCC is responsible for ensuring that a medication is reordered. -The RCC had no idea why the medication had run out. -The RCC did not know which pharmacy Resident #5's Prednisone came from. -The Director and RCC were unaware that Resident #5 was out of medications. -Resident #5 never mentioned anything related to not receiving medication to them. -They could not explain who "dropped the ball" on the medication reorder. -There were no faxes or confirmations on hand related to the pharmacy reorder for Resident #5. -The medication aides are supposed to notify the RCC when medications are not on the cart or have been reordered. Interview with the facility's primary pharmacy provider revealed: -There was no record of any refill request for Resident #5's Prednisone. -They did not fill Resident #5's Prednisone. -They did not have an order for Resident #5's Prednisone. Interview with the facility's backup pharmacy provider revealed: -There were 12 Prednisone 20mg tablets filled and picked up by the facility on 6/18/16 at 12:58pm with instructions for 3 tablets daily for 4 days (ending 6/22/16). -There were no refill requests received from the	D 358		

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D 358	Continued From page 12 facility for Resident #5's Prednisone. Interview with the RCC on 6/24/16 at 10:05am revealed Resident #5 was being taken to the emergency room today for precautions and to obtain another prednisone prescription. Interview with Resident #5 on 6/24/16 at 3:10pm revealed: -The resident received another 5-day dose of Prednisone. -The facility had it filled at the pharmacy on the way back to the facility. -The resident was already feeling better after the first dose at the hospital 3 hours earlier. Interview with the RCC on 6/24/16 at 3:30am revealed: -The hospital had reissued another 5-day daily dosage of Prednisone 60mg. -Resident #5 had the Prednisone on hand. -He would ensure that the medication aides followed up on her care for the full 5-day regimen of Prednisone 2. Review of Resident #1's current FL-2 dated 2/23/16 revealed that Resident #1 has diagnoses of pancreatitis, Crohn's disease, chronic pain and depression. Review of Resident #1's Medication Administration Record (MAR) for June 2016 revealed: -Resident #1 was prescribed Hydrocodone/APAP 7.5-325 one tablet by mouth three times daily. -Documentation on the MAR stated the order for Hydrocodone was discontinued on 6/20/16. -Documentation on the MAR stated the administration of Oxycodone 10mg one tablet by	D 358		

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D 358	Continued From page 13 mouth twice daily began on 6/17/16. Review of Medication Orders for Resident #1 revealed an order written by the facility's physician dated 6/16/16 stated to discontinue Hydrocodone and begin Oxycodone 10mg one tablet by mouth twice daily. Interview with Resident Care Coordinator (RCC) on 6/24/16 at 10:00am revealed: -The RCC denied any overlap in the administration of Hydrocodone and Oxycodone. -The facility physician discontinued the Hydrocodone and wrote the new order for Oxycodone on 6/16/16. -Resident #1 told the RCC not to discontinue the Hydrocodone until the Oxycodone came into the facility from the pharmacy. -The physician called the order into the pharmacy after 3:00pm on 6/16/16. -The RCC was unable to order the medication from the back-up pharmacy because the facility did not have access to a hard copy prescription. Interview with Resident #1 on 6/24/16 at 10:40am revealed: -The facility physician changed Resident #1's prescription from Hydrocodone to Oxycodone. -Resident #1 asked to see the physician's order and the Resident Care Coordinator (RCC) provided the order. -Resident #1 stated the order was written to discontinue Hydrocodone and begin Oxycodone on 6/16/16. -The medication aides continued to administer Hydrocodone along with Oxycodone. -Resident #1 questioned the Medication Aides about the medication. -The Medication Aides stated the Hydrocodone was not discontinued on the Medication	D 358		

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	HAL031006	A. BUILDING: _____ B. WING _____	R 06/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAM HALL	329 COOPER STREET KENANSVILLE, NC 28349

(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 358	Continued From page 14	D 358		

Administration Record and they had to continue administering the medication.
-Resident #1 denied any adverse reaction to the medication.
-Due to high tolerance of pain medications, Resident #1 was not afraid of the medication causing harm if not discontinued.
-The facility staff did not order medication in a timely manner.
-Resident #1 had gone without medication in the past over a weekend (Saturday and Sunday) before.
-Resident #1 felt there was a miscommunication between the RCC and Medication Aides.
-Resident #1 was told by the RCC that the Medication Aides are responsible to inform the RCC when medications run low.
-Resident #1 was told by the Medication Aides it is the RCC's job to check medications on the cart and reorder when they run low.

3. Review of Resident #2's current FL2 dated 5/20/16 revealed:
-Diagnoses included acute renal failure, chronic kidney disease, and type 2 diabetes.
-There was a medication order for Ferrous Sulfate (a type of iron used to treat iron deficiency anemia) 325mg 1 tablet to be administered every other day.

Review of the Resident Register for Resident #2 revealed he was admitted to the facility on 5/20/16.

Review of subsequent orders for Resident #2 revealed there was no subsequent order for Ferrous Sulfate.

Review of the June 2016 Medication Administration Record (MAR) for Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 15	D 358		

revealed:
-Ferrous Sulfate 325mg 1 tablet was printed on the MAR with instructions to administer every other day.
-Ferrous Sulfate 325mg 1 tablet had been documented as administered every day at 8:00am June 1, 2016 through June 23, 2016.
-Resident #2 had been given a prn medication for constipation on 2 occasions in June.
-On June 11 and June 12, 2016, 2 Senna S (used to treat constipation) tabs 4.6 mg each had been administered to Resident #2.

Interview with the medication aide on 6/123/16 at 3:00pm revealed:
-Resident #2 had been receiving the Ferrous Sulfate every morning.
-He was not aware the order was for every other day.

Interview with Resident #2 on 6/23/16 at 3:15pm revealed:
-He was not aware of the medications that were administered to him.
-He had experienced some constipation, and had received medication for the constipation.

Interview with the RCC on 6/24/16 at 10:40am revealed:
-He was responsible for processing medication orders.
-He was not aware Resident #2's Ferrous Sulfate was written for every other day.
-Resident #2 had been receiving the Ferrous Sulfate every morning at 8:00am.
-He must have overlooked the every other day.
-He would assure the medication would be given as ordered going forward.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 390	Continued From page 16	D 390		
D 390	10A NCAC 13F .1007 (e) Medication Disposition 10A NCAC 13F .1007 Medication Disposition e) Records of medications destroyed or returned to the pharmacy shall include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. These records shall be maintained by the facility for a minimum of one year. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to maintain records of controlled medications that were returned to the pharmacy. The findings are: Review of Resident #1's Medication Administration Record(MAR) for June 2016 revealed: -Resident #1 was prescribed Hydrocodone/APAP 7.5-325 one tablet by mouth three times daily. -Documentation on the MAR stated the order for Hydrocodone was discontinued on 6/20/16. -Documentation on the MAR stated the administration of Oxycodone 10mg one tablet by mouth twice daily began on 6/17/16. Review of controlled medication log book on 6/24/16 at 1:00pm revealed: -There was no log for Resident #1's Hydrocodone.	D 390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 390	Continued From page 17 -There was a log for Resident #1's Oxycodone. Review of Medication Orders for Resident #1 revealed an order written by the facility physician dated 6/16/16 which stated to discontinue Hydrocodone and begin Oxycodone 10mg one tablet by mouth twice daily. Interview with the facility's primary pharmacy on 6/24/16 at 2:20pm revealed: -The physician order for Hydrocodone was written 5/31/16 and discontinued 6/16/16. -The physician order for Oxycodone was written on 6/16/16. -The order was received by the pharmacy and dispensed to the facility on 6/16/16. -Pharmacy records indicate the facility has not yet returned the Hydrocodone to the pharmacy. Interview with Resident Care Coordinator (RCC) on 6/24/16 at 2:45pm revealed: -The Hydrocodone should have been returned to the pharmacy on 6/20/16. -The nighttime Medication Aides sent back the medications to the pharmacy. -The RCC could not account for the receipt of the Hydrocodone from the pharmacy. -The RCC contacted the pharmacy and was informed there was no record that the Hydrocodone was returned. -The RCC did not have any documentation related to the amount of Hydrocodone being returned to the pharmacy.	D 390		