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 08/05/2016

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 a follow up survey on 8/2/16 through 8/5/16.	{D 000}		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation, the facility failed to keep ceilings, floors and floor coverings clean and in good repair. Observation of the floors on the East Hall (men's hallway) on 8/2/16 revealed: -The carpet on the floors throughout the men's hallway were soiled, with black spots. -A strip of black duct tape at the first men's bathroom door entrance joined the carpet and the restroom tile. -A strip of black duct tape at first men's shower room entrance joined the carpet and shower room tile. -A strip of black duct tape was on the floor entrance and joined the carpet to the tile of occupied resident rooms 302. -A strip of black duct tape was on the floor entrances and joined the carpet to the tile of occupied resident room 309. -At the entrance of room 309 the corner end of the duct tape near the wall was peeling, and sticking up and could be a tripping hazard. -A strip of black duct tape was on the floor	{D 074}		

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NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

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{D 074}	Continued From page 1	{D 074}		

entrances and joined the carpet to the tile of occupied resident room315.
-At the entrance of room 315, the corner end of the duct tape near the wall was peeling, and sticking up, and could be a tripping hazard.
-A strip of black duct tape was on the floor entrances and joined the carpet to the tile of occupied resident rooms317.

Observation of room 320 on 8/2/2016 during facility tour at 10:20am revealed black scuff marks over 85 percent of floor.

Observations on the East Hall during the facility tour at 10:20am on 8/2/16 revealed
-A patch of black duct tape had been applied over a section of the carpet that was the approximate size of a large book located on the floor near the entrance of the dining room.
-The area underneath the black tape was not leveled.

Observations of the dining room during the facility tour at 10:20am on 8/2/16 and at 11:45pm on 8/5/16 revealed:
-All 3 entrances to the dining room from the hallway had a strip of black duct tape that joined the carpet from the hallway to the tile in the dining room.
-The dining room tile was covered with black scuff marks throughout the dining room.
-The ceiling in the dining room had 3 old. large water spots.
-Two of the water spots were located over tables where residents were seated to eat their meals.
-The water spots varied in size with the largest of the three, located closer to the kitchen than the other two.
-The largest water spot was about the size of a

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NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

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{D 074}	Continued From page 2 truck tire, and was located over a resident table. -The largest water spot was peeling paint and had areas of chipped and missing paint. -The smallest water spot was located in front the entrance of the dining room near the medication room. -The 3rd water spot was located near the AC unit. -The 3rd water spot was also located over resident dining tables. -Next to the third water spot was an outlet plug in the ceiling with the edges pulling away from the ceiling (it was not flush). Interview with the Maintenance Director on 8/5/16 at 1:00am revealed: -They shingles on the roof over the dining room had recently been repaired, due to previous leaks. -The repair of the dining room ceiling had been put off. -Some of the ceiling tiles needed to be taken out because of the water damage that was done. -He mentioned that to the painters and inquired about when the ceiling would be fixed about "2 weeks ago", but he had not heard anything else about it. -He showed the construction crew the water spots in the dining room and the chipped paint on the ceiling. -The kitchen staff were responsible for cleaning the dining room floors and it had gotten better. -Sometimes the kitchen staff was good about keeping the floor clean and sometimes they were not. -They would often bleach the floor, and the bleach would remove the finish. -He finished waxing the dining room floors about 3 months ago. -He placed the duct tape strips on the floors to	{D 074}		

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NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

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{D 074}	Continued From page 3 keep residents from tripping, at least 4 months ago. -The rubber strips (transition piece) on the floors that separate the carpet from the tile peel and can be a tripping hazard for the residents. -The transition pieces come up all the time and constantly need to be replaced. The construction crews have replaced some, but they have not replaced all of them. -The Management was aware of the duct tape on the floor and the reason why it was there. -The path of black duct tape on the floor in front of the dining room was there because there was a rip in the carpet and he did not want anyone to trip and fall.	{D 074}		
{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 keep 2 of 3 common bathrooms on the East Hall used by residents clean, and free from obstructions and hazards. The findings are: Observations of the first common men's shower room on the East Hall on 8/2/16 revealed: -The lower third of the entrance door had worn,	{D 079}		

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

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{D 079}	Continued From page 4 scuffed marks. -The lower third of the door frame entrance had worn missing paint. -Cracks and missing edges on the vanity, covered with dirty, white duct tape. -The top sides of the vanity were held together with dirty, white duct tape. -The bottom leg and cabinet on the vanity was held together with dirty, white duct tape. -The bottom cabinet was hanging crooked. Observation of the second common men ' s shower room on the East Hall on 8/2/16 revealed: -The lower third of the entrance door had worn, scuffed marks. -The lower third of the door frame entrance had worn missing paint. -Dirty, white duct tape held the top back of the vanity together. -Dirty, white duct tape was along the side of the vanity away from the wall. Interview with the Administrator Intern on 8/2/16 at 11:00am revealed: -Both of the men's bathrooms were going to be renovated but she did not know when they would be started. -Management was aware of the condition of the men's bathrooms. Interview with the Maintenance Director on 8/5/16 at 11:00am revealed: -He placed the duct tape on the vanity to hold it together and keep the residents safe, the edges of the vanity are sharp and someone could get hurt. -Management was waiting for the work crew to renovate the bathrooms, but he did not know when that would happen. -He spoke with management about the broken	{D 079}		

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	HAL092186	A. BUILDING: _____ B. WING _____	R-C 08/05/2016

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

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{D 079}	Continued From page 5 vanities in both of the men's bathrooms about 2 months ago. He had not heard anything else about it.	{D 079}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Type B VIOLATION Based on observation, interview and record review, the facility failed to assure that medications were administered as ordered for 4 of 7 sampled residents (#1, #2, #4, #6) to include not administering Methadone, Novolin 70/30, Seroquel, Norvasc, Losartan as ordered; and 3 of 9 sampled residents (#8, #9, #11) observed during the medication passes to include the administration of Aspirin and Sodium Bicarb without an order and the administration of Carafate Suspension and Xanax over 1 hour past the scheduled administration time. The findings are: 1. Review of Resident #4's current FL2 dated 5/23/16 revealed: -Diagnoses included type 2 diabetes, hypertension and depression.	{D 358}		

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NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

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{D 358}	Continued From page 6 -There was a physician order for Novolin 70/30 insulin 65 units to be injected subcutaneously (SQ) before breakfast. (70/30 insulin is a mixture of long acting insulin and fast acting insulin used for lowering blood sugar.) -There was a physician order for Novolin 70/30 insulin 50 units SQ before dinner. Review of the Resident Register for Resident #4 revealed an admission date of 5/28/16. a. Review of the June 2016 Medication Administration Record (MAR) for Resident #4 revealed documentation that 55 units of Novolin 70/30 insulin (this was not the ordered dose of 65 units) had been administered from 6/1/16 through 6/30/16 at 8:00am. Review of subsequent physician orders for Resident #4 dated 7/11/16 revealed: -There was an order to stop Novolin 70/30 insulin. -There was an order to start Novolin R (Regular Insulin) 15 units, give 15 minutes before breakfast, lunch and dinner. (Novolin R is a fast acting insulin used to treat diabetes and lowers the blood sugar.) Review of the July 2016 MAR for Resident #4 revealed: -Novolin 70/30 50 units before dinner had been discontinued on 7/11/16. -Novolin 70/30 55 units before breakfast (this was not the ordered dose of 65 units) had not been discontinued and was documented as administered before breakfast from 7/11/16 through 7/11/16. -Novolin R 15 units SQ was documented as administered before each meal 7/12/16 through 7/31/16.	{D 358}		

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{D 358}	Continued From page 7 Refer to interview with the Administrator in Training on 8/3/16 at 11:00am. b. Review of Resident #4's current FL2 dated 5/23/16 revealed a physician order for Seroquel 50mg two times a day. (Seroquel is used to treat certain mental/mood conditions). Review of the August 2016 MAR for Resident #4 revealed: -Seroquel 50mg was scheduled to be administered two times a day at 9:00am and 9:00pm. -There was documentation that Resident #4 missed 7 doses of Seroquel 50mg on 8/1/16, 8/2/16, 8/3/16 and the 9:00am dose on 8/4/16. -On the back of the MAR, the medication aide had documented, " awaiting Seroquel 50mg tablets " . Interview with Resident #4 on 8/2/16 at 11:05am revealed he was not aware of the medications that were administered to him. Observation of the medication cart on 8/3/16 at 4:15pm revealed there was no Seroquel 50mg tablets on the medication cart for Resident #4. Interview with the medication aide on 8/3/16 at 4:15pm revealed: -There was no Seroquel 50mg tablets on the medication cart for Resident #4. -Resident #4 received his medications in the mail. -Resident #4 received his last dose of Seroquel on 7/31/16. -Seroquel 50mg for Resident #4 should be coming in any day. Interview with the Resident Care Coordinator (RCC) on 8/3/16 at 1:15pm revealed:	{D 358}		

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

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{D 358}	Continued From page 8 -On the medication cards, there was a blue marking to indicate there was 7 days left of the medication on the card. -Medications were to be reordered when there was a 7 day supply left. -Lately, medications had not been reordered properly and residents have been running out of medications. Interview with the Administrator in Training on 8/4/16 at 12:55pm revealed: -When Resident #4's medications come in, they have a refill slip in the package with the medications. -When the medications are received, the medication aide was supposed to sign the refill slip and send it back to the sender so the medications could continue on a cycle fill without any breaks. -There was also a reminder on the refill slip if there was a new order needed. -If there was a new order needed, the medication aide was to send the notification with the resident to their doctor ' s appointment to receive a new order without a break in receiving medication. -More than likely, the refill slip was not sent back when the last package of medication was received, and that was why Resident #4 ran out of Seroquel. Observation of the medication cart on 8/5/16 at 4:00pm revealed the Seroquel 50mg tablets for Resident #4 were on the cart. 2. Review of Resident #6's current FL2 dated 7/19/16 revealed: -Diagnoses included Atrial Flutter with Rapid Ventricular Rate and hypotension, anemia, diabetes with hypoglycemia, and chronic kidney disease.	{D 358}		

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	HAL092186	A. BUILDING: _____ B. WING _____	R-C 08/05/2016

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 358}	Continued From page 9 -There was no physician order for Norvasc 10mg daily (used to treat high blood pressure/ hypertension). Review of the Resident Register for Resident #6 revealed she was admitted to the facility on 8/31/11. Review of the July 2016 MAR for Resident #6 revealed Norvasc 10mg 1 tablet daily was documented as administered to Resident #6 from 7/1/16 through 7/31/16. Review of subsequent physician orders for Resident #4 revealed there were no subsequent orders for Norvasc 10mg to be administered to Resident #6. Review of hospital admission and discharge records for Resident #6, dated 5/26/16 revealed: -Resident #6 had been hospitalized on 5/19/16 for atrial flutter with rapid ventricular rate and hypotension. -Resident #6 was discharged from the hospital on 5/26/16. -There was a list of medications ordered on the discharge for Resident #6. -Norvasc 10mg daily was not listed as a discharge medication for Resident #6. Review of the facility admission/ readmission orders dated 5/31/16 for Resident #6 revealed there were no orders for Norvasc 10mg to be administered to Resident #6. Observation of the medication cart on 8/3/16 at 1:15pm revealed, Norvasc 10mg tablets were on the medication cart, along with the rest of the ordered medication for Resident #6.	{D 358}		

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	HAL092186	A. BUILDING: _____ B. WING _____	R-C 08/05/2016

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

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{D 358}	Continued From page 10 Interview with the Medication aide on 8/3/16 at 1:15pm revealed: -Norvasc 10mg was administered to Resident #6 daily. -She had administered the Norvasc 10mg to Resident #6 on 8/1/16 and 8/2/16 at 8:00am. -The medication had been discontinued on 8/2/16 after she had given the daily dose. -The medication was still on the medication cart, but Resident #6 no longer received the medication. Interview with the Administrator in Training on 8/3/16 at 11:00am revealed: -She could not find a recent order for Norvasc 10mg daily to be administered to Resident #6. -The most recent order she could find for Norvasc 10mg daily to administered to Resident #6, was dated 5/14/15. The medication was given in error. -She would contact the physician and make her aware of the medication error and do a medication error report. Refer to interview with the Administrator in Training on 8/3/16 at 11:00am: 3. Review of Resident #2's current FL2 dated 3/14/16 revealed: -Diagnoses included chronic systolic congestive heart failure. -There was a physician ' s order for Losartan 50mg 1 tablet daily (used to treat high blood pressure/hypertension). Review of the Resident Register for Resident #2 revealed he was admitted to the facility on 9/3/13. Review of subsequent orders for Resident #2 dated 6/15/16 revealed a physician order for	{D 358}		

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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 358}	Continued From page 11 Losartan 100mg 1 tablet daily. Review of the June 2016 MAR for Resident #2 revealed: -There was no change in the documented dose of losartan for Resident #2 in the month of June 2016. -Losartan 50mg tablet had been documented as administered from 6/1/16 through 6/30/16. Refer to interview with the Administrator in Training on 8/3/16 at 11:00am: _____ Interview with the Administrator in Training on 8/3/16 at 11:00am revealed: -She had been working as the Administrator in Training for 3 weeks. -Prior to the 3 weeks as Administrator in Training, she had worked as the RCC. -When orders were received on weekdays, they were received by her. -She would fax the new order or order change to pharmacy. -She would transcribe the new order or order change onto the resident's MAR. -She would make a copy of the new order or order change and place it into the New Order Book that was kept in the RCC's office. -When the RCC was not present and new orders or order changes were received, the shift supervisor would receive the order and fax to pharmacy. -The supervisor would transcribe the new or changed order on the resident's MAR. -The supervisor was supposed to make a copy of the order and place it in the New Order Book. -The supervisor was also supposed to make the RCC aware of the new order or order change verbally, if they did not place the order in the New Order Book.	{D 358}		

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 08/05/2016

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

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{D 358}	Continued From page 12 -The orders in the New Order Book was compared with the resident MAR's monthly by the RCC. -The new RCC should have been following the same system. 4. Review of Resident #1's FL-2 dated 12/21/2015 revealed: -Diagnoses included Insulin Dependent Diabetes Mellitus, Atypical Psychosis, Hypertension, Osteoarthritis, Coronary Artery Disease, and Anxiety Disorder. -There was an order for Methadone (Methadone is an opioid or narcotic used to reduce withdrawal symptoms in people addicted to heroin or other narcotic drugs and pain, in some cases) 10mg, take four tablets (40mg) by mouth two times a day. Review of Resident #1's June 2016 Medication Administration Record (MAR) revealed: - He was scheduled to receive Methadone 10mg, 4 tablets (40mg) at 8:00 A.M. and 8:00 P.M. every day. -The June 2016 MAR showed initials with a circle around them from June 1, 2016 thru June 16, 2016 at 8:00 A.M. -There were initials with a circle around them for June 17 and June 18, 2016 for the 8:00 A.M. doses. -On the back of the June 2016 MAR, under Nurse's Medication Notes, for the dates initialed and circled, it was noted that Methadone was not given. The reason noted was that facility was "awaiting script from resident". Review of Resident #1's physician ' s order dated 6/16/16 revealed a new order for Methadone 10mg, take three tablets (30mg) twice daily.	{D 358}		

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	HAL092186	A. BUILDING: _____ B. WING _____	R-C 08/05/2016

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 358}	Continued From page 13 Review of Resident #1's August 2016 MAR revealed: -He was scheduled to receive Methadone 10mg, three tablets (30mg) at 8:00 A.M. and 8:00 P.M. every day. -The August 2016 MAR showed initials with a circle around from August 1, 2016 thru August 5, 2016 at 8:00 A.M. - On the back of August 2016 MAR, under Nurse's Medication Notes, for the dates initialed and circled, it is noted that Methadone was not given. The reason noted was that facility was "awaiting script from resident". Interview with Resident Care Coordinator (RCC) on 8/3/16 at 9:45 A.M. revealed the medication was not given when an initial had a circle around it. Interview with Resident Care Coordinator (RCC) on 8/5/16 at 10:45 A.M. revealed: -Resident #1 would not provide the prescription after his visit to the clinic. -The facility had not been able to reach the clinic either by phone or fax. -The facility had been trying to reach the clinic since 8/2/16. -Resident #1 had a phone number to reach the clinic but refuses to share that phone number with facility staff. Interview with Resident #1 on 8/5/16 at 11:20 A.M. revealed: -Methadone had been stopped by the physician. -He told facility Methadone would not be coming in anymore. 5. The medication error rate was 14% as evidenced by the observation of 4 errors out of 27 opportunities during the 8:00am/9:00am	{D 358}		

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	HAL092186	A. BUILDING: _____ B. WING _____	R-C 08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 358}	Continued From page 14	{D 358}		

medication pass on 8/3/16 and the 12noon and 2:00pm medication pass on 8/4/16.

A. Review of Resident #8's FL-2 dated 6/21/16 revealed:
-Diagnoses included Ambulatory Dysfunction, history of Glaucoma, history of Urinary Tract Infection with Sepsis, Renal Failure, Hypertension, Dementia, and Altered Mental Status.
-There was an order for Aspirin (used to treat or prevent heart attacks, strokes, and chest pain) 81mg, one tablet daily.

Observation of Resident #8 during the 9:00 A.M. medication pass revealed:
-There was a medication package that contained Aspirin 325mg.
-Resident #8 received Aspirin 325mg enteric coated on 8/3/16 at 9:22 A.M.

Review of Resident #8's June 2016 Medication Administration Record (MAR) revealed:
-There was an entry for Aspirin 325mg enteric coated each morning at 9:00 A.M.
-Documentation throughout the month of June 2016 showed resident received Aspirin 325mg enteric coated daily at 9:00 A.M.

Review of Resident #8's July 2016 MAR revealed:
-There was an entry for Aspirin 325mg enteric coated each morning at 9:00 A.M.
-Documentation throughout the month of July 2016 showed resident received Aspirin 325mg enteric coated daily at 9:00 A.M.

Review of Resident #8's August 2016 MAR revealed:
-There was an entry for Aspirin 325mg enteric

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	HAL092186	A. BUILDING: _____ B. WING _____	R-C 08/05/2016

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NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

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{D 358}	Continued From page 15	{D 358}		

coated each morning at 9:00 A.M.
-Documentation showed resident received Aspirin 325mg enteric coated from August 1, 2016 through August 3, 2016 at 9:00 A.M.

Interview with Resident #8 on 8/3/16 at 11:00 A.M. revealed she " felt fine " .

Interview with the Resident Care Coordinator (RCC) on 8/3/16 at 10:20 A.M. revealed:
-Resident #8 has been receiving Aspirin 325 milligrams for the months of June, July and August 2016.
-The facility did not realize that the dosage ordered on the FL-2 dated 6/21/16 had changed from Aspirin 325 milligrams Enteric Coated to Aspirin 81 milligrams.
-The facility would get clarification from the physician concerning which dosage of Aspirin to give Resident #8.

Review of the physician's order for Resident #8 dated 8/4/16 revealed the facility is to continue Aspirin 325mg enteric coated daily.

B. Review of Resident #9's FL-2 dated 5/17/16 revealed:
-Diagnoses included Type II Diabetes, Peripheral Vascular Disease, Hypertension, Mononeuropathy, Hearth Disease of Native Coronary, Anxiety Disorder and Hyperlipidemia unspecified.

1. Observation of 9:00 A.M. medication pass on 8/3/16 revealed Resident #9 received a scheduled dose of Carafate 1 Gram at 9:50 A.M. (Carafate is used to treat and prevent ulcers in the intestines.)

Review of Resident #9's August 2016 Medication

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 08/05/2016

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

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{D 358}	Continued From page 16 Administration Record (MAR) revealed: -There was an entry for Carafate Suspension 1Gram per 10mls before meals and at bedtime. -The scheduled times for administration were 7:30 A.M., 11:30 A.M., 4:30 P.M. and 8:00 P.M. Interview with Resident Care Coordinator (RCC) on 8/3/16 at 9:50 A.M. revealed Resident #9 had not eaten yet this morning. Observation of Resident #9 on 8/3/16 at 11:05 A.M. revealed the resident was lying in bed supine with eyes closed and making snoring sounds. Interview with the RCC on 8/3/16 at 11:00 A.M. revealed: -Resident #9 had eaten a snack at 10:55 A.M. -He ate snacks in his room. -He had a snack cake out of the snack machine and a K-Cup drink he keeps in his room. Interview with the RCC on 8/3/16 at 12:00 P.M. revealed Resident #9 had received his next dose of Carafate 1 Gram as scheduled for 11:30 A.M. Interview with RCC on 8/3/16 at 12:00 P.M. revealed: -The facility policy and procedure, when administering medications outside of the scheduled time, is to call the physician and get order to give medication outside of scheduled time. -The RCC had called the physician at 11:00 A.M. concerning Resident #9 ' s Carafate being given late and received a verbal order to give Carafate as scheduled for 11:30 A.M. Interview with Resident #9 on 8/3/16 at 1:17 P.M. revealed:	{D 358}		

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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 358}	Continued From page 17 -He had not eaten lunch yet. -Someone is bringing food from outside of facility. -He receives his scheduled 7:30 A.M. and 8:00 A.M. medications each day when he gets up anywhere from 7:30 A.M. to 10:00 A.M. -He receives his scheduled 7:30 A.M. and 8:00 A.M medications at 10:00 A.M at the latest. -They never brought medications to my room during the day. -I usually have to go to the medication room to get my medications. Interview with Administrator in Training on 8/5/16 at 11:40 A.M. revealed: -The facility's policy and procedure is to notify the physician when medications are been given outside of the scheduled time. -The RCC is also notified; and, the RCC relays that information to the Administrator in Training. -For the most part, the medication pass is on time each day. -She could not recall a time that medications have been given late. 2. Observation of 9:00 A.M. medication pass on 8/3/16 revealed that Resident #9 received Xanax 1mg at 9:50 A.M. (Xanax is used to treat anxiety disorders, panic disorders and anxiety caused by depression.) Review of Resident #9's August 2016 Medication Administration Record (MAR) revealed: -There was an entry for Xanax 1mg four times per day. -The scheduled times for administration were 8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M. Interview with RCC on 8/3/16 at 12:00 P.M. revealed: -Resident #9 received his next dose of Xanax	{D 358}		

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{D 358}	Continued From page 18 1mg as scheduled for 12:00 P.M. -The facility policy and procedure, when administering medications outside of scheduled time, is to call the physician and get an order to give medication outside of scheduled time. -The RCC called the physician at 11:00 A.M. concerning Resident #9 ' s Xanax being given late and received a verbal order to give Xanax as scheduled for 12:00 P.M. Interview with Resident #9 on 8/3/16 at 1:17 P.M. revealed: -They never brought medications to the resident ' s room during the day. -He usually had to go to the medication room to get his medications. Interview with Administrator in Training on 8/5/16 at 11:40 A.M. revealed: -The facility's policy and procedure is to notify physician when medications have been given outside of the scheduled time. -The RCC is also notified; and, the RCC relays that information to the Administrator in Training. -For the most part, the medication pass is on time each day. -She could not recall a time that medications have been given late. C. Review of Resident #11's FL-2 dated 11/16/15 revealed: -Diagnoses included Abnormal Chest x-ray, Chronic Kidney Disease Stage IV, Human Immunodeficiency Virus, Dementia, Hypertension and Hyperlipidemia. -There was an order for Sodium Bicarbonate 650mg, 2 tablets twice daily. (Sodium bicarbonate is used to treat heartburn, indigestion and upset stomach.)	{D 358}		

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{D 358}	Continued From page 19 Observation of 2:00 P.M. medication pass on 8/4/16 revealed Resident #11 received 4 tablets of Sodium Bicarbonate 650mg at 1:15 P.M. Review of Resident #11's June 2016 Medication Administration Record (MAR) revealed an entry for Sodium Bicarbonate 650mg, 4 tablets by mouth three times a day. Review of Resident #11's July 2016 Medication Administration Record (MAR) revealed an entry for Sodium Bicarbonate 650mg, 4 tablets by mouth three times a day. Review of Resident #11's August 2016 Medication Administration Record (MAR) revealed an entry for Sodium Bicarbonate 650mg, 4 tablets by mouth three times a day. Review of Resident #11's physician ' s orders revealed there was no order to increase Sodium Bicarbonate from 2 tablets twice daily to 4 tablets three times daily. Interview with Resident Care Coordinator on 8/4/16 at 3:30 P.M. revealed: -The order should be located in Resident #11's records. -She would locate the order before end of survey. No order to increase the Sodium Bicarbonate was received by the end of the survey. Review of the Plan of Protection received from the Administrator in Training on 8/3/16 revealed: -Staff will review times that medications are to be given; weekly X4 weeks and monthly thereafter and will adjust times or medication administration times accordingly beginning 8/3/16.	{D 358}		

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{D 358}	Continued From page 20 -The RCC/Administrator/Designee will review MARs weekly X4 weeks and monthly thereafter to ensure medications are being administered as ordered beginning 8/3/16. -The facility will ensure that medications are not administered without a physician order beginning 8/3/16. -The RCC/Designee will review all new orders weekly X4 and monthly thereafter to ensure they are transcribed correctly beginning 8/3/16. -The RCC/Designee will receive clarification of all admit/ readmit orders if there are any changes to medications previously given beginning 8/3/16. -The RCC/ Designee will review MARs for accurate time of medication administration weekly X4 weeks and monthly thereafter beginning 8/3/16. CORRECTION DAT FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 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	{D912}		

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{D912}	Continued From page 21 relates to Medication Administration. The findings are: Based on observation, interview and record review, the facility failed to assure that medications were administered as ordered for 4 of 7 sampled residents (#1, #2, #4, #6) to include not administering Methadone, Novolin 70/30, Seroquel, Norvasc, Losartan as ordered; and 3 of 9 sampled residents (#8, #9, #11) observed during the medication passes to include the administration of Aspirin and Sodium Bicarb without an order and the administration of Carafate Suspension and Xanax over 1 hour past the scheduled administration time. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		