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PIEDMONT VILLAGE OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 000	Initial Comments The Adult Care Licensure Section and Yadkin County Department of Social Services conducted an annual and complaint investigation on August 2-4, and August 8, 2016 with an exit conference via telephone on August 12, 2016. The complaint investigation was initiated by the Yadkin County Department of Social Services on July 21, 2016.	D 000		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule	D 201		

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D 201	Continued From page 1 .0606 of this Subchapter.) This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure minimum staffing requirements for aides was provided for 10 out of 47 shifts from 6/25/16 through 7/10/16. The findings are: Review of the facility census provided by the Administrator on 8/04/16 revealed: -A census of 33 to 38 from 6/25/16 through 7/6/16. -A census of 42 residents from 7/7/16 through 7/10/16. Interview on 8/8/16 at 11:16am with the Resident Care Coordinator (RCC) revealed: -She was responsible for the schedule and if possible assured all shifts were covered, but there had been a few occasions where there had not been available staff to schedule and she worked some of those shifts. -Staff did not stay long after they were hired. -Their policy is that staff on duty have to stay on duty if someone is scheduled to work and does not show up for their shift. -She worked 48 hours one time in July because they were short staffed, sometimes as Medication Aide (MA) and sometimes as Personal Care Aide (PCA). -She did not have any documentation for her hours worked between 6/25/16 through 7/10/16. -The Supervisors were also qualified as PCAs and many times had to work as a PCA if needed. 1. Review of timesheets for first shift from 6/25/16	D 201		

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D 201	Continued From page 2 through 7/6/16 revealed the following hours worked for personal care staff (included 4 hours from supervisory staff): -6/25: 12 hours -6/30: 15 hours -7/4: 12 hours 2. a. Review of timesheets for second shift from 6/25/16 through 7/6/16 revealed the following hours worked for personal care staff (included 4 hours from supervisory staff): -6/25: 8 1/2 hours -7/2: 13 1/2 hours -7/4: 12 1/2 hours b. a. Review of timesheets for second shift from 7/7/16 through 7/10/16 revealed the following hours worked for personal care staff (included 4 hours from supervisory staff): -7/7: 14 1/2 hours -7/8: 13 1/2 hours -7/10: 10 1/2 hours Review of timesheets for third shift from 6/25/16 through 7/10/16 revealed the following hours worked for personal care staff (included 8 hours from supervisory staff): -6/28: 12 hours Interview with the RCC on on 8/8/16 at 11:16am revealed she worked the following dates and shifts which were not included on her timesheets: -8 hours on 1st shift on 6/30 and 7/4 -8 hours on 2nd shift on 7/2, 7/4, 7/7, 7/8, and 7/10 -4 hours on 3rd shift on 6/28 Interview with the Administrator on 8/9/16 at 8:55am revealed: -Staff had quit recently and they were in the	D 201		

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process of hiring and training new staff.
-She said she understood the staffing requirements for personal care staff which was based on census.
-She also said she knew that personal care staff were not supposed to do housekeeping and food service duties between 7:00am and 9:00pm, but they did not have a laundry staff person or enough food service staff.
-She stated the facility was sprinklered.

Confidential interviews with 4 staff revealed:
-There were some shifts where only 1 staff has worked.
-They always called the RCC and let her know and she comes in if she can.
-The PCAs were required to do laundry and some food service duties on first and second shifts which made it more difficult if they were short staffed.
-The PCAs were required to set the dining room tables for all shifts and after the meal took the dirty trays back to the kitchen and swept the floor in addition to taking the food to the tables and assisting any residents.
-The Supervisors were aware that "we have been short staffed."
-There was not enough staff on all shifts.
-Staff get hired with no experience and find out they do not want to work there.
-We "do what we can" so the residents' needs will be met, but sometimes their care may be delayed if we are short staffed.
-"It is worse on the week-ends."
-"It is hard to take a break" and the MAs work 12 hour shifts.
-We have a "lot of call-outs."

Confidential interviews with 2 residents revealed:
-"The staff stay busy and right now I have a

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D 201	Continued From page 4 basket of dirty clothes that needs washing but they will wash it when they get to it." -"They come help us if we need it...when they get time."	D 201		
D 206	10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staff The following describes the nature of the aide's duties, including allowances and limitations: (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure that all housekeeping performed by personal care staff between the hours of 7:00am and 9:00pm was limited to occasional, non-routine tasks. The findings are: Review of facility current census on 8/2/16 revealed a census of 41. Confidential interviews with 4 staff revealed: -The Personal Care Aides (PCAs) were required to do laundry on first and second shift for all the residents' clothes and their bed linens. -The washer and dryer is in an outside building	D 206		

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D 206	Continued From page 5	D 206		

behind the facility and not connected to the main building.
-The facility now had only one residential washer since the first of April and has two residential dryers which required staff to go out more frequently to put clothes in the washer.
-With the resident census of over 40, there was a lot of laundry to do.
-They are out in the laundry room at least 1 and 1/2 hours per day and fold some clothes inside in addition to the 1 and 1/2 hours per day.
-They needed a commercial size washing machine and dryers.
-They had not had anyone who just did laundry for at least one year.
-The housekeeper stayed busy with cleaning the facility and did not have time to do the laundry.
-When staff did laundry after dark, they did not feel as safe, and tried to have another staff look outside while they went out to the laundry building.

Interview with the Administrator on 8/9/16 at 8:55am revealed:
-She said she knew that personal care staff were not supposed to do housekeeping duties between 7:00am and 9:00pm, but they did not have a laundry staff person.
-She was aware they only had one washer and needed another one or a commercial washer so staff would have to make fewer trips to the laundry room.

Confidential interviews with 1 resident revealed "the staff stay busy and right now I have a basket of dirty clothes that needs washing but they will wash it when they get to it."

Observation of the laundry room on 8/8/16 at 10:15am revealed it was at least 80 feet distance

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D 206	Continued From page 6 away from the facility exit door. Random observations during the survey revealed PCAs going out to the laundry room and coming back in with laundry items. Refer to Tag 201 10A NCAC 13F .0604(e)(1)(A)(B)(C) Personal Care And Other Staffing	D 206		
D 209	10A NCAC 13F .0604 (2-e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care Other Staffing The following describes the nature of the aide's duties, including allowances and limitations (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to assure that all food service duties performed by personal care staff between the hours of 7:00am and 9:00pm was limited only to help with eating and carrying plates, trays or beverages to residents, and resulted in personal care staff performing routine food service duties of setting the tables, cleaning the tables, and sweeping the dining room floors. The findings are: Review of facility current census on 8/2/16	D 209		

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D 209	Continued From page 7 revealed a census of 41. Confidential interviews with 4 staff revealed: -The Personal Care Aides (PCAs) were required to set the tables for all three meals, carry the food out to the residents, clean the tables, and sweep the dining room floor. -When there are only 2 personal care staff on duty the food service duties did take away from resident care, but "we do what we can do." Observation of the dining room on 8/2/16 revealed at 11:30am a PCA was placing all the flatware, napkins, and beverages on the table. Observation of the dining room on 8/3/16 at 8:45am revealed a PCA cleaning the dining room tables. Observation of the dining room on 8/8/16 at 3:38pm revealed a PCA setting the tables with flatware and napkins. Interview with the PCA setting the table on 8/8/16 at 3:38pm revealed she worked second shift and was required to set the tables, clean the tables. and sweep the dining room after the evening meal. Interview with the cook on 8/8/16 at 2:55pm revealed: -He worked from 6:00am to 1:00pm and then returned at 3:00pm to 6:00pm when he is on the kitchen schedule. -Some days he worked alone, times not known, and sometimes he had an assistant. -When he worked alone, he did not have a lot of time to do additional duties which included setting the tables, cleaning the tables, sweeping the dining room floor.	D 209		

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D 209	Continued From page 8 -When he worked alone, he cooked all three meals and cleaned up the kitchen after each meal. Review of the staff time sheets from 6/25/16 through 7/10/16 revealed: -Assistant dietary staff worked three out of sixteen days in dietary when a routine cook was also working. -On 6/21, 6/22, and 6/23, the assistant dietary staff worked from 9:00am 5:00pm with 1 hour lunch deduction. -There was no other staff documented on the time sheets as an assistant cook on these days. Interview with the Administrator on 8/9/16 at 8:55am revealed: -She said she knew that personal care staff were not supposed to do food service duties between 7:00am and 9:00pm, but they did not have enough food service staff to do everything. -There was usually just 1 staff daily assigned for food service. Refer to Tag 201 10A NCAC 13F .0604(e)(1)(A)(B)(C) Personal Care And Other Staffing	D 209		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 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	D 234		

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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:
Type B Violation

Based on interviews and record reviews, the facility failed to assure 2 of 5 residents (#1 and #5) residing in the facility were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.

The findings are:

A. Review of Resident #1's current FL2 dated 7/22/16 revealed diagnoses which included bipolar disorder, post traumatic stress disorder, and borderline personality disorder.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 4/4/16.

Review of Resident #1's record revealed no documentation of any TB tests or results.

Interview with the Administrator on 8/8/16 at 10:30am revealed that Resident #1 was admitted by the former Administrator, while she was not in the facility.

Attempted interview with Resident #1 on 8/8/16 at 2:19pm was unsuccessful.

B. Review of Resident #5's FL2 dated 6/7/16 revealed diagnoses which included schizoaffective disorder bipolar type, diabetes type I uncontrolled, hypertension, and

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D 234	Continued From page 10 hypomagnesemia. Review of Resident #5's Resident Register revealed he was admitted to the facility on 6/7/16. Review of Resident #5's record revealed no documentation of any TB tests or results. Interview with the Administrator on 8/8/16 at 10:30am revealed: -She was not aware Resident #5 did not have any TB tests or results until after he was in jail and had already been issued a discharge effective 7/24/16. -Resident #5 was admitted by the former Administrator, while she was not in the facility. _____ The facility provided the following Plan of Protection on 8/4/16: -Will get two step TB tests for all residents who do not have them. -No resident will be admitted without at least one negative TB test. -Administrator will monitor. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2016.	D 234		
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.	D 273		

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D 273	Continued From page 11 This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 8 sampled residents regarding one resident with medications that were unavailable and frequent inappropriate behaviors (Resident #3), three residents regarding medication refusals (Resident #3, #4, and 5), and one resident who failed to receive a monthly Invega injection (Resident #5). The findings are: A. Review of the current FL2 for Resident #3 dated 1/14/16 revealed: -Diagnoses included traumatic brain injury, schizophrenia disorganized type chronic, neurocognitive disorder, and hypertension. -"Verbally abusive" was marked under "patient information." -Physician orders for amitriptyline (used to treat depression) 75mg at bedtime, atorvastatin (used to treat high cholesterol) 10mg daily, benztropine (used to treat extrapyramidal symptoms) 1mg twice daily, and fluphenazine (used to treat psychosis) 10mg in the morning, 10mg at 2pm, and 20mg at bedtime. Review of Resident #3's Resident Register revealed he was admitted to the facility on 1/14/16. Review of subsequent physician orders for Resident #3 dated 7/20/16 revealed: -Amitriptyline 75mg at bedtime was discontinued. -A new order for divalproex sodium ER 500mg at bedtime (used for mood stabilization and insomnia).	D 273		

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D 273	Continued From page 12 Review of the electronic Medication Administration Records (eMARs) for March 2016 revealed: -Amitriptyline was documented as not administered for 1 occurrence because "med on order", and for 2 occurrences due to "resident refused" out of 14 opportunities. -Atorvastatin was documented as not administered for 2 occurrences out of 14 opportunities because "resident refused." -Benztropine twice daily was documented as not administered for 4 occurrences out of 28 opportunities because "resident refused." -Fluphenazine 10mg twice daily was documented as not administered for 4 occurrences out of 28 opportunities because "resident refused." -Fluphenazine 20mg at bedtime was documented as not administered for 2 occurrences out of 14 opportunities because "resident refused." Review of Resident #3's Mobile Crisis Management (MCM) Report dated 3/4/16 at 8:30pm revealed: -"He has been fussing and yelling. He has threatened to harm and kill people if he is not taken away tonight. He has been hitting the counters and pacing the halls yelling. He wants things his way and if not he will yell and throw things. He has refused to take his medications tonight. He states he does not want the cheap medicine they have here, but the good medicine they give him at the VA." -Demeanor is documented as hostile and demanding. -Mood is documented as irritable. -Behavior is documented as agitated and aggressive. -Interventions include: stabilize mood, decrease aggression, inpatient mental health treatment.	D 273		

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-"Current behaviors and cognition are outside of the abilities of the Assisted Living Facility (ALF) staff."
-Resident #3 was sent to the local hospital for involuntary commitment.

Review of the Emergency Room (ER) record for Resident #3 dated 3/4/16 at 10:59pm revealed:
-The presenting complaint was homicidal threats and violent behavior.
-He was "evaluated by tele-psychiatry they felt patient was not a threat to himself or anyone else at this time."
-He was discharged back to the facility on 3/5/16 at 12:25pm.
-He was to follow-up with his primary Mental Health provider on Monday (3/7/16).
-Discharge instructions were given to the facility's Resident Care Coordinator (RCC).

Review of a local police department report dated 3/15/16 revealed:
-Resident #3 assaulted another resident by punching him.
-Resident #3 was upset and was standing in the lobby talking with police.
-The other resident walked by and exchanged words with Resident #3.
-Resident #3 got up and physically assaulted the resident by punching him in the head, face and body.
-The other resident had no injuries.
-Resident #3 was in jail from 3/15/16 at 3:29am through 4/20/16 at 3:11pm.

Review of the eMAR for April 2016 revealed:
-Amitriptyline was documented as not administered for 1 occurrence out of 11 opportunities because "med on order."
-Atorvastatin was documented as not

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administered for 6 occurrences out of 11 opportunities because "med on order."
-Fluphenazine 20mg was documented as not administered for 1 occurrence out of 11 opportunities because "med on order."
-There were no refusals documented.

Review of Resident #3's record revealed there were no documented inappropriate behaviors in April 2016.

Review of the eMAR for May 2016 revealed:
-Amitriptyline was documented as not administered for 10 occurrences because "med on order", and for 1 occurrence due to "resident refused" out of 31 opportunities.
-Atorvastatin was documented as not administered for 18 occurrences because "med on order" and for 1 occurrence due to "resident refused" out of 31 opportunities.
-Benztropine twice daily was documented as not administered for 2 occurrences because "med on order" and for 1 occurrence due to "resident refused" out of 62 opportunities.
-Fluphenazine 10mg twice daily was documented as not administered for 14 occurrences because "med on order" and for 1 occurrence due to "resident refused" out of 62 opportunities.
-Fluphenazine 20mg was documented as not administered for 11 occurrences out of 31 opportunities because "med on order" and for 1 occurrence due to "resident refused" out of 31 opportunities.

Review of Resident #3's record revealed there were no documented inappropriate behaviors in May 2016.

Review of the eMAR for June 2016 revealed:
-Amitriptyline was documented as not

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administered for 24 occurrences out of 30 opportunities because "med on order."
-Atorvastatin was documented as not administered for 8 occurrences out of 30 opportunities because "med on order."
-Fluphenazine 10mg twice daily was documented as not administered for 1 occurrence because "med on order" and for 2 occurrences due to "resident refused" out of 60 opportunities.

Review of a Progress Note dated 6/12/16 revealed an entry at 6:30am "Came up to med room asked MT (Medication Aide) if she would call the cops because he is not getting his money. She told him no she would not call them. So he got mad started cussing. Went behind PCA (Personal Care Aide) desk call 911. MT told him not to be behind the PCA desk and not to call the cops. Then he tried to hit MT, MT walked away so she would not get hit. Then he went to his room cussing, hitting things and being very loud."

Review of the eMAR for July 2016 revealed:
-Amitriptyline was documented as not administered for 17 occurrences because "med on order" and for 2 occurrences due to "resident refused" out of 19 opportunities (medication was discontinued on 7/20/16) .
-Atorvastatin was documented as not administered for 8 occurrences because "med on order" and for 3 occurrences due to "resident refused" out of 24 opportunities.
-Benztropine twice daily was documented as not administered for 17 occurrences because "med on order" and for 3 occurrences due to "resident refused" out of 49 opportunities.
-Fluphenazine 10mg twice daily was documented as not administered for 5 occurrences because "med on order" and for 1 occurrence due to "resident refused" out of 50 opportunities.

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-Fluphenazine 20mg was documented as not administered for 4 occurrences because "med on order" and for 2 occurrences due to "resident refused" out of 24 opportunities.
-Divalproex Sodium ER was documented as not administered for 5 occurrences out of 5 opportunities because "med on order" (medication was started on 7/20/16).

Review of Resident #3's MCM Report dated 7/14/16 at 10:20pm revealed:
-"Staff reports client is acting out, slamming doors, smoking in his room and screaming at other residents."
-MCM was cancelled by the supervising staff because Resident #3 had calmed down and was asleep.

Review of Resident #3's Mental Health provider visit note dated 7/20/16 revealed:
-He was last seen by the Mental Health provider on 8/5/15.
-He was brought in by facility staff who reported he had been having episodes of verbal aggression, increased yelling, and was difficult to redirect.
-Facility staff reported to the Mental Health provider that no physical aggression had been observed, only that he paced through the home and yelled at times.
-Resident #3 denied any issues and was calm during the appointment.
-Medication changes included to stop amitriptyline and start divalproex sodium ER 500 mg at bedtime for mood stabilization and sleep, continue fluphenazine and benztropine for psychosis and extrapyramidal symptoms.

Review of an incident report dated 7/23/16 revealed:

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D 273	Continued From page 17 "Was reported by telephone to Administrator by SIC (Supervisor In Charge) that another resident had gotten into this resident's (Resident #3) bed by mistake. SIC heard this resident (Resident #3) yelling and walked up to find this resident with a wet floor sign getting ready to hit the resident that was in his bed. SIC attempted to intervene, when resident (Resident #3) became aggressive to her. She then called 911. Police came, talked to resident. Administrator directed staff to be sure to give resident his prn for agitation and to keep an eye on him. Directed her to call mobile crisis if needed. No more problems from resident for the remainder of the day." Observation on 8/4/16 at 3:20pm of video surveillance dated 7/24/16 revealed: -One Personal Care Aide (PCA) was in dining room serving food, with her back towards the residents. Resident #3 was about to sit in another resident's usual chair when that resident touched Resident #3. Resident #3 then elbowed the other resident forcefully in the chest/stomach area and began hitting him repeatedly with his fists. The other resident then fell backwards and hit his head on the dining room table. Another resident ran towards Resident #3 and wrapped his arms around him and took him to the floor to stop the fight. Review of an incident report dated 7/24/16 revealed: "Was reported to Administrator by RCC that this resident (Resident #3) hit another resident and that the other resident was being sent to hospital via EMS. RCC reported that police were called but did not arrest this resident. Administrator directed staff to call mobile crisis for this resident. Resident's sister was notified of the incident. (Resident #3's) guardian was notified."	D 273		

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D 273	Continued From page 18 Review of an incident report dated 7/25/16 revealed: "Administrator reviewed footage on security camera. During afternoon snack, this resident (Resident #3) sat in the chair where other resident normally sits. The other resident hit this resident on his shoulder with the back of his hand. This resident then attacked the other resident, causing him to hit the back on his head on a dining room table. Another resident tackled this resident to the floor. Staff intervened. Emergency Medical Services (EMS) was called for the other resident. He is currently admitted at (name of area hospital) Intensive Care Unit (ICU) with some concerns for blood on his brain. RCC called VA crisis line, since (Resident #3) is a VA resident. VA crisis line is in New York, so they offered assistance. RCC then called (named mobile crisis) again, they stated that they would be at the facility within the hour. RCC also called (named police department) again. They stated that they could not arrest (Resident #3), but that they will issue a protective order." Review of Resident #3's MCM Report dated 7/25/16 at 11:20am revealed: -"Client (Resident #3) assaulted another resident yesterday which led to the other resident being admitted to the ICU for bleeding of the brain. On 7/23/16 client assaulted another resident who was sleeping in his bed and another staff member (Staff A). Client picked the other resident up out of his bed and threw him on the ground then began hitting him with a wet floor sign. Client has been taking most of his medications as prescribed according to the MAR provided by the ALF. Staff states that he refuses to take his medication often, however, and will often become verbally aggressive with them. Client has a	D 273		

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D 273	Continued From page 19 history of getting angry and destroying property or assaulting staff or other residents. Today client became aggressive with staff members when they would not give him a pen and told them to (expletive) off. Client did not assault anyone during this episode." -Demeanor was noted as demanding -Activity was noted as agitated. -Mood was noted as angry and irritable. -Behavior was noted as agitated, impulsive, alert, and restless. -"Client needs inpatient admission due to dangerous behaviors and actions and lack of emotional stability client is appropriate for Involuntary Commitment (IVC) at this time." -Disposition was documented as inpatient commitment. -Report documented that Resident #3 "does not feel remorse for the assaults, states that the other residents deserved it." Review of a local police report dated 7/24/16 revealed: -Resident #3 had assaulted another resident in the dining room of the facility on 7/24/16. Resident #3 was seated in a chair that another resident normally sat in and that resident touched Resident #3 on the shoulder. Resident #3 began to hit the other resident with his fist and knocked the other resident to the floor. -Another resident in the dining room saw Resident #3 hit the other resident and he wrapped his arms around Resident #3 to stop him from hitting the other resident. -Resident #3 did not stop hitting the other resident until another resident "wrapped him up and pulled him away." -Resident #3 stated that he stood up after the other resident touched him, began making noises and waving his arms and he hit him with his fist.	D 273		

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D 273	Continued From page 20 -The other resident had touched Resident #3 on the shoulder to get him to move because he could not speak. -The PCA, Staff D was present during the fight and relayed the same information to the officer. -EMS was called to the scene and transported the other resident to the local hospital and reported that he had scratches on his head and left elbow. Interview with the Administrator on 8/4/16 at 3:20pm revealed: -One resident hit his head on the table during a fight with Resident #3. -The same resident sustained a brain bleed as a result. -Resident #3 "can't come back here.....if he did the other residents would gang up on him for what he did." Interview with PCA, Staff D on 8/8/16 at 12:49pm revealed: -She was scared of Resident #3 and stated "I don't like to turn my back to him." -Resident #3 started the fight on 7/24/16. -"My back was turned, tried to keep my eyes on him (Resident #3)." -Staff called 911 and when EMS arrived they transported (named resident) to the hospital. -Law enforcement was called, but did not take Resident #3 into custody. -She had never had a problem with Resident #3 but was told to "watch out" for him. Interview with Medication Aide (MA), Staff A on 8/12/16 at 1:00pm revealed: -She was outside taking a break when the incident happened on 7/24/16. -The PCA, Staff D was in the dining room and called for her help.	D 273		

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D 273	Continued From page 21 -MCM was called for Resident #3 on 7/24/16 but did not come out until the next day. Telephone interview with local police department staff on 8/4/16 at 10:25am revealed Resident #3 had only been involved in incidents on 3/15/16 and 7/24/16. Interview with the Transporter on 8/8/16 at 12:35pm revealed: -She had notified the provider during the 7/20/16 visit about Resident #3's behaviors and had one new prescription filled while at the provider's office. -She returned to the facility with the new medication for Resident #3 and gave it to the MAs. Interview with MA, Staff A, on 8/4/16 at 12:10pm revealed: -Resident #3 had inappropriate behaviors prior to 7/24/16. -He had tried to hit her one time because another resident was in his bed. -Resident #3 "led the fight" in the dining room on 7/24/16.. -"There is supposed to be someone in the dining room with the residents at all times." Interview with MA, Staff C on 8/8/16 at 10:45am revealed: -Resident #3 "was doing good until the end of July." -She never had issues with him. Interview with the Administrator on 8/8/16 at 10:30am and 11:00am revealed: -The facility's policy was for staff to notify the pharmacy, physician, and herself when medications were missed for 1 to 3 days	D 273		

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depending on the medication that was not administered.
-She was unaware of medications being unavailable and not administered to Resident #3 until 7/24/16 when he got into an altercation with another resident in the facility.
-She became aware of the medication issue when she reviewed his chart.
-She was unsure if the provider was notified regarding Resident #3 missing doses of medications because he was out of medications.
-Resident #3's last day in the facility was 7/25/16. He was involuntarily committed to the local hospital.

Subsequent interview with the Administrator on 8/8/16 at 12:23pm revealed interventions for behaviors included the use of as needed (PRN) medications, 15 minute checks, contact MCM, contact the VA crisis line, or initiate an emergency discharge if behaviors did not improve.

Review of the Notice of Transfer/Discharge dated 7/25/16 revealed Resident #3 was discharged from the facility effective 7/26/16 due to "the safety of this resident or other individuals in this facility is endangered."

Interview with the RCC on 8/8/16 at 3:10pm revealed:
-Interventions used by the facility for behaviors included talking to the resident first, use of PRN medications, doing 15 minute checks, and calling MCM.
-MCM would decide if a resident was safe to stay in the facility or if they needed to be admitted to the hospital.
-There is a facility form that is utilized for the 15 to 30 minute checks.
-The 15 to 30 minute check form was used for

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falls or behaviors and would be labeled as such.
-She was able to "talk him down" and not call MCM for the incident that occurred 6/12/16.
-MCM saw Resident #3 on 7/25/16 (Monday) and had him "IVC'd" for his behaviors on 7/23/16 and 7/24/16.

Telephone interview with the RCC on 8/11/16 at 2:04pm revealed:
-She was responsible for faxing Progress Notes to the VA Crisis Line for Residents that had inappropriate behaviors.
-She was unsure if the VA Crisis Line had been faxed regarding Resident #3's behaviors.
-The Medication Aide (MA) was responsible to send the fax if the RCC was unavailable.

Further review of the eMARs for March, April, May, June and July 2016 revealed:
-There was no documentation on the eMARs that Resident #3's Mental Health provider or Primary Care Provider (PCP) had been notified that he was out of medications.
-There was no as needed (PRN) medication listed on the eMAR for anxiety or agitation.

Telephone interview with a Social Worker at the VA Primary Care Outpatient Clinic on 8/11/16 at 2:51pm revealed:
-Resident #3 had only seen his Mental Health provider on 7/20/16.
-There was no documentation of inappropriate behaviors at his 6/13/16 appointment with his PCP.
Further review of Resident #3's record revealed:
-He did not follow-up with the Mental Health provider on 3/7/16.
-There was no documentation related to the incident on 3/15/16.
-There were 15-30 Minute Check forms dated

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D 273	Continued From page 24 6/7/16 at 6:00am to 6/15/16 at 11:45am, with no documentation to describe the reason for the frequent checks to be done. -The Mental Health provider and PCP were not notified of his behaviors from 3/4/16 to 7/24/16. -He had missed scheduled appointments with his Mental Health provider on 1/27/16 and 6/13/16 due to "no show." Attempted telephone interview with Resident #3's Mental Health provider on 8/11/16 at 3:00pm was not successful. Attempted telephone interview with Resident #3's Guardian on 8/10/16 at 2:56pm was unsuccessful. Refer to review of the facility's medication policies. Refer to interview with the Administrator on 8/3/16 at 9:00am. B. Review of Resident #5's FL2 dated 6/7/16 revealed: -Diagnoses which included schizoaffective disorder bipolar type, diabetes type I, uncontrolled hypertension, and hypomagnesemia. Physican orders for lithium carbonate 450mg ER, 2 times daily after meals (used to treat bipolar disorder), magnesium oxide 400mg, 2 twice daily "for low amount of magnesium in the blood", metformin 500mg 2 times daily (used to control high blood sugar), B complex, vitamin-C, folic acid 0.8mg daily (a nutritional supplement), hydroxyzine pamoate 50mg every 4 hours as needed for anxiety, trazadone 50mg 1 tablet at bedtime as needed for sleep, and Invega Sustenna 156mg 1 ml intramuscular (IM) injection	D 273		

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D 273	Continued From page 25 every month. (used in patients with schizophrenia and schizoaffective disorders). Review of Resident #5's Resident Register revealed he was admitted to the facility on 6/7/16. Review of a physician order dated 6/13/16 from a local medical care center revealed an order for Amoxicillin 875mg twice daily for 10 days (an antibiotic). Review of Resident #5's June 2016 electronic Medication Administration Record (eMAR) revealed: -"DC'd" entered on all medication entries, but no date documented when discharged. -No medications were documented as administered from 6/28 through 6/30. -Lithium carbonate was documented as not administered because out of the facility for 16 occurrences, and refused for 2 occurrences. -Magnesium oxide was documented as not administered because out of the facility for 8 occurrences, and refused for 6 occurrences -Metformin was documented as not administered because out of the facility for 15 occurrences, and refused for 1 occurrence. -B complex, vitamin-C, folic acid was documented as not administered because out of the facility for 4 occurrences, and refused for 6 occurrences. -Amoxicillin was documented as not administered because out of the facility for 7 occurrences, and refused for 1 occurrence. -Hydrocodone-acetaminophen as needed for pain was documented as administered twice on 6/17 and once on 6/19, 6/20, 6/22, and 6/27 (no order in resident record). -Hydroxyzine Pamoate as needed for anxiety was not documented as administered.	D 273		

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D 273	Continued From page 26 -Trazadone as needed for sleep was not documented as administered. -Invega Sustenna IM injection was not documented as administered. Review of the local police reports for Resident #5 revealed: -Resident #5 was arrested by police on 7/8/16 for "begging" in town but was released. -Resident #5 was arrested by police on 7/9/16 at 9:10pm for begging in town and was taken to jail. -Resident #5 was arrested by police on 7/14/16 at 8:55pm for trespassing at a business and taken to jail. Review of Resident #5's record revealed there was no documentation that the in house Primary Care Provider (PCP) had been notified of medications not being administered due to refusals or being out of the facility. Telephone interview with a nurse at the local medical care center on 8/12/16 at 2:30pm revealed: -The amoxicillin and the hydrocodone acetaminophen 5-300 mg were prescribed on 6/13/16 when Resident #5 came into the local clinic to be treated for a toothache. -The hydrocodone acetaminophen 5-300 was to be taken every 6 hours as needed for pain. Telephone interview on 8/3/16 at 10:45am with a Pharmacist at the facility pharmacy provider revealed: -Lithium ER 450mg, 30 pills, a 15 day supply, on 6/8/16 and 6/23/16. -Magnesium oxide 400mg, 30 pills on 6/8/16 and 6/23/16. -Metformin HCL 500mg, 30 pills on 6/8/16 and 6/23/16.	D 273		

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D 273	Continued From page 27 -B complex, vitamin-C, folic acid 0.8mg, 15 pills on 6/8/16 and 6/23/16. -Amoxicillin 875mg, 20 pills on 6/15/16. -Hydrocodone-acetaminophen 5-300mg, 10 pills on 6/15/16. -Invega Sustenna 156mg 1 ml IM injection was not dispensed because the facility did not request it. -Pharmacy staff entered the "DC'd" on the eMAR after a Medication Aide (MA), Staff A, called on 6/27/16 and stated that Resident #5 had been discharged from the facility. -When facility staff call the pharmacy and report that a resident has been discharged from the facility, "the pharmacy takes their word for it," and does not require a physician order to discontinue medications. -The pharmacy staff entered the "DC'd" on the eMAR which automatically deleted the administration record for that resident from the system and the pharmacy could not dispense any more medications. -The pharmacy cannot enter a resident back into the eMAR system without a new FL2 with admission medication orders. -When the pharmacy receives orders for bedtime, the eMAR system automatically enters 8:00pm, or if a medication is ordered twice daily, the system automatically enters 8:00am and 8:00pm. -If a resident is out of the facility routinely for a routine medication pass, the facility Administrator can go into the e-MAR system and change the administration times or the staff can call the pharmacist to change administration times for medications unless the time for administration is clinically necessary. -Facility staff never requested the pharmacy dispense the Invega Sustenna 156 mg IM injection.	D 273		

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D 273	Continued From page 28 Further review of Resident #5's record revealed no physician orders to discontinue any of his medications. Interview with the Resident Care Coordinator (RCC) on 8/4/16 at 4:00pm revealed: -Staff A should not have called the pharmacy and told them Resident #5 had been discharged because the discharge was not effective until 7/24/16. -When she saw that the pharmacy had "DC'd" all Resident #5's medications and the eMAR system was not available for documenting the administration of medication, she called the pharmacy to request they reenter Resident #5 back into the system because Resident #5 came back to the facility from the jail the "end of June." -Pharmacy staff said they could not re-enter Resident #5's orders into the eMAR without a new FL2 with admission orders. -The MAs could not administer any medications after 6/27/16 after Resident #5 was taken out of the eMAR system. -The in house PCP never saw Resident #5 after his admission on 6/7/16 because he was never in the facility when she came. -The in house PCP would not sign a new FL2 or any physician orders for Resident #5 without seeing him. -The in house PCP came to the facility every two weeks but Resident #5 was never in the building when she was there. -The Mental Health Provider was in the facility on 6/23/16 but Resident #5 refused to see her. -Resident #5 would leave in the mornings and not come back until late in the evenings sometimes 9:00pm, sometimes as late as 11:00pm and they had "to stick to the 2 hour window" for administering medications. -When Resident #5 left the facility in the	D 273		

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mornings, the MAs asked Resident #5 if he needed to take any medications with him and he would always say he was coming back for the medication pass.
-The facility staff would tell Resident #5 when the in house physicians were coming and asked him to be available.
-Most medications are routinely dispensed in cassettes with a 14 day supply from the facility pharmacy provider.
-There was no eMAR system available for administering medication in July 2016 when Resident #5 was in the facility.
-A new FL2 dated 7/1/16 and signed by the in house PCP was found after Resident #5 left the facility on 7/14/16 in a stack of papers to file but she did not know how the FL2 got signed because the in-house PCP had refused to sign the FL2.
-The FL2 dated 7/1/16 was never faxed to the pharmacy because no one found it in time.
-The facility did obtain orders from the in house mental health provider on 7/8/16 for 4 medications but the pharmacy would not fill them without a new admission FL2.
-No medications came into the facility from the pharmacy for Resident #5 in July 2016.
-Resident #5 last received his Invega Sustenna injection in June 2016 before his admission to the facility, but the RCC was unsure if there was any documentation with that information.
-Resident #5 refused the Invega Sustenna injection every 30 days but she did not know why it was never dispensed.
-Invega Sustenna injections were normally administered by the Home Health nurse, but it was never set-up for Resident #5..

Review of the 6/7/16 through 7/24/16 MARs and the physician orders compared to the medications

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D 273	Continued From page 30 dispensed which included the times Resident #5 was in jail revealed: -Invega Sustenna 156mg IM every 30 days with none dispensed since admission on 6/7/16 was not available for administration. -Lithium carbonate 450mg ER, 15 day supply was dispensed on 6/8/16 and 6/23/16 should have been available for administration through 7/7/16, but the resident was not administered 24 doses of the medications in June and received none in July. -Magnesium oxide 400mg, 15 day supply dispensed on 6/8/16 and 6/23/16 should have been available for administration through 7/7/16, but the resident was not administered 24 doses of the medication in June and received none in July. -Metformin 500mg, 15 day supply dispensed on 6/8/16 and 6/23/16 should have been available for administration through 7/7/16, but the resident missed 22 doses in June and received none in July. -B complex, vitamin-C, folic acid 0.8mg, 15 day supply dispensed on 6/8/16 and 6/23/16 should have been available for administration through 7/7/16, but the resident missed 10 doses of the supplement in June and received none in July. -Hydroxyzine pamoate 50mg, 16 tablets dispensed on 6/10 should have been available for administration. -Trazadone 50mg, 16 tablets dispensed on 6/10 should have been available for administration. -Amoxicillin 875mg, 20 tablets dispensed on 6/15 should have been available for administration until completed, but the resident missed 8 doses of the medication. -Hydrocodone-acetaminophen 5-300mg, 10 tablets dispensed on 6/15 should have been available for administration. Further review of Resident #5's record revealed	D 273		

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no documentation related to Resident #5 refusing his Invega Sustenna 156mg IM injection every 30 days, notification of the physician, the last time he had received it, requesting it from the pharmacy, or any arrangements related to who was to administer the injection (MAs are not allowed to administer IM injections).

Interview with the Administrator on 8/8/16 at 10:30am revealed:
-She became aware that Resident #5 had not been receiving his medications around 7/14/16 when Resident #5's guardian called and told her Resident #5 was in jail.
-The facility policy was for the facility staff to notify the physician if a resident was missing medications because he was out of the facility, refusing, or none available, and to notify the Administrator.
-There was a lot of confusion surrounding Resident #5's medication and the 7/1/16 FL2.
-Resident #5 was out of the facility almost every day and was not there during medication passes.
-Because the facility could not meet Resident #5's health care needs, he was issued a discharge on 6/24/16, which was a 30 day notice and the official discharge date for Resident #5 was 7/24/16.
-Resident #5 was in jail one time the end of June 2016 and two times in July 2016.
-She became the Administrator on 6/6/16 and the other Administrator left on 6/2/16.

Review of the 4 medication orders prescribed by the in house Mental Health provider on 7/8/16 revealed:
-Lithium ER 450mg twice daily at 8:00am and 4:00pm.
-Invega ER 6mg every morning.
-Trazadone 50mg every 8 hours as needed for

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insomnia, not to exceed 1 in 24 hours.
-Hydroxyzine 50mg every 4 hours as needed for anxiety, not to exceed 2 in 24 hours.

Attempted telephone interview on 8/11/16 at 10:10am to the in house Mental Health provider who signed the 7/8/16 medication order for Resident #5 was not successful.

Telephone interview with the in house PCP on 8/12/16 at 10:42am revealed:
-She refused to sign the 7/1/16 FL2 because Resident #5 was not in the facility when she was there.
-She was not aware the 7/1/16 FL2 had been stamped with her signature.
-She was in the facility on 7/1/16 and the FL2 must have been stamped in error by MA, Staff C in a stack of orders when they were seeing residents in the facility.
-In the past, she did request the MA, Staff C stamp orders with her signature stamp when she was in the facility, because they have so much to do on the days she sees residents.
-She would not answer questions related to the significance of Resident #5 not receiving his medications because she did not seen him in June or July 2016.

Telephone interview with the MA, Staff C, on 8/12/16 at 1:30pm revealed:
-She did not remember stamping Resident #5's FL2 with the PCP's signature on July 1, 2016, but she "might have when she was stamping a pile of orders" for the in house PCP.
-She did not know why the 7/1/16 FL2 was not sent to the pharmacy after it was signed.
-The 7/1/16 FL2 must have been lost in a stack of orders until after Resident #5 was discharged.
-Resident #5 would "not take medications

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anyway."
-If residents did not take their medications, it was the MAs responsibility to tell the RCC or the Administrator.

Telephone interview with Resident #5's guardian on 8/12/16 at 11:15am revealed:
-He was not aware Resident #5 was not receiving his medications at the facility until after 7/14/16 when he called the facility and asked questions.
-Resident #5 had been taken to jail one time in June 2016 and two times in July 2016.
-When Resident #5 was in jail on 7/14/16, the guardian called the facility and asked them to send Resident #5's medications to the jail.
-A facility staff told him him the facility did not have an updated FL2 for Resident #5 and the pharmacy would not send any medications and they did not have any medications for Resident #5.
-The guardian called the facility more than one time in July 2016 to ask about the medications and did not know all the names of staff he talked to but he did talk to the RCC "off and on."
-Resident #5 stayed in jail until the court date of 7/27/16 and on that day, the guardian picked him up at the jail and took him to a medical psychiatric service center in another town.
-When the guardian picked up Resident #5 on 7/27/16 to transport him from the jail, Resident #5 was "extremely psychotic, very emotional, happy and crying, talkative, and was delusional with mood changes."
-He said he believed the facility was responsible for Resident #5 becoming extremely psychotic in July while in because the facility did not administer medications when he was in the facility and did not obtain medications for Resident #5 while he was in jail.
-After the guardian transported Resident #5 to the

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hospital, Resident #5 was held for observation at the medical psychiatric hospital for observation" until a room was found.
-On 8/5/16, Resident #5 was released from the psychiatric hospital and was admitted to a "long term" psychiatric hospital in another town where he was currently residing.

Interview with the MA, Staff A on 8/4/16 at 12:00pm revealed:
-She did call the pharmacy in June, did not know the exact date, and told them Resident #5 had been discharged.
-She called the pharmacy because the RCC or the Administrator told her Resident #5 had been discharged, but she did not say they told her to call the pharmacy.
-Resident #5 would ask for his pain medication but did not want to take his other medications.

Review of Resident #5's record revealed no documentation of the dates he was in jail or dates when he returned to the facility from the jail.

Telephone interview with the nurse at the jail on 8/11/16 at 1:40pm revealed:
-Resident #5 entered the jail on 6/24/16 and was released back to the facility on 6/26/16, entered again on 7/9/16 and was released back to the facility on 7/13/16, entered again on 7/14/16 and was released to the guardian on 7/27/16, but she did not know the times of day he entered or was released.
-During the July 2016 visits, the staff at the jail called the facility for Resident #5's medications and each time the staff told them they did not have the medications.
-The facility did not provide any medications for Resident #5 for any of the three times he was in the local jail.

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D 273	Continued From page 35 Review of Resident #5's hospital visit after he was discharged from the facility revealed: -He was admitted to the hospital on 7/27/16 with "disorganized thinking, was psychotic and delusional upon admission." -Reason for admission on 7/27/16 included "mood instability." -He was admitted to "care health for psychiatric management and for tooth pain." -He "has a med refusal issues at this point in time which has contributed to his decompensation. He will need a few days inpatient perhaps a week to reorganize and..." -"It has been over 6 weeks since his last dose of Invega Sustenna." Review of the facility "Medication Disposition Sheet" dated 7/20/16 and signed by a former MA revealed the following medications for Resident #5 were returned to the pharmacy: -Magnesium Oxide 400mg quantity 48. -Metformin HCL 500mg quantity 12. -Lithium ER 450mg quantity 24. -B complex, vitamin-C, folic acid 0.8mg quantity 5. Medication dispensing records for all of Resident #5's medications before discharged as requested by surveyor were not provided by the survey exit date. Attempted telephone interview on 8/8/16 at 8:03am to the physician who signed the admission FL2 dated 6/7/16 was not successful. Refer to the facility's medication policies. C. Review of Resident #4's current FL2 dated 6/14/16 revealed diagnoses which included	D 273		

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paranoid schizophrenia, neurocognitive disorder, anxiety, and hypertension.

Review of Resident #4's Resident Register revealed he was admitted to the facility on 6/14/16.

Review of Resident #4's hospital discharge assessment dated 5/22/16 before his admission to the facility revealed:
-Resident was assessed as "depressed," but the block for "angry" was not checked.
-Resident was assessed as "no suicidal or homicidal ideations endorsed."
-Resident was also assessed as having insight "poor."

Review of Physician orders for Resident #4's FL2 dated 6/14/16 included:
-Sertraline 25mg daily at noon (used for anxiety)
-Divalproex 1500mg at noon (mood stabilizer)

Review of the June and July 2016 eMARs revealed:
-Sertraline HCL was documented as not administered because the resident was out of the facility on 7/5, 7/8, 7/9, 7/10, 7/11, 7/13, 7/18, and 7/19.
-Divalproex was documented as not administered because the resident was out of the facility on 7/5, 7/8, 7/9, 7/10, 7/11, 7/13, 7/18, and 7/19, and 15 tablets were documented as administered in June, and July.
-There was no documentation that the physician had been notified of the refusals.

Telephone interview on 8/4/16 at 2:26pm with a staff at the dispensing pharmacy revealed the medications which were dispensed or not dispensed before Resident #4 left the facility on

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D 273	Continued From page 37 7/19 included: -Sertraline HCL 25mg, a 15 day supply was dispensed on 6/14/16 and on 6/29/16 and none in July 2016. -She did not know why sertraline HCL was not dispensed in July 2016. -Divalproex 500mg, a 30 day supply, 90 tablets, was dispensed on 6/14/16 and again on 7/19/16. -The pharmacy dispensed medications at the window for pick up or by mail for the residents. -If mailed, the facility staff has to request the medications by fax or by telephone 2 weeks prior to running out of medications. Review of the June and July 2016 eMAR and the physician orders compared to the medications dispensed for Resident #4 revealed: -There should have been sertraline HCL 25mg available for administration from 6/16/16 when it was first documented as administered through 6/30/16 and available again from 7/2/16 though 7/16, three days before he left for jail, but the resident missed 9 doses. -There should have been divalproex 500mg available for administration from 6/16/16 when it was first documented as administered through 7/19/16 when the resident left for jail but the resident missed 8 doses. Review of the Medication Release for Resident #4 which was sent to the jail dated 7/19/16 revealed medications included: -Five tablets sertraline HCL 50mg tablet at noon. -Fifteen tablets divalproex sodium 500mg 3 tablets at noon. Interview with the Resident Care Coordinator (RCC) on 8/4/16 at 4:00pm revealed: -Resident #4 was out of the facility routinely for the day and was not there at times of	D 273		

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administration for some medications.
-They could not give medications out of the 2 hour window for administration for routine medications.
-They always asked residents before they left for the day if they were going to be back for med pass and Resident #4 always said he would be back.
-She never witnessed any behaviors from Resident #4 before 7/19/16.
-Other staff in the facility that day during the time of the incident included Staff C and Staff F.
-The MAs were supposed to document on a medication log when medications were ordered from the VA hospital, document when the medication arrived, and call the pharmacy or physician if it does not come as ordered.

Telephone interview with Resident #4's Mental Health Provider on 8/10/16 at 2:15pm revealed:
-The consequence of Resident #4 missing Depakote could have resulted in some "bearing" on his anger, but he would not comment if there was any connection for his missing medications and any behaviors.
-He was "not too worried" if Resident #4 was not administered the sertraline because the Invega injection every 28 days was the most critical medication for him and Resident #4 did receive his Invega Sustenna injection on 7/5/16 at the office.

Interview with the Administrator on 8/8/16 at 10:30am revealed:
-She was not aware Resident #4 had missed any medications until 7/19/16, when she looked at his records.
-She had taken medications to Resident #4 twice since he had been in jail, on 7/19/16 and on 8/4/16.

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PIEDMONT VILLAGE OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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-She did not know why all medications were not picked up at the pharmacy upon Resident #4's discharge from the hospital and she did not know who transported Resident #4 from the hospital to the facility on 6/14/16 upon admission, but may have been the former transporting staff who left on 7/20/16.
-Their policy was for staff to call the pharmacy, the physician, and herself when medications were missed for 1 to 3 days depending on what the medication was that was not administered.

Interview with PCA, Staff E on 8/8/16 at 12:30pm revealed:
-She never witnessed any behaviors with Resident #4 before the 7/19/16 incident.
-She was not afraid of Resident #4.

Interview with a MA, Staff A, on 8/4/16 at 12:00 noon revealed:
-She never witnessed any behaviors from Resident #4 before 7/19/16 and none of the residents complained about him.
-She had seen him get "moody" when he did not get cigarettes, but not angry.
-She called the physician and the pharmacy and about Resident #4's medications, but was not sure she documented the calls.

Interview on 8/4/16 at 3:05pm with a MA, Staff C, revealed the MAs were supposed to call the pharmacy when medications were not dispensed as ordered, call the physician when residents were refusing or missing their medications, and notify the RCC or the Administrator.

Review of Resident #4's Progress Notes revealed an entry dated 7/8/16 and signed by the Administrator revealed "Clinical staff brought to my attention that resident was out of the facility

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D 273	Continued From page 40 often when it is time for him to get his meds. Spoke with resident about coming back in time to get his meds and the importance of taking his medications. Resident stated that he understood and would start coming back at med time." Telephone interview with Resident #4's guardian on 8/10/16 at 10:50am was not successful. Refer to the facility's medication policies. Refer to interview with the Administrator on 8/3/16 at 9:00am. _____ Review of the facility's Medication Administration Policies revealed: -"It is the facility's responsibility to document, monitor and report medication refusal by a resident. Residents have the right to refuse their medication. Certified staff will document a medication refusal with their initials circled on the MAR. Staff will report medication refusals to the RCC within 24 hours of the refusal. Staff will complete the medication refusal report and deliver to the RCC within 24 hours of the refusal. The RCC will monitor medication refusal sheets and report to the prescribing practitioner whenever a resident refuses medication for three consecutive days and/or three or more doses in one week." -"If a Resident is out of the facility at the prescribed medication times, medications may be given an hour before or an hour after the prescribed. If the resident returns to the facility outside of this window, the medication tech will call the prescribing physician to ask for approval to give the medication at the time the resident has returned. The call is to be documented in the residents chart and the given medication on the	D 273		

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D 273	Continued From page 41 resident's MAR along with an explanation as to why the medication is being given outside the allowed time frame." Interview with the Administrator on 8/3/16 at 9:00am revealed: -They started a tracking log the end of June 2016 which designated the date Veterans Administration (VA) medications were ordered and delivered. -The Medication Aides (MA) were supposed to fill out the tracking log when they ordered medications and when they were delivered. -MAs were to call the physician or pharmacy if medications were not delivered as ordered or not available for administration and let her know. -She came to the facility on 6/6/16 as Administrator and the other Administrator left on 6/2/16. _____ The facility provided the following Plan of Protection on 8/4/16: -The RCC, Administrator, and MAs will be trained to contact medical health providers for all referrals, medication refusals, medications not dispensed, and medications not administered due to residents being out of the facility. -A tracking system is in place for medication orders. -Transportation staff will schedule and track provider referrals and appointments. -Administrator will monitor all health care referrals. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2016.	D 273		

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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 observations, interviews, and record reviews, the facility failed to assure medications for 5 of 8 sampled residents (#3, 4, 6, 7, and 8) were available and administered as ordered. The findings are: A. Review of the current FL2 for Resident #3 dated 1/14/16 revealed: -Diagnoses included traumatic brain injury, schizophrenia disorganized type chronic, neurocognitive disorder, and hypertension. -"Verbally abusive" was marked under "patient information." -Physician orders for amitriptyline (used to treat depression) 75mg at bedtime, atorvastatin (used to treat high cholesterol) 10mg daily, benztropine (used to treat extrapyramidal symptoms) 1mg twice daily, and fluphenazine (used to treat psychosis) 10mg in the morning, 10mg at 2pm, and 20mg at bedtime. Review of Resident #3's Resident Register revealed he was admitted to the facility on	D 358		

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D 358	Continued From page 43 1/14/16. Review of subsequent physician orders for Resident #3 dated 7/20/16 revealed: -Amitriptyline 75mg at bedtime was discontinued. -A new order for divalproex sodium ER 500mg at bedtime (used for mood stabilization and insomnia). Review of the electronic Medication Administration Record (eMAR) for March 2016 revealed amitriptyline 75mg was documented as not administered for 1 occurrence out of 14 opportunities because "med on order." Review of Resident #3's Mobile Crisis Management (MCM) Report dated 3/4/16 at 8:30pm revealed: -"He has been fussing and yelling. He has threatened to harm and kill people if he is not taken away tonight. He has been hitting the counters and pacing the halls yelling. He wants things his way and if not he will yell and throw things. He has refused to take his medications tonight. He states he does not want the cheap medicine they have here, but the good medicine they give him at the VA." -Demeanor is documented as hostile and demanding. -Mood is documented as irritable. -Behavior is documented as agitated and aggressive. -Interventions include: stabilize mood, decrease aggression, inpatient mental health treatment. -"Current behaviors and cognition are outside of the abilities of the Assisted Living Facility (ALF) staff." -Resident #3 was sent to the local hospital for involuntary commitment.	D 358		

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D 358	Continued From page 44 Review of the Emergency Room (ER) record for Resident #3 dated 3/4/16 at 10:59pm revealed: -The presenting complaint was homicidal threats and violent behavior. -He was "evaluated by tele-psychiatry they felt patient was not a threat to himself or anyone else at this time." -He was discharged back to the facility on 3/5/16 at 12:25pm. -He was to follow-up with his primary Mental Health provider on Monday (3/7/16). -Discharge instructions were given to the facility's Resident Care Coordinator (RCC). Review of a local police department report dated 3/15/16 revealed: -Resident #3 assaulted another resident by punching him. -Resident #3 was upset and was standing in the lobby talking with police. -The other resident walked by and exchanged words with Resident #3. -Resident #3 got up and physically assaulted the resident by punching him in the head, face and body. -The other resident had no injuries. -Resident #3 was in jail from 3/15/16 at 3:29am through 4/20/16 at 3:11pm. Review of the eMAR for April 2016 revealed: -Amitriptyline 75mg was documented as not administered for 1 occurrence out of 11 opportunities because "med on order." -Atorvastatin 10mg was documented as not administered for 6 occurrences out of 11 opportunities because "med on order." -Fluphenazine 20mg was documented as not administered for 1 occurrence out of 11 opportunities because "med on order."	D 358		

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D 358	Continued From page 45 Review of Resident #3's record revealed there were no inappropriate behaviors documented for April 2016. Review of the eMAR for May 2016 revealed: -Amitriptyline 75mg was documented as not administered for 10 occurrences out of 31 opportunities because "med on order." -Atorvastatin 10mg was documented as not administered for 18 occurrences out of 31 opportunities because "med on order." -Benztropine 1mg twice daily was documented as not administered for 2 occurrences out of 62 opportunities because "med on order." -Fluphenazine 10mg twice daily was documented as not administered for 14 occurrences out of 62 opportunities because "med on order." -Fluphenazine 20mg was documented as not administered for 11 occurrences out of 31 opportunities because "med on order." Review of Resident #3's record revealed there were no inappropriate behaviors documented for May 2016. Review of the eMAR for June 2016 revealed: -Amitriptyline 75mg was documented as not administered for 24 occurrences out of 30 opportunities because "med on order." -Atorvastatin 10mg was documented as not administered for 8 occurrences out of 30 opportunities because "med on order." -Fluphenazine 10mg twice daily was documented as not administered for 1 occurrence out of 60 opportunities because "med on order." Review of a Progress Note dated 6/12/16 revealed an entry at 6:30am "Came up to med room asked MT (Medication Aide) if she would call the cops because he is not getting his money.	D 358		

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D 358	Continued From page 46 She told him no she would not call them. So he got mad started cussing. Went behind PCA (Personal Care Aide) desk call 911. MT told him not to be behind the PCA desk and not to call the cops. Then he tried to hit MT, MT walked away so she would not get hit. Then he went to his room cussing, hitting things and being very loud." Review of the eMAR for July 2016 revealed: -Amitriptyline 75mg was documented as not administered for 17 occurrences out of 19 opportunities because "med on order" (medication was discontinued on 7/20/16). -Atorvastatin 10mg was documented as not administered for 8 occurrences out of 24 opportunities because "med on order." -Benztropine 1mg twice daily was documented as not administered for 17 occurrences out of 49 opportunities because "med on order." -Fluphenazine 10mg twice daily was documented as not administered for 5 occurrences out of 50 opportunities because "med on order." -Fluphenazine 20mg was documented as not administered for 4 occurrences out of 24 opportunities because "med on order." -Divalproex Sodium ER 500mg was documented as not administered for 5 occurrences out of 5 opportunities because "med on order" (medication was started on 7/20/16) Review of Resident #3's MCM Report dated 7/14/16 at 10:20pm revealed: -"Staff reports client is acting out, slamming doors, smoking in his room and screaming at other residents." -MCM was cancelled by the supervising staff because Resident #3 had calmed down and was asleep. Review of Resident #3's Mental Health provider	D 358		

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D 358	Continued From page 47 visit note dated 7/20/16 revealed: -He was last seen by the Mental Health provider on 8/5/15. -He was brought in by facility staff who reported he had been having episodes of verbal aggression, increased yelling, and was difficult to redirect. -Facility staff reported to the Mental Health provider that no physical aggression had been observed, only that he paced through the home and yelled at times. -Resident #3 denied any issues and was calm during the appointment. -Medication changes included to stop amitriptyline and start divalproex sodium ER 500 mg at bedtime for mood stabilization and sleep, continue fluphenazine and benztropine for psychosis and extrapyramidal symptoms. Review of an incident report dated 7/23/16 revealed: -Another resident had gotten into Resident #3's bed by mistake. -Resident #3 was yelling and holding a wet floor sign getting ready to hit the other resident that was in his bed. -Resident #3 became aggressive towards staff. -The Administrator directed staff to call mobile crisis if needed. -"No more problems from resident for the remainder of the day." Review of an incident report dated 7/24/16 revealed: -Resident #3 hit another resident and that resident was being sent to the hospital via EMS. -The police were called but did not arrest Resident #3. -The Administrator directed staff to call mobile crisis for Resident #3.	D 358		

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D 358	Continued From page 48 -Resident #3's guardian was notified of the incident. Review of an incident report dated 7/25/16 revealed the Administrator had reviewed the security camera footage of the incident that occurred on 7/24/16. Observation on 8/4/16 at 3:20pm of video surveillance dated 7/24/16 revealed: -One PCA was in the dining room serving food, with her back towards the residents. Resident #3 was about to sit in another resident's usual chair when that resident touched Resident #3. Resident #3 then elbowed the other resident forcefully in the chest/stomach area and began hitting him repeatedly with his fists. The other resident then fell backwards and hit his head on the dining room table. Another resident in the dining room, ran towards Resident #3 and wrapped his arms around him and took him to the floor to stop the fight. Review of Resident #3's MCM Report dated 7/25/16 at 11:20am revealed: -"Client (Resident #3) assaulted another resident yesterday which led to the other resident being admitted to the ICU for bleeding of the brain. On 7/23/16 client assaulted another resident who was sleeping in his bed and another staff member (Staff A). Client picked the other resident up out of his bed and threw him on the ground then began hitting him with a wet floor sign. Client has been taking most of his medications as prescribed according to the MAR provided by the ALF. Staff states that he refuses to take his medication often, however, and will often become verbally aggressive with them. Client has a history of getting angry and destroying property or assaulting staff or other residents. Today client	D 358		

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became aggressive with staff members when they would not give him a pen and told them to (expletive) off. Client did not assault anyone during this episode."
-Demeanor was noted as demanding
-Activity was noted as agitated.
-Mood was noted as angry and irritable.
-Behavior was noted as agitated, impulsive, alert, and restless.
-"Client needs inpatient admission due to dangerous behaviors and actions and lack of emotional stability client is appropriate for Involuntary Commitment (IVC) at this time."
-Disposition was documented as inpatient commitment.
-Report documented that Resident #3 "does not feel remorse for the assaults, states that the other residents deserved it."

Review of a local police report dated 7/24/16 revealed:
-Resident #3 had assaulted another resident in the dining room of the facility on 7/24/16. Resident #3 was seated in a chair that the other resident normally sat in and that resident touched Resident #3 on the shoulder. Resident #3 began to hit the other resident with his fist and knocked him to the floor.
-Another resident saw Resident #3 hit the other resident and he wrapped his arms around Resident #3 to stop him from hitting him.
-Resident #3 did not stop hitting the other resident until another resident "wrapped him up and pulled him away."
-Resident #3 stated that he stood up after the other resident touched him, made noises and waved his arms, and he hit the other resident with his fist.
-The other resident touched Resident #3 on the shoulder to get him to move because he could

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not speak.
-The PCA, Staff D was present during the fight and relayed the same information to the officer.
-EMS was called to the scene and transported (named resident) to the local hospital and reported that he had scratches on his head and left elbow.

Telephone interview with staff at the pharmacy provider on 8/10/16 at 9:18am revealed:
-Amitriptyline 75mg, 30 day supply was last dispensed on 2/15/16, and did not know why it was not dispensed after that.
-Atorvastatin 20mg (1/2 tablet at bedtime) 30 day supply was mailed on 5/19/16 and 7/13/16.
-Benztropine 1mg 30 day supply was mailed on 5/6/16, and on 7/20/16 was dispensed at the pharmacy window.
-Fluphenazine 10mg, 30 day supply was mailed on 2/16/16, and on 7/25/16 was dispensed at the pharmacy window.
-Divalproex sodium ER 500mg, 30 day supply was dispensed at the pharmacy window on 7/20/16.

Review of the medications dispensed list provided by the VA pharmacy from March 2016 to July 2016 revealed:
-Amitriptyline 75mg was not on the list.
-Atorvastatin 20mg #15 was dispensed on 6/10/16 and 7/11/16.
-Benztropine 1mg #60 was dispensed on 7/20/16.
-Fluphenazine 10 mg #120 was dispensed on 5/25/16 and 7/11/16,
-Fluphenazine 10mg #120 was dispensed on 7/25/16.
-Divalproex Sodium ER 500mg #30 was dispensed on 7/20/16.

Review of the tracking logs for Resident #3

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D 358	Continued From page 51 revealed: -Amitriptyline was not documented on the tracking logs. -The 6/22/16 log noted that fluphenazine was ordered on 7/11/16 and included a 10 day shipping time, benztropine had no refills and the pharmacy was requesting refills, and that atorvastatin was ordered on 7/11/16, with a 10 day shipping time. -The 7/15/16 tracking log noted there was no fluphenazine, benztropine, and atorvastatin available in backup and no refills were available. Observation of medications on hand on 8/3/16 at 2:45pm revealed: -Atorvastatin 20 mg (take ½ tablet) filled 7/13/16 #15. -Benztropine 1mg filled 7/20/16 #60. -Divalproex Sodium ER 500mg filled 7/20/16 #30. -Fluphenazine 10mg filled 7/12/16 #120, and 7/20/16 #120. Interview with the Resident Care Coordinator (RCC) on 8/4/16 at 10:50am and 4:00pm revealed: -"Med on order" meant the medication was not available to be given to the resident and was possibly an issue with the resident's physician and/or pharmacy. -The MAs were supposed to document on a medication log when medications were ordered from the VA hospital, document when the medication arrived, and call the pharmacy or physician if it did not come as ordered. Interview with MA, Staff A on 8/4/16 at 12:10pm revealed: -When a resident ran out of medication they would notify the provider and document in the chart.	D 358		

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D 358	Continued From page 52 -It took 10 days for medications to arrive once refills had been requested. -The MAs were supposed to keep one bottle of medications in the medication cart and one in back up. -She could not recall if she had contacted the pharmacy or the provider for Resident #3 being out of medications. Interview with a MA, Staff C on 8/4/16 at 3:05pm revealed the MAs were supposed to call the pharmacy when medications were not dispensed as ordered, call the physician when residents were refusing or missing their medications, and notify the RCC or the Administrator. Interview with Staff C on 8/8/16 at 10:45am revealed: -Resident #3 was required to see his mental health provider in July in order to get new prescriptions written. -She had called the provider regarding Resident #3 being out of medications. -She stated it took 10 days from the prescription order date to receive the mailed medications. -She had notified the RCC, the Administrator, and other MAs about Resident #3 being out of medications. -"He [Resident #3] was doing good until the end of July, he always took his meds, I never had issues with him." -Contact with the provider would be documented on the eMAR or on progress notes. Interview with the Administrator on 8/8/16 at 10:30am and 11:00am revealed: -The facility's policy was for staff to notify the pharmacy, physician, and herself when medications were missed for 1 to 3 days depending on the medication that was not	D 358		

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administered.
-She was unaware of medications being unavailable and not administered to Resident #3 until 7/24/16 when he got into an altercation with another resident in the facility.
-She became aware of the medication issue when she reviewed his chart.
-She was unsure if the provider was notified regarding Resident #3 missing doses of medications because he was out of medications.
-Resident #3's last day in the facility was 7/25/16. He was involuntarily committed to the local hospital.

Interview with the Transporter on 8/8/16 at 12:35pm revealed:
-She had notified the provider during the 7/20/16 visit about Resident #3's behaviors and had one new prescription filled while at the provider's office.
-She returned to the facility with the new medication for Resident #3 and gave it to the MAs.

Review of Resident #3's record revealed:
-He had missed scheduled appointments with his Mental Health provider on 1/27/16 and 6/13/16.
-Both appointments were documented as "no show."

Interview with the Administrator on 8/8/16 at 12:23pm revealed interventions for behaviors included the use of as needed (PRN) medications, 15 minute checks, contact MCM, contact the VA crisis line, or initiate an emergency discharge if behaviors did not improve.

Interview with the RCC on 8/8/16 at 3:10pm revealed:
-Interventions used by the facility for behaviors

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included talking to the resident first, use of PRN medications, doing 15 minute checks, and calling MCM.
-MCM would decide if a resident was safe to stay in the facility or if they needed to be admitted to the hospital.
-There is a facility form that is utilized for the 15 to 30 minute checks.
-The 15 to 30 minute check form was used for falls or behaviors and would be labeled as such.
-She was able to "talk him down" and not call MCM for the incident that occurred 6/12/16.
-MCM saw Resident #3 on 7/25/16 (Monday) and had him "IVC'd" for his behaviors on 7/23/16 and 7/24/16.

Interview with the RCC on 8/11/16 at 2:04pm revealed:
-The RCC was responsible for faxing Progress Notes to the VA Crisis Line for Residents that had inappropriate behaviors.
-She was unsure if the VA Crisis Line had been faxed regarding Resident #3's behaviors.
-The Medication Aide (MA) was responsible to send the fax if the RCC was unavailable.

Further review of the eMARs for March, April, May, June, and July 2016 revealed:
-There was no documentation that the provider had been notified that Resident #3 was out of medications.
-There was no as needed (PRN) medication listed on the eMAR for anxiety or agitation.

Attempted telephone interview with Resident #3's Mental Health provider on 8/11/16 at 3:00pm was not successful.

Attempted telephone interview with Resident #3's Guardian on 8/10/16 at 2:56pm was

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D 358	Continued From page 55 unsuccessful. Refer to review of the facility's medication policies. Refer to interview with the Administrator on 8/3/16 at 9:00am. B. Review of Resident #4's current FL2 dated 6/14/16 revealed: -Diagnoses which included paranoid schizophrenia, neurocognitive disorder, anxiety, and hypertension. -Order for monthly blood pressures. Review of Resident #4's Resident Register revealed he was admitted to the facility on 6/14/16. Review of Resident #4's hospital discharge assessment dated 5/22/16 before his admission to the facility revealed: -Resident was assessed as "depressed," but the block for "angry" was not checked. -Resident was assessed as "no suicidal or homicidal ideations endorsed." -Resident was also assessed as having insight "poor." Review of physician orders for Resident #4's FL2 dated 6/14/16 included: -Lisinopril 20mg daily at noon (for hypertension). -Trazadone 100mg at bedtime (for sleep). Review of the June and July 2016 eMARs revealed: -Lisinopril 20mg daily at noon was documented as not administered, med on order, from 6/16/16 through 7/19/16. -Trazodone 100mg every night at bedtime was	D 358		

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D 358	Continued From page 56 documented as not administered, med on order from 6/16/16 through 7/19/16. Telephone interview on 8/4/16 at 2:26pm with a staff at the dispensing pharmacy revealed the medications which were dispensed or not dispensed before Resident #4 left the facility on 7/19 included: -Lisinopril 20mg was not dispensed for Resident #4 until 7/22/16. -Trazodone 100mg was not dispensed for Resident #4 until 7/22/16. -She did not know why Lisinopril 20mg and the Trazodone 100mg was not dispensed until 7/22/16. -The pharmacy dispensed medications at the window for pick up or by mail for the residents. -If mailed, the facility staff had to request the medications by fax or by telephone 2 weeks prior to running out of medications. Review of the June and July 2016 eMARs and the physician orders compared to the medications dispensed for Resident #5 revealed: -Lisinopril 20mg was not available and was not documented as administered. -Trazodone 100mg was not available and was not documented as administered. Interview with the Resident Care Coordinator (RCC) on 8/4/16 at 4:00pm revealed: -Facility staff made attempts for the Lisinopril 20mg and the Trazadone 100mg to be clarified by the pharmacy. -She never witnessed any behaviors from Resident #4 before 7/19/16. -Other staff in the facility that day during the time of the incident included Staff C and Staff F. -The MAs were supposed to document on a medication log when medications were ordered	D 358		

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D 358	Continued From page 57 from the VA hospital, document when the medication arrived, and call the pharmacy or physician if it does not come as ordered. Telephone interview with Resident #4's Mental Health Provider on 8/10/16 at 2:15pm revealed: -He was "not too worried" if Resident #4 was not administered the Trazodone because the Invega injection every 28 days was the most critical medication for him and Resident #4 did receive his Invega Sustenna injection on 7/5/16 at the office. -The physician would not comment on Resident #4 missing his Lisinopril. Interview with the Administrator on 8/8/16 at 10:30am revealed: -She was not aware Resident #4 had missed any medications until 7/19/16, when she looked at his records. -She had taken medications to Resident #4 twice since he had been in jail, on 7/19/16 and on 8/4/16. -She did not know why all medications were not picked up at the pharmacy upon Resident #4's discharge from the hospital and she did not know who transported Resident #4 from the hospital to the facility on 6/14/16 upon admission, but may have been the former transporting staff who left on 7/20/16. -She did not know why the lisinopril and the trazodone were not dispensed and sent to the facility before Resident #4 was discharged. -Their policy was for staff to call the pharmacy, the physician, and herself when medications were missed for 1 to 3 days depending on what the medication was that was not administered. Interview with PCA, Staff E on 8/8/16 at 12:30pm revealed:	D 358		

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D 358	Continued From page 58 -She never witnessed any behaviors with Resident #4 before the 7/19/16 incident. -She was not afraid of Resident #4. Interview with a MA, Staff A, on 8/4/16 at 12:00pm revealed: -She never witnessed any behaviors from Resident #4 before 7/19/16 and none of the residents complained about him. -She had seen him get "moody" when he did not get cigarettes, but not angry. -She called the physician and the pharmacy and about Resident #4's medications, but was not sure she documented the calls. Interview on 8/4/16 at 3:05pm with a MA, Staff C, revealed the MAs were supposed to call the pharmacy when medications were not dispensed as ordered, call the physician when residents were refusing or missing their medications, and notify the RCC or the Administrator. Review of Resident #4's Progress Notes revealed: -Entry dated 6/21/16 and initialed by the RCC revealed "Was checking on all VA meds...checked on Resident #4's Lisinopril and Trazodone and I told them I will still keep follow up and keep checking to see if there have been and clarification on when they spoke with doc." -Entry dated 6/14/16 and signed by the Administrator revealed "VA sent all meds except Trazodone HCL 100mg and Lisinopril 20 mg. Call placed to VA pharmacy they stated meds were on order should arrive in facility mail in a few days." -Entry dated 6/29/16 and signed by the former medication aide/transportation staff, "No one ever called back about [Resident #4's] Lisinopril. I will call in the am." -Entry dated 7/8/16 and signed by the	D 358		

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D 358	Continued From page 59 Administrator revealed "Clinical staff brought to my attention that resident was out of the facility often when it is time for him to get his meds. Spoke with resident about coming back in time to get his meds and the importance of taking his medications. Resident stated that he understood and would start coming back at med time." Review of record revealed no documented blood pressure in June or July 2016. Attempted telephone interview with Resident #4's guardian on 8/10/16 at 10:50am was not successful. Refer to the facility's medication policies. Refer to interview with the Administrator on 8/3/16 at 9:00am. C. Review of Resident #7's current FL2 dated 10/29/15 revealed: -Diagnoses included diabetes and history of schizophrenia. -"Intermittently" was marked under disoriented under the patient information section. Review of physician orders on the FL2 dated 10/29/15 included: -Meloxicam 7.5mg every morning after breakfast (pain medication) -Razadyne 4mg twice daily after meals (used for cognitive impairment). Review of the March 2016 eMAR for Resident #7 revealed meloxicam 7.5mg at 8:00am was documented as not administered because "med on order" on 3/26, 3/27, 3/28, and 3/29. Review of the April 2016 eMAR for Resident #7	D 358		

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revealed meloxicam 7.5mg at 8:00am was documented as not administered because "med on order" on 4/2, 4/3, 4/5, 4/7, 4/8, 4/9, 4/10, 4/13, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, 4/27, and 4/30.

Review of the May 2016 eMAR for Resident #7 revealed meloxicam 7.5mg at 8:00am was documented as not administered because "med on order" on 5/1, 5/2, 5/5, 5/6, 5/8, 5/9, 5/12, 5/14, 5/15, 5/16, 5/18, 5/22, 5/25, 5/26, and 5/28.

Review of the June 2016 eMAR for Resident #7 revealed:
-Meloxicam 7.5mg at 8:00am was documented as not administered because "med on order" on 6/1, 6/3, 6/4, 6/6, 6/7, 6/11, 6/12, 6/14, 6/15, 6/16, 6/17, 6/18, 6/20, and 6/21.
-Razadyne 4mg twice daily at 8:00am and 8:00pm was documented as not administered because "med on order" at 8:00am on order on 6/6, 6/7, 6/10, 6/11, 6/12, and 6/14 and not administered because "med on order" at 8:00pm on 6/6, 6/7, 6/8, 6/9, 6/11, 6/12, and 6/13.

Telephone interview with staff at the dispensing Pharmacist on 8/5/16 at 2:45pm revealed:
-A 30 day supply of meloxicam 7.5mg was dispensed on 2/16/16, on 7/15/16, on 7/19/16, and on 7/29/16.
-A 90 day supply of Razadyne 4mg was dispensed on 4/6/16 and 6/25/16.
-Resident #7 saw his PCP and his Mental Health provider on 2/5/16.

Review of the April, May, and June 2016 eMARs and the physician orders compared to the medications dispensed by the pharmacy revealed:
-A 30 day supply of meloxicam 7.5mg was

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dispensed on 6/15/16, which was 129 days after the 30 day supply was dispensed on 2/16/16, staff documented the resident missed 49 doses, but the medication was delayed by 99 days which would have been 99 doses unavailable.
-A 90 day supply of Razadyne 4mg was dispensed on 4/6/16 and should have been a sufficient supply through June 2016, but the resident missed 13 doses.

Review of Resident #7's resident record revealed no documentation that staff had called the pharmacy or the physician when he was out of the meloxicam 7.5mg and the Razadyne 4mg.

Telephone interview with the prescribing physician on 8/10/16 at 3:43pm revealed:
-Resident #7 missing the Razadyne was "not a danger, but must be taken daily to be fully effective" and was prescribed to improve memory.
-The meloxicam 7.5mg was prescribed for Resident #7's joint pain.

Interview with the Administrator on 8/8/16 at 10:30am revealed:
-She was not aware Resident #7 had missed any medications.
-She had not witnessed Resident #7 with any unusual behaviors.
-Their policy was for the staff to call the pharmacy, physician, and herself when medications are missed for 1 to 3 days depending on what the medication missed.

Interview with the Resident Care Coordinator (RCC) on 8/4/16 at 4:00pm revealed:
-She never witnessed any unusual behaviors from Resident #7
-She stated the Medication Aides (MAs) were

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D 358	Continued From page 62 supposed to call the pharmacy or physicians when medications were not available to let her or the Administrator know. -The MAs were supposed to document on a medication log when medications were ordered from the VA hospital, document when the medication arrived, and call the pharmacy or physician if it does not come as ordered. -She could not explain how meloxicam was on order in May 2016 for a few days and then available for a few days, for example not available for the 2nd and 3rd but available on the 4th, on order on the 5th, available on the 6th, and on order for the next 4 days unless the MAs were not documenting the MARs accurately. Observation of medications on hand for Resident #7 on 8/2/16 at 2:00pm revealed all current medications were available for administration. Interview with MA, Staff A on 8/8/16 at 12:30pm revealed: -She never observed Resident #7 have any behaviors, did not observe any changes in him, and he had not complained of pain. -She did not remember if she called the pharmacy about the meloxicam or Razadyne. -She did not know why the meloxicam was not requested or dispensed earlier so he would not have been out of meds. -She did not know why the Razadyne was documented as "med on order" but some MAs document in error that med is on order when the resident is out of the facility or refuses the medication. Interview with Resident #7 on 8/2/16 at 11:15am revealed: -He was not aware of any medications not being administered as ordered.	D 358		

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D 358	Continued From page 63 -He had been taking his medications. Refer to the facility's medication policies. Refer to interview with the Administrator on 8/3/16 at 9:00am. D. Review of current FL2 for Resident #6 dated 1/25/16 revealed: -Diagnoses included multinodular goiter, vitamin D deficiency, and history of vitamin B12 deficiency. -"Constantly" disoriented was marked under "patient information." -Physician orders for trazodone 50mg at bedtime (antidepressant and for insomnia), vitamin B12 500mcg take 2 daily (used to treat pernicious anemia, and Abilify 20mg 1/2 tablet daily (antipsychotic medication). Review of Resident #6's Resident Register revealed he was admitted to the facility on 9/4/09. Review of a subsequent physician order for Resident #6 dated 3/31/16 revealed olanzapine 10mg dissolve 1 tablet in mouth in the morning for mood stabilization and hallucinations. Review of the Resident #6's electronic Medication Administration Records for April, May, June, and July 2016 revealed: -Olanzapine 10mg at 8:00am was documented as not administered because "med on order" on 4/1, 4/2, 4/3, 4/5, 4/6, 4/29, 5/20, 5/21, 5/30, 5/23, 5/30, 6/2, 6/8, 6/9, 6/10, and 6/13. -Abilify 20mg at 8:00am was documented as not administered because "med on order" on 6/1, 6/12, and 6/26. -Trazodone 50mg at 8:00pm was documented as not administered because "med on order" on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099014	A. BUILDING: _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT VILLAGE OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 358	Continued From page 64 6/11, 6/12, 6/14, 6/15, 6/16, 6/18, 6/20, 6/21, and 6/22. -Vitamin B12 500mcg 2 daily at 8:00am was documented as not administered because "med on order" on 7/1, 7/3, 7/4, 7/6, 7/7, 7/9, 7/10, and 7/11. -There was no documentation on the eMAR that Resident #6's physician had been notified that he was out of medications. Telephone interview with staff at the pharmacy provider on 8/4/16 at 2:26pm revealed: -Olanzapine 10mg 30 day supply was mailed out to the facility on 4/18/16, on 5/8/16, on 6/7/ 16, 7/10/16, and on 8/6/16 and did not know why Olanzapine 10mg was not dispensed before 4/18/16. -Trazodone 50mg 30 day supply was mailed out to the facility on 4/18/16, on 6/15/16, and 7/5/16 and did not know why Trazodone 50 mg was not dispensed in May 2016. -Abilify 20mg 30 day supply was mailed on 4/12/16, on 5/2/16, and 6/1/16. -Vitamin B12 500mcg 90 day supply was mailed on 2/7/16 and on 7/5/16 and she did not know why none was dispensed between 2/7/16 and 7/5/16. -She said the facility staff had to request medications 2 weeks before they ran out, to assure they arrived at the facility on time. -Medications were not automatically mailed to the facility. Review of the April, May, June, and July 2016 eMARs and the physician orders compared to the medications dispensed by the pharmacy revealed: -Olanzapine 10mg was not mailed out to the facility until 18 days after the physician order on 3/31/16 but should have been available the day of	D 358		

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D 358	Continued From page 65 mail delivery in April (not known) through June 2016. -Trazodone 50mg 30 day supply mailed on 6/15/16 was 58 days after the first 30 day supply was mailed on 4/18/16 and a 30 day supply was not dispensed in May and 9 doses documented as not administered. -Abilify 20mg should have been available for administering since a 30 day supply was mailed on 4/12/16, 5/2/16, and 6/1/16. -Vitamin B 12 500mcg 90day supply mailed on 7/5/16 was 151 days after the last supplement was mailed on 2/7/16. Interview with the Administrator on 8/3/16 at 9:00am revealed: -She was not aware that Resident #6 had missed some medications. -She was not aware of any unusual behaviors from Resident #6. Interview with Resident #6 on 8/2/16 at 11:22am revealed: -"I've pulled my time, leaving Monday." -He had been getting all of his medications. Observations of medications on hand available for administration on 8/4/16 at 12:00 pm revealed all medications were available. Interview with MA, Staff C on 8/4/16 at 3:05pm revealed: -She had not witnessed any changes in Resident #6. -He never had any problems sleeping. -She did not know why all of Resident #6's medications had not been available for administration because the MAs were supposed to track the orders on the VA tracking log.	D 358		

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D 358	Continued From page 66 Interview with MA, Staff A on 8/8/16 at 12:30pm revealed she never observed Resident #6 have any behaviors, had not seen any changes in him, but he did talk to himself. Attempted telephone interview with the prescribing physician on 8/11/16 at 11:11am was not successful. Refer to the facility's medication policies. Refer to interview with the Administrator on 8/3/16 at 9:00am. E. Review of Resident #8's current FL2 dated 4/15/16 revealed: -Diagnoses included anemia, schizophrenia, hyperlipidemia, and benign hypertension. -Physician orders included Ferrous Sulfate 325mg (to treat iron deficiency anemia) three times daily (TID). Review of a hospital discharge summary revealed: -Resident #8 was admitted to the hospital on 4/12/16. -Resident #8 was released from the hospital on 4/19/16 with a discharge diagnosis of schizophrenia disorganized type. Record review of a FL2 dated 10/26/15 revealed Resident #8 was initially admitted to the facility on 6/04/2014. Review of the eMARs for April, May, and June, 2016 revealed: -Ferrous Sulfate 325mg TID scheduled for 6:00am, 12:00 pm and 5:00pm was documented as not administered because "med on order" at 5:00pm on 4/25/16, at 6:00am on 5/3 and at	D 358		

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D 358	Continued From page 67	D 358		

12:00pm on 5/6, not administered because "med on order", three times per day, on 4/26, 4/27, 4/28, 4/30, 5/1, 5/2, and not administered because "med on order" at the 6:00am and 5:00pm on 4/29.
-There was no documentation on the MAR that Resident #8's physician had been notified that he was out of medications.

Telephone interview on 8/4/16 at 2:26pm with a staff at the dispensing pharmacy revealed:
-A 90 day supply of Ferrous Sulfate 325mg TID was mailed to the facility on 4/28/16.
-She did not know why the Ferrous Sulfate was not sent earlier than 4/28/16, but the facility staff had to call 2 weeks in advance if medications were mailed to them.

Review of the facility census for June 2016 and interview with the Administrator on 8/8/16 at 10:30am revealed:
-Resident #8 was sent to the emergency room on 6/21/16 because he was lethargic and was diagnosed with pneumonia.
-She was not aware that Resident #8 missed any medications.
-Resident #8's family transferred him to another facility after his last hospitalization in June 2016.
-The Administrator had noted on the census that his discharge date was 7/17/16.

Review of the hospital discharge record for Resident #8 dated 7/6/16 revealed:
-He was admitted to the hospital on 6/22/16 with "lethargy, fever, and altered mental status.
-The diagnoses included pneumonia.
-Laboratory levels included: Hemoglobin 11.1 on 6/22/16 with reference range as 13.11-16.01.

Interview with MA, Staff C on 8/4/16 at 3:05pm

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D 358	Continued From page 68 revealed she never witnessed any change in behaviors in Resident #8. Telephone interview with Resident #8's guardian on 8/2/16 at 3:26pm revealed: -She was not aware if Resident #8 had missed any medications at the facility. -Resident #8 was admitted to the hospital 6/21/16 because he had pneumonia. Refer to review of the facility's medication policies. Refer to interview with the Administrator on 8/3/16 at 9:00am. _____ Review of the facility's Medication Administration Policies revealed: -"It is the facility's responsibility to document, monitor and report medication refusal by a resident. Residents have the right to refuse their medication. Certified staff will document a medication refusal with their initials circled on the MAR. Staff will report medication refusals to the RCC within 24 hours of the refusal. Staff will complete the medication refusal report and deliver to the RCC within 24 hours of the refusal. The RCC will monitor medication refusal sheets and report to the prescribing practitioner whenever a resident refuses medication for three consecutive days and/or three or more doses in one week." -"If a Resident is out of the facility at the prescribed medication times, medications may be given an hour before or an hour after the prescribed. If the resident returns to the facility outside of this window, the medication tech will call the prescribing physician to ask for approval to give the medication at the time the resident has	D 358		

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D 358	Continued From page 69 returned. The call is to be documented in the residents chart and the given medication on the resident's MAR along with an explanation as to why the medication is being given outside the allowed time frame." Interview with the Administrator on 8/3/16 at 9:00am revealed: -They started a tracking log the end of June 2016 which designated the date Veterans Administration (VA) medications were ordered and delivered. -The Medication Aides (MA) were supposed to fill out the tracking log when they ordered medications and when they were delivered. -MAs were to call the physician or pharmacy if medications were not delivered as ordered or not available for administration and let her know. -She came to the facility on 6/6/16 as Administrator and the other Administrator left on 6/2/16. The facility provided the following Plan of Protection on 8/3/16: -The Administrator and RCC will review all orders that are entered on the Medication Administration Record. -The RCC will then review the MAR to assure medications are delivered as ordered. -Medications not available policy and medication refusal policy will be reviewed with all staff and followed. -Daily review of MARs will be completed by the RCC. -Will review medication ordering policy with the pharmacy. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2016.	D 358		

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D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 400		

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D 400	Continued From page 71	D 400		

reviews, the facility failed to assure adequate medication reviews were completed for 4 of 6 sampled residents (#6, #7, #8, #3) in the areas of medication refusals and medications unavailable to administer.

The findings are:

A. Review of Resident #8's current FL2 dated 4/15/16 revealed:
-Diagnoses included anemia, schizophrenic, hyperlipidemia, and benign hypertension.
-Physician orders included Ferrous Sulfate 325 mg (to treat iron deficiency anemia) three times daily (TID).

Review of Resident #8's electronic Medication Administration Records (eMARs) for April and May 2016 revealed:
-Ferrous Sulfate 325 mg TID scheduled for 6:00am, 12:00 pm and 5:00pm was documented as not administered because "med on order" at 5:00pm on 4/25/16, at 6:00am on 5/3 and at 12:00pm on 5/6, not administered because "med on order" three times daily on 4/26, 4/27, 4/28, 4/30, 5/1, and 5/2, and not administered because "med on order" at 6:00am and 5:00pm on 4/29, and not administered because "out of the facility" at 12:00pm on 5/12.

Review of pharmacy review dated 5/16/16 revealed:
-A recommendation to request lab results from the veterans administration.
-There was no documentation related to Resident #8 missing any medications.

Telephone interview on 8/4/16 at 2:26pm with a staff at the dispensing pharmacist revealed:
-A 90 day supply of Ferrous Sulfate 325 mg TID

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D 400	Continued From page 72	D 400		

was mailed to the facility on 4/28/16.
-She did not know why the Ferrous Sulfate was not sent earlier than 4/28/16, but the facility staff have to call 2 weeks in advance if medications are mailed to them.

Attempted telephone interview on 8/10/16 at 12:33pm with the pharmacist who signed the 5/16/16 pharmacy reviews was not successful.

Refer to telephone interview on 8/10/16 at 2:25pm with a pharmacist.

Refer to interview with the Administrator on 8/11/16 at 2:26pm.

B. Review of Resident #7's current FL2 dated 10/29/15 revealed:
-Diagnoses included diabetes and history of schizophrenia.
-"Intermittently" was marked under disoriented under the patient information section.
-A Physician order for meloxicam 7.5mg every morning after breakfast (pain medication).

Review of March, April, and May 2016 eMARs for Resident #7 revealed:
-Meloxicam 7.5mg at 8:00am was documented as not administered because "med on order" on 3/26, 3/27, 3/28, 3/29, 4/2, 4/3, 4/5, 4/7, 4/8, 4/9, 4/10, 4/13, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, 4/27, 4/30, 5/1, 5/2, 5/5, 5/6, 5/8, 5/9, 5/12, 5/14, 5/15, and 5/16.

Review of pharmacy review dated 5/16/16 revealed:
-A recommendation to request lab results from the veterans administration.
-There was no documentation related to Resident #7 missing any medications.

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D 400	Continued From page 73 Telephone interview with staff at the dispensing pharmacist on 8/5/16 at 2:45pm revealed: -Meloxicam 7.5mg after breakfast 30 day supply was dispensed on 2/16/16. -She did not know why Meloxicam 7.5mg was not dispensed after 2/16/16. -The facility staff had to request medications, they were not automatically mailed to the facility. Refer to telephone interview on 8/10/16 at 2:25pm with a pharmacist. Refer to interview with the Administrator on 8/11/16 at 2:26pm. C. Review of current FL2 for Resident #6 dated 1/25/16 revealed diagnoses included multi-nodular goiter, vitamin D deficiency, and history of vitamin B12 deficiency. Review of subsequent physician orders for Resident #6 dated 3/31/16 revealed olanzapine 10mg dissolve 1 tablet in mouth in the morning for mood stabilization and hallucinations. Review of Resident #6's eMARs for April and May 2016 revealed olanzapine 10mg at 8:00am was documented as not administered because "med on order" on 4/1, 4/2, 4/3, 4/5, 4/6, and 4/29. Review of Resident #6's pharmacy reviews completed 2/18/16 and 5/16/16 revealed no recommendations. Telephone interview with staff at the pharmacy provider on 8/4/16 at 2:26pm revealed: -Olanzapine 10mg 30 day supply was mailed out to the facility on 4/18/16 and 5/8/16. -She did not know why olanzapine 10mg was not	D 400		

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D 400	Continued From page 74 dispensed before 4/18/16. -She said the facility staff had to request medications 2 weeks before they ran out, to assure they arrived at the facility on time. -Medications were not automatically mailed to the facility. Review of the April and May 2016 eMARs and the physician orders compared to the medications dispensed by the pharmacy revealed olanzapine 10mg in the morning was not mailed to the facility until 18 days after the physician order of 3/31/16. Refer to telephone interview on 8/10/16 at 2:25pm with a pharmacist. Refer to interview with the Administrator on 8/11/16 at 2:26pm. D. Review of the current FL2 for Resident #3 dated 1/14/16 revealed: -Diagnoses included traumatic brain injury, schizophrenia disorganized type chronic, neurocognitive disorder, and hypertension. -"Verbally abusive" was marked under "patient information." -Physician orders for amitriptyline (used to treat depression) 75mg at bedtime, atorvastatin (used to treat high cholesterol) 10mg daily, benztropine (used to treat extrapyramidal symptoms) 1mg twice daily, and fluphenazine (used to treat psychosis) 10mg in the morning, 10mg at 2pm, and 20mg at bedtime. Review of the eMARs for March, April and May 2016 revealed: -Amitriptyline 75mg was documented as not administered for 12 occurrences because "med on order", and 3 occurrences because "resident refused" out of 56 opportunities.	D 400		

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D 400	Continued From page 75 -Atorvastatin 10mg was documented as not administered for 24 occurrences because "med on order", and 3 occurrences because "resident refused" out of 55 opportunities. -Benztropine 1mg twice daily was documented as not administered for 2 occurrences because "med on order", and 5 occurrences because "resident refused" out of 110 opportunities. -Fluphenazine 10mg twice daily was documented as not administered for 14 occurrences because "med on order" and 5 occurrences because "resident refused" out of 110 opportunities. -Fluphenazine 20mg was documented as not administered for 12 occurrences because "med on order" and 3 occurrences because "resident refused" out of 56 opportunities. Review of a local police department report dated 3/15/16 revealed Resident #3 was in jail from 3/15/16 at 3:29am through 4/20/16 at 3:11pm. Review of pharmacy review dated 5/16/16 revealed: -A recommendation to request lab results from the Veterans Administration. -There was no documentation related to Resident #3 refusing or being out of any medications. Refer to telephone interview on 8/10/16 at 2:25pm with a pharmacist. Refer to interview with the Administrator on 8/11/16 at 2:26pm. _____ Telephone interview on 8/10/16 at 2:25pm with a pharmacist revealed: -He worked with the pharmacist who signed the 5/16/16 pharmacy reviews. -The pharmacist did look at eMARs and for	D 400		

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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
D 400	Continued From page 76 medications which were circled and not administered when they completed the reviews. -He looked for "trends" like if a resident was refusing medications. -They can monitor the eMARs if they see a trend and call the facility if they need to but they do not do that routinely. -They did not routinely see medications not available unless it was a "speciality order." -He could not speak specifically why the pharmacist did not document any particular residents at this facility not receiving medications. Interview with the Administrator on 8/11/16 at 2:26pm revealed: -She was unsure if the facility had a contract with the pharmacy provider that did the quarterly reviews. -She expected the review to include looking at the eMARs, physician orders and to verify medication on hand. -The pharmacy provider would come to the facility once every 3 months and would have reviewed all the records by lunch time.	D 400		
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 observations, interviews and record reviews, the facility failed to assure that every	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099014	A. BUILDING: _____ B. WING _____	08/12/2016

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D912	Continued From page 77 resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. The findings are: A. Based on interviews and record reviews, the facility failed to assure 2 of 5 residents (#1 and #5) residing in the facility were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 234, 10A NCAC 13F .0703(a) Tuberculosis Test (Type B Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure medications for 5 of 8 sampled residents (#3, 4, 6, 7, and 8) were available and administered as ordered. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. C. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 8 sampled residents regarding one resident with medications that were unavailable and frequent inappropriate behaviors (Resident #3), three residents regarding medication refusals (Resident #3, #4, and 5), and one resident who failed to receive a monthly Invega injection (Resident #5). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. D. Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to Adult Care Home Personal Care and Other Staffing requirements, Tuberculosis Testing of Residents, Health Care, Medication	D912		

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D912	Continued From page 78 Administration, and Pharmaceutical Care. [Refer to Tag 980, G.S. 131D-25 Implementation (Type B Violation)].	D912		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to Adult Care Home Personal Care and Other Staffing requirements, Tuberculosis Testing of Residents, Medication Administration, Health Care, and Pharmaceutical Care. The findings are: Interview with the Administrator on 8/9/16 at 8:55am revealed staff had quit recently and they were in the process of hiring and training new staff. Interview with the Administrator on 8/11/16 at 2:26pm revealed: -She worked Monday through Friday from 8:30am to 5:00pm. -She would sometimes work as late as 7:00pm. -Her supervisor usually spent 1 to 1.5 hours per	D980		

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D980	Continued From page 79 week in the facility. Subsequent interview with the Administrator on 8/12/16 at 3:00pm revealed: -She had been the Administrator of the facility since 6/6/16. -The previous Administrator had left on 6/2/16. Non-compliance identified during the survey included: A. Based on interviews and record reviews, the facility failed to assure minimum staffing requirements for Aides was provided for 10 out of 47 shifts from 6/25/16 through 7/10/16. [Refer to Tag 201, 10A NCAC 13F .0604(e)(1)(A)(B)(C) Personal Care and Other Staffing]. B. Based on observations, interviews, and record reviews, the facility failed to assure that all housekeeping performed by personal care staff between the hours of 7:00am and 9:00pm was limited to occasional, non-routine tasks. [Refer to Tag 206, 10A NCAC 13F .0604(e)(2)(B) Personal Care and Other Staffing]. C. Based on observation, interviews, and record reviews, the facility failed to assure that all food service duties performed by personal care staff between the hours of 7:00am and 9:00pm was limited only to help with eating and carrying plates, trays or beverages to residents, and resulted in personal care staff performing routine food service duties of setting the tables, cleaning the tables, and sweeping the dining room floors. [Refer to Tag 209, 10A NCAC 13F .0604(e)(2)(E) Personal Care and Other Staffing]. D. Based on interviews and record reviews, the facility failed to assure 2 of 5 residents (#1 and #5) residing in the facility were tested upon	D980		

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D980	Continued From page 80 admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 234, 10A NCAC 13F .0703(a) Tuberculosis Test (Type B Violation)]. E. Based on observations, interviews, and record reviews, the facility failed to assure medications for 5 of 8 sampled residents (#3, 4, 6, 7, and 8) were available and administered as ordered. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. F. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 8 sampled residents regarding one resident with medications that were unavailable and frequent inappropriate behaviors (Resident #3), three residents regarding medication refusals (Resident #3, #4, and 5), and one resident who failed to receive a monthly Invega injection (Resident #5). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. G. Based on observations, interviews, and record reviews, the facility failed to assure adequate medication reviews were completed for 4 of 6 sampled residents (#6, #7, #8, #3) in the areas of medication refusals and medications unavailable to administer. [Refer to Tag 400, 10A NCAC 13F .1009(a)(1)(A) Pharmaceutical Care]. The facility provided the following Plan of Protection on 8/11/16: -The licensee and Administrator will be responsible for ensuring rule areas are met and will work with the County and the Division of Health Service Regulation to get rule areas back in compliance. -Training will include policies and procedures	D980		

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D980	Continued From page 81 concerning rule areas cited, inservices from the pharmacy, inservice from the VA Registered Nurse on ordering medications, and implementation of the VA medication tracking log. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2016.	D980		