Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: ______ B. WING ______	R-C 11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 11/15/16-11/17/16 and 11/21/16-11/22/16 with an exit conference conducted by telephone on 11/22/16.	{D 000}		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was free of safety and fall hazards as evidenced by stacking and storing boxes in the resident common area, creating a safety and fall risk. The findings are: Observation on the initial facility tour on 11/15/16 at 10:04am revealed: -There were 15 residents in the common room on the left side of the middle hall participating in an activity led by the Activity Director (AD). -There were more than 40 cardboard boxes stacked on the floor to the left of the exit door in close proximity to where the residents were seated. -The boxes were various sizes, with the largest boxes measuring approximately 18 inches by 36	D 079		

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inches.
-The boxes were stacked on top of each other in multiple stacks ranging from 2 to 6 boxes high, greater than 6 feet high.
-At the conclusion of the activity, the residents exited the common room, walking directly past the stacked boxes.

Interview with the AD on 11/15/16 at 10:05am revealed:
-The boxes in the common room had been stacked there since a shipment arrived in the facility "last week."
-The facility had a storage building outside.

Interview with a staff member of 11/15/16 at 10:53am revealed the boxes in the common room had been delivered "the other day."

Interview with the Business Office Manager (BOM) on 11/15/16 at 10:55am revealed:
-The boxes stacked in the common room were from a delivery; it had "probably been a week" since the boxes were delivered.
-The merchandise in the boxes needed to be put in the storage room.
-The BOM acknowledged the stacked boxes were a fall risk and "safety hazard."
-The BOM would make sure the boxes were removed that day (11/15/16).

Interview with the Executive Director (ED) on 11/15/16 at 10:58am revealed:
-The facility received a big delivery the previous week.
-The facility had gotten what they could of the delivery put into storage.
-The boxes should have been moved before now.
-The ED would make sure the boxes were moved to the outside storage building that day

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D 079	Continued From page 2 (11/15/16). Observation on 11/15/16 at 4:40pm revealed the boxes stacked on the floor in the resident common room were no longer there.	D 079		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider of acute health care needs of 3 of 5 sampled residents (#1, #2 and #5) where one resident did not receive a prescribed antibiotic resulting in hospitalization with a diagnoses of Sepsis (#5); for a second resident with eleven finger stick blood sugar results greater than 401 (#1); and for a third resident who needed a two-day follow up evaluation after a hospital visit (#2). The findings are: 1. Review of Resident #5's current FL-2 dated 10/27/16 revealed diagnoses included Change in Mental Status and Congestive Heart Failure. Interview with the Primary Care Provider (PCP) on 11/16/16 at 11:11am revealed: -There was an incident where he had seen	{D 273}		

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Resident #5 at the facility (on 10/19/16) for looking "a little sick" and he prescribed antibiotics for an upper respiratory infection.
-Resident #5's family member was responsible for getting her medications and bringing them to the facility but did not bring the antibiotic for one week.
-Facility staff did not notify him that the resident had not received the antibiotic until he returned to the facility (on 10/24/16) for a follow up visit with Resident #5.
-Upon seeing the resident, he found her to be quite sick, not acting like herself, had no verbal response and he, therefore, admitted her to the hospital where she was diagnosed with Sepsis requiring intravenous antibiotics.
-The PCP expected medications to be given as ordered, prescribed antibiotics to be started within 24 hours and for staff to notify him immediately if staff could not get medications for a resident.

Review of "Physician Order Request" sheet for Resident #5 dated 10/19/16 revealed an order signed by the PCP for Bactrim DS one tablet twice daily for 7 days then one tablet daily for 30 days for an acute and chronic urinary tract infection. (Bactrim is a broad spectrum antibiotic used to treat infections.)

Review of Resident #5's October 2016 electronic Medication Administration Record (eMAR) revealed:
-According to the eMAR, one dose of Bactrim DS was documented as administered to Resident #5 on 10/24/16 at 8:00am.
-Staff documented under "Pass Notes" on 10/21/16 at 8:00am and 10/23/16 at 8:00pm for Bactrim DS that the "family did not provide."

Review of "Care Notes" for Resident #5 revealed:

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-On 10/20/16, staff documented the resident was seen 10/19/16 by the PCP and the order for Bactrim was faxed to the pharmacy.
-Staff documented a voice message was left for the Power of Attorney (POA) to pick up and deliver the Bactrim.
-On 10/23/16, staff documented the resident had an antibiotic waiting to be picked up from the pharmacy.
-The resident's POA had been at the facility on 10/23/16 and staff reminded him the resident needed the antibiotic from the pharmacy.
-The POA left the facility and returned on 10/23/16 without the antibiotic and said he would pick it up on 10/24/16.
-On 10/27/16, staff documented the resident had returned from the hospital following admission for Altered Mental Status due to Sepsis from a Urinary Tract Infection.
-There was no documentation that the PCP was contacted 10/19/16 through 10/27/16.

Review of hospital records dated 10/24/16 through 10/27/16 for Resident #5 revealed:
-Resident #5 had symptoms of an upper respiratory tract infection and a urinary tract infection on 10/19/16, did not receive antibiotic until 10/24/16 and presented on 10/24/16 to the hospital looking septic and was nonresponsive to verbal commands.
-She had chills, malaise, fatigue, diaphoresis, cough, sensory and speech changes and rales in her lung sounds.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with Resident #5's POA on 11/17/16 at 2:55pm was unsuccessful.

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Interview with a Medication Aide (MA) on 11/17/16 at 4:07pm revealed:
-She had written the care notes on 10/20/16 and 10/27/16 for Resident #5.
-She could not remember all the details between 10/20/16 and 10/27/16 because Resident #5 "gets like that sometimes" where she had a blank stare, sweats and her body would be cold so staff would just send her to the emergency room.
-The MA thought the PCP saw Resident #5 in his office on 10/19/16 and then decided to admit her to the hospital, but she was not sure of the date.
-She had left a voice message for Resident #5's POA to get the antibiotic because he picked up her medications from an outside pharmacy and brought them to the facility.
-Staff could not administer medications if they were not at the facility and she could not really say what had been done between 10/20/16 and 10/24/16.

Interview with the PCP on 11/21/16 at 11:30am revealed:
-Resident #5 had symptoms of both an upper respiratory infection and a urinary tract infection when he had seen her on 10/19/16.
-He admitted Resident #5 to the hospital on 10/24/16 after seeing that she was "out of it" and learning from staff that she had not received the antibiotic.
-He discussed his concerns about the resident not receiving the antibiotic for four days with a MA on duty and with the Executive Director (ED) on 10/24/16.
-"All it would have took was a phone call and I could have fixed this and helped get her medications."

Interview with the ED on 11/17/16 at 4:19pm revealed:

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-It took "reminders" to get Resident #5's POA to bring the antibiotics in, "sometimes."
-The ED did not know how long Resident #5's antibiotics had been delayed.
-Resident #5's physician was notified of the delay in getting the antibiotics but the ED was "unsure" how the physician was notified.
-The ED did not know if there was any documentation of the physician being notified.

Interview with the ED on 11/17/16 at 6:42pm revealed:
-The former Memory Care Manager (MCM) was responsible for monitoring orders at that time.
-The ED expected MAs to contact the PCP if there were any problems with a resident's medications and document all contacts with the PCP in the resident's record.

Attempted interview with the former Memory Care Manager (MCM) on 11/21/16 at 4:52pm was unsuccessful.

Review of the facility's "Medication Administration" Policy revealed:
-"In the event that starting a particular order within these time frames is not possible due to extenuating circumstances, the physician shall be notified immediately and documentation of such circumstances shall be made in the nurse's notes of the resident's medical record."
-"Antibiotic: Administration of...antibiotic shall be started no later than 9:00am of the following day unless the order is designated by the physician as urgent."

2. Review of Resident #1's current FL-2 dated 03/11/16 revealed diagnoses included Alzheimer type dementia, diabetes mellitus type2 and encephalopathy (acute toxic-metabolic).

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{D 273}	Continued From page 7 Review of current medication orders revealed: -An order for Januvia 100mg tablet daily. -An order for Novolog 70/30 insulin, 18 units to be injected subcutaneously (SQ) every morning, and 16 units to be injected at bedtime. -An order for fingerstick blood sugars (FSBS) three times per day and dose with sliding scale insulin -An order for Novolog Flexpen insulin as needed per sliding scale of blood sugar (BS) of 200-250 give 2 units; BS of 251-300 give 3 units; BS of 301-350 give 4 units; BS of 351-400 give 5 units; BS of 401-450 give 6 units and call the doctor. Review of the electronic Medication Administration Record (eMAR) for Resident #1 for September 2016 revealed: -During the month of September 2016, Resident #1's FSBS were above 401 on 11 of 90 opportunities ranging from 402 to 474. Review of the care notes failed to produce documentation that the medical provider was notified of the blood sugars greater than 400. Interview with the Executive Director on 11/17/16 at 2:10pm revealed: -That the medical provider should have been notified of the elevated FSBS. -She had been unable to locate communications from the facility to the prescribing provider for any of the 11 occasions that Resident #1's FSBS was greater than 400. Interview with the prescribing provider on 11/17/16 at 4pm revealed: -He did not remember being notified of Resident #1's blood sugars being greater than 400. -If he had been notified at the time of the blood	{D 273}		

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sugars, he would have ordered more insulin to be administered.
-He expected the facility to follow his written orders.

3. Review of Resident #2's current FL-2 dated 02/17/16 revealed diagnoses included Alzheimer's disease, hypertension, degenerative joint disease, and arthritis.

Review of Resident #2's "Care Notes" dated 08/31/16 revealed:
-There was an untimed entry which read "Staff was in the room with Resident to get up. Once resident was in wheelchair, resident became unresponsive, however by the time EMT (emergency medical transport) came, resident was responsive." Resident #2 was sent to the local hospital.
-There was another untimed entry which read "Resident returned to the facility from the ER at [hospital name] at about 3:30pm.... Resident to follow-up with PCP (primary care provider) in 2 days."

Review of the hospital discharge summary for Resident #2 dated 08/31/16 revealed:
-Resident #2 was evaluated in the emergency department and discharged 08/31/16.
-There was a physician order for Resident #2 to follow up with his Primary Care Provider Priovider (PCP) in 2 days.

Review of Resident #2's "Care Notes" and physician evaluation notes revealed there was no documentation Resident #2 followed-up with his PCP in two days.

Interview with two Medication Aidess on 11/17/16

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at 12:30pm revealed:
-The facility had three PCPs who came to the facility to evaluate/treat residents.
-Whenever a resident was sent to the hospital, the facility notified the resident's PCP.
-When a resident returned from the hospital, the MAs read the hospital discharge orders.
-If an outside follow-up medical appointment was ordered, the MAs gave a copy of the hospital order to the Activity/Transportation staff member so that staff could schedule the follow up medical appointment and transport the resident to the appointment.
-For follow-up medical appointments with the PCP who came routinely to the facility, MAs did not always call the PCP; the MAs put a copy of the hospital discharge paperwork in the PCP's folder to see the next time the PCP was in the facility.
-When there was a hospital order for the resident to follow up with their PCP, the MAs were supposed to assure the resident received follow up with their PCP.
-The facility did not document or keep a list of which residents needed to be evaluated by the PCPs each week.

Interview with the Activity Director/Transportation staff on 11/16/16 at 3:55pm revealed:
-If a resident had an order for a follow up "specialty appointment", the MAs made a copy of the order and put it in his (Activity Director/Transportation staff's) box.
-He called the specialty provider to schedule the appointment and then transported the resident to the specialty appointment.
-He only scheduled specialty appointments.
-If a resident had orders for an "in house" follow up appointment, he would not schedule that appointment; the MA would make sure the

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{D 273}	Continued From page 10 resident saw the physician the next time the physician was in the facility. Based on observations, record reviews, and interviews, Resident #2 was not interviewable. Telephone interview with Resident #2's Power of Attorney (POA) on 11/16/16 at 2:18pm revealed: -The facility called the POA whenever Resident #2 went to the hospital. -In August or September 2016, Resident #2 went to the hospital because he would become "non-responsive." -Resident #2 saw his physician as ordered as far as the POA knew. Interview with the Executive Director (ED) on 11/16/16 at 3:00pm revealed: -When a resident returned from the hospital, it was facility procedure for the MAs to read the discharge orders for changes in orders, new orders, and follow up appointments. -If a follow up specialty appointment was ordered, the MA was supposed to make a copy of the order and give it to the transportation staff to schedule the follow up specialty appointment. -If the hospital discharge contained orders for a resident to follow up with their in-house PCP, the MA put a copy of the hospital orders in the PCP's folder for the PCP to review, and notified the PCP to see the resident at their next facility visit. -If the hospital discharge orders contained orders for follow up with the PCP in 1-2 days, the MA was supposed to notify the PCP for orders. -"Sometimes" hospital discharge orders were faxed to the PCP. Interview with the ED on 11/17/16 at 08:24am revealed: -The ED was unable to locate any documentation	{D 273}		

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{D 273}	Continued From page 11 that Resident #2 saw the physician for a 2 day follow up after his hospital visit on 08/31/16. -The ED had documentation that the hospital discharge orders for Resident #2 were faxed to the physician on 09/01/16. -The ED expected the physician to notify the facility whether he wanted Resident #2 brought to his office for follow-up or seen on rounds; that was what the physician did "99% of the time." -The facility followed their policy by notifying the physician by fax. -The ED did not know if the physician was ever called about Resident #2's follow-up for the 08/31/16 hospital visit. Review of the "Fax Send Image" report stamped at the top with date/time 09/01/16 at 10:54am revealed the hospital discharge summary for Resident #2 dated 08/31/16 was faxed to the PCP's office. Interview with Resident #2's physician on 11/16/16 at 11:15am revealed: -The physician expected residents to receive follow up per hospital discharge instructions. -The physician expected the facility to bring residents with "acute changes" to his office for follow up appointments according to orders. -There had been problems in the past with the facility getting residents to follow up appointments because the facility did not have staff or a vehicle to take the residents to the appointments. -The physician did not recall being notified about Resident #2's 08/31/16 hospital visit or two day follow up. -The physician expected the facility to bring Resident #2 to his office for a two day follow-up appointment or let the office know if they could not bring Resident #2 to the office so he could stop by the facility to evaluate Resident #2.	{D 273}		

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The failure of the facility to assure the Primary Care Provider was notified for 3 of 5 sampled residents with acute health care needs resulted in Resident #5 not receiving an antibiotic for five days, being hospitalized with diagnoses of Sepsis, Congestive Heart Failure and Urinary Tract Infection and requiring intravenous antibiotics. This non-compliance constitutes a TYPE A1 violation for serious physical harm and neglect. (Sepsis is a life threatening complication of infection.)

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Review of the facility's Plan of Protection dated 11/16/16 revealed:
-An immediate chart audit would begin on 11/16/16 to ensure all orders needing follow up have been completed as ordered.
-The chart audit will be completed by an ED designee.
-Two MAs will be trained immediately regarding this system and communication with the physician.
-Staff will be retrained on the "bucket system" for processing and follow-up of orders on 11/21/16.
-Two MAs will be designated to ensure all orders are processed as ordered by the physician.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 12/22/16.

{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care	{D 276}		

10A NCAC 13F .0902 Health Care
(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and

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ASHE GARDENS	**300 WEST ASHE STREET BURGAW, NC 28425**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to implement Primary Care Provider orders for weekly weights and monthly vital signs for 2 of 5 sampled residents (#2 and #3).

The findings are:

1. Review of Resident #3's current FL-2 dated 9/28/16 revealed diagnoses included Alzheimer's Dementia, Unspecified Contact Dermatitis, Constipation, Essential Hypertension, Enlarged Prostate, Hyperlipidemia and Insomnia.

Review of a "Physician's Order Request" form for Resident #3 dated 8/29/16 and signed by the provider revealed an order to weigh the resident every Tuesday and document.

Review of "Monthly Weight and Vital Signs" sheet in the weight book for Resident #3 revealed there were no weights recorded.

Review of Resident #3's September, October and November 2016 electronic Medication Administration Record (eMAR) revealed there was no entry for a weight every Tuesday for the resident nor any recorded weights.

Review of a Hospice note for Resident #3 dated 11/3/16 revealed Resident #3 was admitted to hospice with mouth cancer, had difficulty swallowing, his appetite was poor, he had poor

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endurance, he weighed 105 pounds and was 5 feet and 4 inches.

Interview with a Medication Aide (MA) on 11/17/16 at 12:25pm revealed:
-The MAs were responsible for weighing residents and documenting the weights in the weight book.
-The weight book was the only place weights were written down.

Interview with a second MA on 11/17/16 at 5:10pm revealed:
-All new orders were faxed to the pharmacy to add or take off orders on the eMAR.
-The Memory Care Manager (MCM) was responsible for verifying orders on the eMAR and in the absence of the MCM, the MAs could verify the orders.

Review of a Psychiatric Provider visit note dated 10/24/16 revealed the provider documented the resident "appears to have lost weight."

Telephone interview with the Primary Care Provider (PCP) on 11/21/16 at 11:30am revealed:
-He could not recall specifically ordering weekly weights for Resident #3, but said there must have been a concern for weight loss if it was ordered.
-He expected to have documented weight results, but did not have any weights for Resident #3.

Interview with the Executive Director (ED) on 11/17/16 at 6:42pm revealed:
-Orders for weights were faxed to the pharmacy and put on the eMAR to alert MAs to get the weight.
-The ED did not know why weights would not have been on Resident #3's eMAR and were not recorded in the weight book as ordered by the

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PCP.
-The ED expected staff to get weights and vital signs as ordered.
-The Personal Care Aides (PCA) and MAs were able to obtain weights and vital signs, but only the MA was able to document results on the eMAR.

2. Review of Resident #9's current FL-2 dated 10/19/16 revealed:
-Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), diabetes, and hypertension.
-There was a physician order to obtain Resident #9's vital signs (blood pressure, pulse, temperature, and respiration rate) monthly.

Review of Resident #9's previous FL-2 dated 03/11/16 revealed there was a physician order to obtain Resident #9's vital signs monthly.

Review of Resident #9's "Care Notes" revealed he was sent to the hospital on 11/06/16.

Interview with the Business Office Manager (BOM) on 11/15/16 at 9:00am revealed Resident #9 was not in the facility at that time due to hospitalization.

Review of Resident #9's "Monthly Weight and Vital Signs" log for 2016 revealed Resident #9's vital signs were not documented in September 2016, October 2016, or November 2016.

Review of Resident #9's Treatment Administration Records (TARs) for September 2016-November 2016 revealed there were no vital signs documented on the TARs.

Resident #9 was hospitalized the duration of the survey and not available for interview.

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{D 276}	Continued From page 16 Interview with a Medication Aide (MA) on 11/17/16 at 4:05pm revealed: -Staff checked Resident #9's oxygen saturation twice daily. -Resident #9 was weighed monthly. -The MA did not know if Resident #9's vital signs were checked monthly but they would be documented on his TARs or in the weight book. Interview with the Executive Director (ED) on 11/17/16 at 6:00pm revealed: -Vital signs were documented on the TARs or the monthly weight book, if they were done. -The ED expected residents' vital signs to be completed per their physician orders. -The MAs or Personal Care Aides (PCAs) were responsible for checking vital signs per the physician orders; the MAs were responsible for documenting the vital signs. Telephone interview with the Medical Assistant at Resident #9's physician's office on 11/21/16 at 9:18am revealed the physician expected vital signs to be obtained and to be notified of any problems.	{D 276}		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 283		

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failed to assure food being prepared and served was free of contamination as evidenced by flies in the kitchen and dining room.

The findings are:

Observation of the lunch meal on 11/15/16 from 12:03pm-12:50pm revealed:
-There were 3 or 4 flies flying around the dining room, landing on the tables and residents.
-There was a fluorescent insect deterrent device mounted on the wall in the dining room on the left side of the window; the light was lit.

Observations of the kitchen on 11/17/16 at 11:58am revealed:
-The Dietary Manager (DM) was plating the food and the Dietary Aide was washing dishes.
-Approximately 10 flies were observed flying and landing on different surfaces in the kitchen.
-Flies were on the edge of the sink, the food prep table, on serving utensils, and the beverage cart.
-Flies were landing on staff member's hair and face requiring that they wave them away.

Observation of the lunch meal on 11/17/16 from 11:58am -12:56pm revealed:
-The fluorescent light on the insect deterrent device was lit.
-There were multiple flies flying around the dining room throughout the meal service.
-Flies were on landing on the table closest to the counter and the center table.
-There was a fly flying around Resident #8's face and head.
-Resident #4 removed his baseball cap from his head and used it to attempt to kill a fly that was on the table where he was seated.

Observation of the dining room on 11/17/16 at

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3:40pm revealed:
-There were multiple flies flying around the dining room and landing on the tables and residents while the residents were being served and eating their snack.
-A staff member used her hand to shoo a fly out of her face.

Observation of the kitchen on 11/17/16 at 3:32pm revealed there were flies flying around the kitchen and landing on the food prep tables.

Interview with three residents on 11/17/16 at 12:00pm revealed:
-Flies were in the dining room "sometimes."
-All three residents were not bothered by the flies.

Interview with a Personal Care Aide (PCA) on 11/17/16 at 12:16pm revealed:
-The hot weather had caused the flies.
-"Not much else can be done."

Interview with a Cook on 11/17/16 at 3:42pm revealed:
-Flies were in the kitchen "all the time."
-The staff did the best they could to keep the food covered.

Interview with Dietary Manager on 11/17/16 at 12:15pm revealed:
-The DM tried to control the flies by spraying after food service was done.
-Every time the backdoor was opened, more flies entered.
-The dumpster was near the backdoor and she thought that was why the flies were so bad.
-Plates of food that were not served immediately were covered with plastic wrap to keep them warm and to keep flies out.

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D 306	Continued From page 19	D 306		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to assure water was served to 3 of 3 residents sampled (#2, #4, and #8) who had orders for thickened liquids at 4 of 4 meals observed. The findings are: Observation of the lunch meal on 11/15/16 from 12:03pm-12:50pm revealed: -Residents #2, #4, and #8 were not served water. -All other residents were served water with the lunch meal. Observation of the supper meal on 11/15/16 from 5:05pm-5:40pm revealed: -Residents #2, #4, and #8 were not served water. -All other residents were served water at the supper meal. Observation of the breakfast meal on 11/16/16 from 08:00am -08:39am revealed Residents #2, #4, and #8 were not served water. Observation of the lunch meal on 11/17/16 from 11:58am -12:56pm revealed -Residents #2, #4, and #8 were not served water.	D 306		

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D 306	Continued From page 20 -All other residents were served water during the lunch meal. Based on observations, record reviews, and interviews, Resident #2 was not interviewable. Telephone interview with Resident #2's Power of Attorney (POA) on 11/16/16 at 2:18pm revealed the POA did not know if Resident #2 was served water at meals. Interview with Resident #4 on 11/16/16 at 10:50am revealed: -Resident #4 did not know if he was served water at meals. -Resident #4 thought he got juice at meals. -Resident #4 liked the food and tea. Based on observations, record reviews, and interviews, Resident #8 was not interviewable. Confidential staff interview revealed: -Water was not routinely served at meals to residents with orders for thickened liquids. -The staff member had observed pre-thickened lemon flavored water on hand and served to residents on thickened liquids one time, two months ago. Confidential interview with a second staff revealed: -Residents with orders for thickened liquids were not served water at meals. -Residents with orders for thickened liquids were only served tea or juice at meals. Observation of the kitchen on 11/15/16 at 2:30pm revealed: -There was "honey-like consistency" orange juice and apple juice, and "nectar-like consistency"	D 306		

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sweetened tea in the walk in cooler.
-There were instant single use packets of "nectar-like consistency thickened coffee drink mix" and instant single use packets of "honey consistency instant food and beverage thickener" in the pantry storage area.
-There was no thickened water on hand.

Interview with the Dietary Manager (DM) on 11/15/16 at 2:40pm revealed:
-The facility did not have any instant thickener agents on hand other than the honey consistency packets or any other pre-thickened beverages such as water on hand.
-The facility tried to ordered pre-thickened liquids so staff did not have to mix anything.
-The DM was not aware there were three different consistencies for liquids; "They don't tell me how thick it's supposed to be. I just order what is thickened."
-The facility ran out of the thickened water "last Wednesday;" the DM ordered more thickened water "this week" and it would arrive at the facility on "Friday" (11/18/16).
-Since the pre-thickened water had been out, staff had been using the instant thickener (honey-like consistency) for residents with diet orders for thickened liquids.
-The DM did not know what consistency of water was on order.
-All residents were supposed to be served water at all meals.

Interview with the Executive Director (ED) on 11/16/16 at 3:00pm revealed:
-The ED was not aware residents with modified liquid consistency diets were not getting water with meals.
-All residents were supposed to be served water at meals, regardless of their diet consistency

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D 306	Continued From page 22 order. -The ED expected water to be served to all residents at all meals.	D 306		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain an accurate and current list of residents with physician-ordered therapeutic diets for the guidance of food service staff for 4 of 5 (#2, #4, #5 and #8) sampled residents. The findings are: Observation of the kitchen on 11/15/16 at 11:53am revealed dietary lists were posted on the glass front of the warming table. 1. Review of Resident #8's current FL-2 dated 08/24/16 revealed diagnoses that included late onset Alzheimer's, diabetes, and hypertension. Review of a "Diet Order" sheet for Resident #8 dated 11/06/16 revealed an order for nectar thickened liquids and a mechanical soft diet. Review of the dietary list posted in the kitchen revealed Resident #8 was not listed on the diet list.	D 309		

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Observation of the supper meal on 11/15/16 from 5:05pm-5:40pm revealed:
-Resident #8 was served pureed pizza, salad, and peaches and nectar thickened tea.
-Resident #8 was not observed to have signs of coughing or gagging while eating the meal.

Refer to the confidential interviews with dietary/kitchen staff.

Refer to the interview with the Dietary Manager on 11/16/16 at 1:55pm.

Refer to the interview with the Executive Director on 11/15/16 at 4:440pm.

2. Review of Resident #2's current FL-2 dated 02/17/16 revealed:
-Diagnoses included Alzheimer's disease, hypertension, degenerative joint disease, and arthritis.
-There was no diet order on Resident #2's FL-2.

Review of Resident #2's "Diet Order" dated 10/04/16 revealed:
-There was a check mark beside "mechanical soft" documenting this texture as Resident #2's modified diet.
-There was a check mark beside "thickened liquids" to document Resident #2 required modified liquids but the "select consistency" section did not contain any documentation.
-The order was signed by Resident #2's physician and dated 10/19/16.

Telephone interview with Resident #2's physician on 11/15/16 at 2:57pm revealed:
-He forgot to mark the consistency on Resident #2's diet order when he signed it on 10/19/16.

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-Resident #2's diet order that he signed on 10/19/16 was an incomplete order and it should have been clarified by the facility.
-The facility had not notified him to clarify Resident #2's diet.
-The physician would assure Resident #2's diet order was clarified that day (11/15/16) and the order would be sent to the facility.

Review of Resident #2's "Diet Orders" on 11/16/16 at 2:40pm revealed there was a new diet order dated 11/15/16 for mechanical soft diet and nectar thickened liquids.

Review of the dietary list posted in the kitchen revealed Resident #2 was listed to receive a "mechanical soft diet with thicken liquids"; no consistency was listed on the diet sheet for Resident #2's liquids.

Observation of Resident #2 during the morning snack on 11/15/16 from 10:15am-10:46am revealed:
-Resident #2 was served pears and nectar thick tea.
-Resident #2 did not exhibit signs of coughing, gagging, or choking when eating the snack.

Observation of Resident #2 during the lunch meal on 11/15/16 from 12:03pm-12:50pm revealed:
-Resident #2 was served pork loin, mashed potatoes, cauliflower, a roll, and nectar thickened tea.
-Resident #2 did not exhibit signs of coughing, gagging, or choking during the meal.

Observation of Resident #2 during the breakfast meal on 11/16/16 from 08:00am -08:39am revealed:
-The breakfast meal was in progress when the

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observation began.
-Resident #2 had pancakes, eggs, sausage, mixed fruit, and honey thickened juice.
-Resident #2 did not cough or choke when eating/drinking.

Observation of Resident #2 during the lunch meal on 11/17/16 from 11:58am -12:56pm revealed:
-Resident #2 was served sloppy joes, green beans, pasta salad, and nectar thickened tea.
-Resident #2 did not exhibit signs of coughing, gagging, or choking cough during the meal.

Refer to the confidential interviews with dietary/kitchen staff.

Refer to the interview with the Dietary Manager on 11/16/16 at 1:55pm.

Refer to the interview with the Executive Director on 11/15/16 at 4:440pm.

3. Review of Resident #4's current Fl-2 dated 10/21/16 revealed:
-Diagnoses included vascular dementia and recurrent urinary tract infections.
-The resident was constantly disoriented.

Review of a Physician's Order Request for Resident #4 dated 08/03/16 revealed an order for nectar thickened liquids.

Review of the "Diet Order" for Resident #4 dated 10/19/16 revealed:
-Resident #4 was ordered a mechanical soft diet.
-The order was signed by Resident #4's primary care provider (PCP) and dated 10/21/16.

Review of a Physician's Order sheet for Resident #4 dated 10/21/16 listed the diet as Pureed with

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"thickened" liquids with the consistency not specified.

Interview with Resident #4's PCP on 11/17/16 at 4pm revealed:
-Resident #4 should be on a mechanical soft diet with nectar thick liquids.
-He expects that the facility to contact him for clarification if there are any questions about his orders.

Review of the Diet list posted in the kitchen revealed there was documentation Resident #4 received a pureed diet and "thicken liquids"; there was no consistency listed for Resident #4's liquids.

Observation of Resident #4 during the lunch meal on 11/17/16 from 11:58am -12:56pm revealed:
-Resident #4 was served a mechanical soft diet of sloppy joes, green beans, pasta salad, with nectar thickened tea.
-Resident #4 did not exhibit signs of coughing, gagging, or choking cough during the meal.

Refer to the confidential interviews with dietary/kitchen staff.

Refer to the interview with the Dietary Manager on 11/16/16 at 1:55pm.

Refer to the interview with the Executive Director on 11/15/16 at 4:440pm.
4. Review of Resident #5's current FL-2 dated 10/27/16 revealed:
-Diagnoses included Change in Mental Status and Congestive Heart Failure.
-Discharge instuctions for a regular diet.

Review of Resident #5's most recent diet order

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D 309	Continued From page 27 sheet dated 11/18/15 revealed the resident was ordered a mechanical soft diet with ground meats. Review of the Rehabilitation facility's discharge instructions dated 10/6/16 revealed Resident #5 was on a pureed diet with thin liquids and required supervision with meals. Review the facility's diet list posted in the kitchen dated 8/10/16 revealed Resident #5 was on a mechanical soft diet. Observation of snack in the dining room on 11/17/16 at 10:47am revealed: -Resident #5 was sitting at the feeding assistance table in the dining room in her wheelchair for snack. -She was served a plate containing tortilla chips, red gelatin and soft cookie with a bowl of popcorn and a cup of milk. -She ate only the cookie and gelatin only without signs of coughing or gagging. Interview with a Personal Care Aide (PCA) on 11/17/16 at 10:47am revealed: -Resident #5 was on a soft mechanical diet because she did not have any teeth and had not had teeth for "a long time." -The personal care aide removed the bowl of popcorn when asked about Resident #5's diet saying "oh she's not supposed to have that." -The resident did not have a problem eating tortilla chips. -The resident had problems with coughing and eating after she returned from the hospital approximately one month ago (late September or early October 2016) which lasted for about a week and she had been fine since then.	D 309		

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Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with Resident #5's Power of Attorney (POA) on 11/17/16 at 2:55pm was unsuccessful.

Refer to the confidential interviews with dietary/kitchen staff.

Refer to the interview with the Dietary Manager on 11/16/16 at 1:55pm.

Refer to the interview with the Executive Director on 11/15/16 at 4:440pm.

____

Confidential interviews with dietary/kitchen staff revealed:
-The diet list in the kitchen included "thicken liquid" on it but did not include which consistency to give each resident so "we just served whatever was here."
-The diet list in the kitchen was not kept up to date.
-Staff did not know the last time the diet list had been updated.
-It was too hard to remember what each resident was supposed to be served; the diet sheets should be kept updated so staff would know what to serve the residents.

Interview with the DM on 11/16/16 at 1:55pm revealed:
-The DM did not know how often the diet list was supposed to be updated in the kitchen.
-The DM did not know who was responsible for updating the diet list for the kitchen.
-The DM always asked a MA for a new diet list when she noticed the diet list was not correct (such as when a resident was on the list but did

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not live in the facility anymore).
-The DM did not know the last time the diet list had been updated in the kitchen.
-If the diet list was not kept up to date, other dietary/kitchen staff would not know what diet to serve to each resident if she was not there.
-The DM did not know what process the facility used for diet orders; the MAs just gave the DM a copy of residents' new diet orders "sometimes."
-The DM could not make sure the residents got the correct diet if the MA did not give her a copy of the diet order.

Interview with the ED on 11/15/16 at 4:40pm revealed:
-The ED expected the diet list to be posted in the kitchen at all times.
-The DM was responsible for assuring the diet list was posted and kept up to date

{D 310} — 10A NCAC 13F .0904(e)(4) Nutrition and Food Service — {D 310}

10A NCAC 13F .0904 Nutrition and Food Service
(e) Therapeutic Diets in Adult Care Homes:
(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION
Based on these findings, the previous Type B Violation was not abated.

Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served to 4 of 5 residents sampled

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(#2, #3, #5, #8,) who had orders for therapeutic diets, thickened liquids, and dietary supplements.

The findings are:

1. Review of Resident #5's current FL-2 dated 10/27/16 revealed:
-Diagnoses included Change in Mental Status and Congestive Heart Failure.
-Discharge instructions for a regular diet.

Review of the facility's diet list posted in the kitchen dated 8/10/16 revealed Resident #5 was on a mechanical soft diet.

Review of Resident #5's most recent diet order sheet dated 11/18/15 and signed by the Primary Care Provider revealed the resident was ordered for a mechanical soft diet with ground meats.

Observation of snacks in the dining room on 11/17/16 at 10:47am revealed:
-Resident #5 was sitting at the feeding assistance table in the dining room in her wheelchair for snack.
-She was served a plate containing tortilla chips, red gelatin and a soft cookie with a bowl of popcorn and a cup of milk.
-She ate only the cookie and gelatin without signs of coughing or gagging.

Interview with a Personal Care Aide (PCA) on 11/17/16 at 10:47am revealed:
-Resident #5 was on a soft mechanical diet because she did not have any teeth and had not had teeth for "a long time."
-The PCA removed the bowl of popcorn when asked about Resident #5's diet saying "oh she's not supposed to have that."
-The resident did not have a problem eating

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tortilla chips.
-The resident had problems with coughing and eating after she returned from the hospital approximately one month ago (late September or early October 2016) which lasted for about a week and she had been fine since then.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with Resident #5's Power of Attorney (POA) on 11/17/16 at 2:55pm was unsuccessful.

Observation of the dinner meal on 11/17/16 at 5:25pm revealed Resident #5 was seated at the feeding assistance table and served a dinner plate containing sweet potato fries, cole slaw and a bologna and cheese sandwich which was broken into small bite size pieces.

Review of "Care Notes" for Resident #5 revealed:
-On 9/19/16, staff documented Resident #5 was sent to the ER for being unresponsive and slumped over in her chair and was admitted with a diagnoses of Sepsis.
-On 10/6/16, staff documented the resident returned to the facility from a rehabilitation facility.

Review of hospital records for Resident #5 dated 9/19/16 revealed:
-Resident #5 was sent to the emergency room (ER) for evaluation of altered mental status on 9/19/16.
-A chest x-ray was done on 9/19/16 with results of new left lung base opacities.
-The resident was started on intravenous antibiotics and admitting diagnoses included Pneumonia.

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Interview with a Medication Aide (MA) on 11/17/16 at 4:07pm revealed:
-The MA was not aware of the discharge diet order from the Rehabilitation facility on 10/6/16.
-Resident #5 coughed if she drank something too fast but not like a "choking cough."
-The former Memory Care Manager (MCM) was responsible for reviewing information sent with discharge instructions and following up with the Primary Care Provider (PCP).
-The MA was going to fax the information to the PCP and see what he wanted to do about Resident #5's diet order.

Attempted interview with the former Memory Care Manager (MCM) on 11/21/16 at 4:52pm was unsuccessful.

Telephone interview with the PCP on 11/21/16 at 11:30am revealed:
-He could not recall facility staff discussing a therapeutic diet order with him following Resident #5's discharge from the Rehabilitation facility on 10/6/16 or discharge from the hospital on 10/27/16.
-It was possible that Resident #5 may have had aspiration pneumonia when she was admitted to the hospital on 9/19/16 especially if she did not receive the therapeutic diet she was supposed to be on.
-The resident should have been on the diet recommended by the swallowing evaluation.

Interview with the Executive Director (ED) on 11/17/16 at 6:42pm revealed:
-The ED was not aware of the swallowing evaluation recommendations or the Rehabilitation facility's discharge instructions for a pureed diet for Resident #5 and that this information had not been communicated to the PCP until 11/17/16.

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-The MAs were responsible for the initial review of discharge instructions and information, then the MCM was supposed to review and assure things were done and follow up with the PCP.
-All staff understood the importance of dysphagia diets including signs of difficulty swallowing and possible aspiration because it was part of their personal care training.

Refer to the interview with the Medication Aide (MA) on 11/15/16 at 1:55pm.

Refer to the interview with the Dietary Manager (DM) on 11/15/16 at 1:55pm.

Refer to the interview with the Executive Director (ED) on 11/15/16 at 2:30pm.

Refer to the interview with the ED on 11/17/16 at 4:19pm.

2. Review of Resident #2's current FL-2 dated 02/17/16 revealed:
-Diagnoses included Alzheimer's disease, hypertension, degenerative joint disease, and arthritis.
-There was no diet order on Resident #2's FL-2.

Observation of Resident #2 during the morning snack on 11/15/16 from 10:15am-10:46am revealed:
-Resident #2 was served pears and nectar thick tea.
-Resident #2 did not cough or choke when eating the snack.

Observation of Resident #2 during the lunch meal on 11/15/16 from 12:03pm-12:50pm revealed:
-Resident #2 was served pork loin, mashed potatoes, cauliflower, a roll, and nectar thickened

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tea.
-Resident #2 did not cough or choke when eating.

Review of Resident #2's "Diet Order" on 11/15/16 at 2:07pm revealed:
-Resident #2's most current "Diet Order" sheet was dated 10/04/16.
-There was a check mark beside "mechanical soft" documenting this texture as Resident #2's modified diet.
-There was a check mark beside "thickened liquids" to document Resident #2 required modified liquids but the "select consistency" section did not contain any documentation.
-The order was signed by Resident #2's physician and dated 10/19/16.

Interview with the Executive Director (ED) on 11/15/16 at 2:30pm revealed:
-Resident #2's diet order dated 10/19/16 should have been clarified because it was incomplete.
-Any incomplete diet orders were supposed to be clarified by the Medication Aide (MAs) and/or the Memory Care Manager (MCM) with the ordering provider.
-Staff would not know what liquid consistency to serve Resident #2 because the order dated 10/19/16 only stated Resident #2 was supposed to get "thickened liquids"; the consistency was not ordered.
-The ED would assure Resident #2's physician was notified that day (11/15/16) to clarify his modified liquid consistency.

Interview with the Dietary Manager on 11/15/16 at 2:40pm revealed:
-The DM was not aware there were three different consistencies for thickened liquids.
-"They don't tell me how thick it's supposed to be. I just order what is thickened."

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-The facility tried to ordered pre-thickened liquids so staff did not have to mix anything.

Telephone interview with Resident #2's physician on 11/15/16 at 2:57pm revealed:
-Resident #2 had several diet changes due to swallowing problems and he had several swallowing studies done (the physician thought this occurred the "end of last year"), so it was important for Resident #2 to get the correct diet and liquid consistency.
-He was not aware of Resident #2 having any difficulty with swallowing or choking "of late."
-He forgot to mark the consistency on Resident #2's diet order when he signed it on 10/19/16; Resident #2 should be receiving the same diet he had previously received.
-Resident #2's diet order that he signed on 10/19/16 was an incomplete order and it should have been clarified by the facility.
-The facility had never notified him to clarify Resident #2's diet.
-The physician would assure Resident #2's diet order was clarified that day (11/15/16) and the order would be sent to the facility.

Observation of Resident #2 during the supper meal on 11/15/16 from 5:05pm-5:40pm revealed:
-Resident #2 was served pizza, salad, peaches, and honey thickened tea.
-Resident #2 did not exhibit signs of coughing, gagging, or choking during the meal.

Observation of Resident #2 during the breakfast meal on 11/16/16 from 08:00am -08:39am revealed:
-The breakfast meal was in progress when the observation began.
-Resident #2 had pancakes, eggs, sausage, mixed fruit, and honey thickened juice.

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-Resident #2 did not exhibit signs of coughing, gagging, or choking during the meal.

Interview with the Medical Assistant from Resident #2's physician's office on 11/16/16 at 11:35am revealed:
-The facility should have notified the physician prior to 11/15/16 that Resident #2 did not have a complete diet order because the consistency was not listed on the October 2016 diet order.
-The physician did not find out that there was a problem with Resident #2's diet order until 11/15/16.
-After review, the physician wrote a diet order for Resident #2 to have a mechanical soft diet and nectar thickened liquids on 11/15/16.
-The new diet order (dated 11/15/16) was faxed to the facility on 11/15/16.

A second interview with the DM on 11/16/16 at 1:55pm revealed all the staff ever knew to do was just to give the residents "thicken (sic) liquids"; staff did not know there were different kinds of liquids.

A second review of Resident #2's "Diet Orders" on 11/16/16 at 2:40pm revealed there was a diet order dated 11/15/16 for mechanical soft diet and nectar thickened liquids.

Observation of Resident #2 during the lunch meal on 11/17/16 from 11:58am -12:56pm revealed:
-Resident #2 was served sloppy joes, green beans, pasta salad, and nectar thickened tea.
-Resident #2 did not exhibit signs of coughing, gagging, or choking during the meal.

Based on observations, interviews, and record reviews, Resident #2 was not interviewable.

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{D 310}	Continued From page 37 Telephone interview with Resident #2's family member/Power of Attorney (POA) on 11/16/16 at 2:18pm revealed: -Resident #2 had trouble swallowing "maybe two years ago" and went to the hospital. -The POA did not know what kind of diet texture or what kind of liquids Resident #2 received because the POA but had not visited/observed Resident #2 during meals "lately." Refer to the interview with the Medication Aide on 11/15.16 at 1:55pm. Refer to the interview with the Dietary Manager on 11/15/16 at Refer to the interview with the Executive Director (ED) on 11/15/16 at 2:30pm. Refer to the interview with the ED on 11/17/16 at 4:19pm. 3. Review of Resident #8's current FL-2 dated 08/24/16 revealed diagnoses included late onset Alzheimer's, hypertension, Type 2 diabetes, anemia, ataxia, and osteoporosis. Review of Resident #8's "Diet Order" dated 11/03/16 revealed: -Resident #8 was ordered a mechanical soft diet and nectar thickened liquids. -The order was signed by Resident #8's Nurse Practitioner (NP) and dated 11/06/16. Observation of Resident #8 during the supper meal on 11/15/16 from 5:05pm-5:40pm revealed: -Resident #8 was served a pureed pizza, salad, and peaches and nectar thick tea. -Resident #8 did not exhibit signs of coughing, gagging, or choking during the meal.	{D 310}		

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{D 310}	Continued From page 38 Based on observations, record reviews, and interviews, Resident #8 was not interviewable. Interview with Resident #8's NP on 11/17/16 at 4:00pm revealed: -The NP expected all orders to be implemented as written. -The NP expected residents to receive their diet as ordered. Refer to the interview with the Medication Aide on 11/15.16 at 1:55pm. Refer to the interview with the Dietary Manager on 11/15/16 at Refer to the interview with the ED on 11/15/16 at 2:30pm. Refer to the interview with the ED on 11/17/16 at 4:19pm. 4. Review of Resident #3's current FL-2 dated 9/28/16 revealed: -Diagnoses included Alzheimer's Dementia, Unspecified Contact Dermatitis, Constipation, Essential Hypertension, Enlarged Prostate, Hyperlipidemia and Insomnia. -A diet order was not specified. Review of "Interdisciplinary Care Notes" for Resident #3 revealed: -The resident was seen on 8/26/16 for follow up with the Speech Therapist who documented requesting Mighty Shake supplement for Resident #3 due to poor intake at observed meals. -The Speech Therapist documented discussing with the "Resident Care Coordinator."	{D 310}		

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Review of a "Physician's Order Request" for Resident #3 dated 8/29/16 and signed by a provider revealed and order for Mighty Shakes three times daily with meals and at bedtime.

Review of a "Physician's Order Request" for Resident #3 dated 9/6/16 revealed an order for Mighty Shakes three times daily with meals.

Review of the facility's "Mighty Shake List" on 11/17/16 posted in the kitchen revealed Resident #3 was not on the list.

Review of Resident #3's September 2016 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Mighty Shakes four times daily with meals and at bedtime with a stop date of 9/7/16 at 11:00am.
-Staff documented administering at 4:00pm and 8:00pm on 9/6/16 and at 8:00am on 9/7/16.
-There was a second entry for Mighty Shakes three times daily at 7:00am, 12:00pm and 5:00pm that staff documented administering 9/7/16 at 12:00pm through 9/30/16 at 5:00pm except 9/12/16 at 7:00am and 12:00pm, 9/19/16 at 7:00am and 12:00pm and 9/25/16 at 12:00pm and 5:00pm.
-Staff documented under exceptions for all six missed administrations on 9/12/16, 9/19/16 and 9/25/16 that there was none in the facility.

Review of Resident #3's October 2016 eMAR revealed:
-There was an entry for Mighty Shakes three times daily that staff documented administering 10/1/16 through 10/31/16 except 10/3/16 at 7:00am and 12:00pm, 10/18/16 at 12:00pm , 10/19/16 at 12:00pm and 10/31/16 at 5:00pm.

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-Staff documented under exceptions on 10/3/16 at 7:28am and 2:27pm that there was none in the facility, on 10/18/16 at 12:48pm the resident was out of the facility and on 10/19/16 at 1:04pm and 10/31/16 at 4:43pm that the resident refused.

Review of Resident #3's November 2016 eMAR revealed:
-There was an entry for Mighty Shakes three times daily that staff documented administering 11/1/16 through 11/16/16 at 12:00pm except 11/1/16 at 5:00pm, 11/2/16 at 5:00pm, 11/3/16 at 7:00am and 11/4/16 at 7:00am.
-Staff documented under exceptions for all four missed administrations on 11/1/16, 11/2/16, 11/3/16 and 11/4/16 that the resident refused.

Review of a Psychiatric Provider visit note dated 10/24/16 revealed the provider documented the resident "appears to have lost weight."

Review of "Monthly Weight and Vital Signs" sheet in the weight book for Resident #3 revealed there were no weights recorded.

Review of a Hospice note for Resident #3 dated 11/3/16 revealed Resident #3 was admitted to hospice with mouth cancer, had difficulty swallowing, his appetite was poor and he had poor endurance.

Interview with the Executive Director (ED) on 11/17/16 at 6:42pm revealed:
-Meal supplements were entered on the eMAR and the Medication Aides (MA) were responsible for administering all meal supplements.
-Mighty shakes were kept in the refrigerator in the kitchen and the ED reported there hadn't been an incident that should could recall for at least a year, where the facility had run out of mighty

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shakes.
-The ED expected staff to give residents meal supplements as ordered.

____

Interview with a MA on 11/15/16 at 1:55pm revealed:
-It was facility procedure to give a copy of diet orders to the Dietary manager (DM); the original diet order was kept in each residents' record.
-The DM was responsible for implementing diet orders.
-Diet orders were not faxed to the pharmacy and were not on the residents' Medication Administration Records (MARs).

Interview with the DM on 11/16/16 at 1:55pm revealed:
-The DM did not know what process the facility used for diet orders; the MAs just gave the DM a copy of residents' new diet orders "sometimes."
-The DM could not make sure the residents got the correct diet if the MA did not give her a copy of the diet order.

Interview with the ED on 11/15/16 at 2:30pm revealed:
-Copies of diet orders were supposed to be given to the DM; original diet orders were filed in the residents' records.
-The DM was responsible for serving each resident their ordered diet.
-Any incomplete orders were supposed to be clarified by the Medication Aide (MAs) and/or the Memory Care Manager (MCM) with the ordering provider.
-If the DM noticed any incomplete diet orders, the ED would expect the DM to ask the MA to contact the provider to clarify the diet order.

Interview with the ED on 11/17/16 at 4:19pm

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{D 310}	Continued From page 42 revealed: -When a MA noted any new dietary orders or changes to dietary orders being received, the MA was supposed to give a copy of the orders to the DM. -The DM was responsible for updating the dietary list and serving the residents their diet as ordered. The facility's failure to assure therapeutic diet orders were implemented and served to 4 of 5 residents sampled in accordance with their provider's orders was detrimental to the welfare of the residents. This non-compliance constitutes a TYPE B violation. ______________________________ Review of the Plan of Protection (POP) submitted by the facility dated 11/15/16 and the addendum to the POP submitted by the facility dated 11/22/16 revealed: -All orders for thickened liquids would be reviewed by the ED or designee to assure each resident was served what matched their order. -Dietary staff would be in-serviced by the ED/designee regarding each residents' orders including how to order and mix. -The Dietary Manager was in-serviced 11/15/16. -All facility would be in-serviced regarding thickened liquid consistencies and assuring residents received the correct liquid consistency. -A diet list would be displayed in the kitchen specifying residents on thickened liquids and their orders. -The diet orders would be updated in the Quick Mar computer system for fast reference. -All diets would be audited to compare current diet orders with the diet the resident was receiving. -Medication Aides would be in-serviced on the bucket system for processing orders.	{D 310}		

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{D 310}	Continued From page 43 -Lead Medication Aides had already been in-serviced on 11/22/16. -Dietary and nursing staff would be in-serviced regarding diet textures. -The diet list posted in the kitchen will be reviewed for accuracy by the Administrator/designee once weekly for one month, twice monthly for two months, and then quarterly.	{D 310}		
{D 312}	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations and interviews, the facility failed to assure residents were provided feeding assistance in manner which promoted dignity and respect and staff sat to feed residents who required assistance for 4 of 4 meals and 1 of 1 snack observed. The findings are: Review of the "Resident Feeding Table" document provided by the Business Office Manager (BOM) on 11/15/16 revealed there were	{D 312}		

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thirteen residents listed by name on the document.

Interview with a Personal Care Aide (PCA) on 11/17/16 at 7:17pm revealed:
-PCAs were responsible for feeding residents who were seated at the middle table for each meal.
-There were a lot of residents who needed assistance and not enough PCAs.

Interview with a second PCA on 11/17/16 at 12:16pm revealed:
-Residents did not have assigned seats in the dining room, but residents that required feeding assistance were all seated at the long table in the center of the dining room.
-Sometimes more staff were needed to provide assistance to the residents seated at the center table.

Confidential staff interview revealed:
-There were usually two or three staff members in the dining room serving and feeding residents during meal times while the Dietary Aide served the drinks.
-There had been more staff in the dining room during meals since the survey started.
-There was not enough staff to feed the residents at the center table; some staff had to feed more than one resident at a time.
-Sometimes the residents would try to grab other residents' food or "drink somebody else's drink."

Confidential interview with a second staff member revealed twelve residents required feeding assistance and there was usually only two staff to feed the twelve residents.

Confidential interview with a third staff revealed:

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-PCAs were responsible for assisting residents in the dining room with meals and assisting residents who stayed in their room for meals.
-There was not enough staff to assist all the residents who needed assistance.
-The PCAs did the best they could for the residents and usually did not receive help from other staff except for one MA who consistently helped with personal care tasks when she was not administering medications.
-She had not received any specific training on assisting residents with meals or feeding residents until 11/16/16 even though she had worked at the facility for several months.

Interview with a Nurse Aide/Medication Aide (NA/MA) on 11/16/16 at 08:17am revealed:
-The PCA and NA staff were supposed to assist the residents with feeding during meals and snacks.
-The PCA and NA staff were supposed to sit residents who required feeding assistance at the long table in the center of the dining room.
-NA/MA did not know if she had received any training from the facility on how to provide feeding assistance to residents; the NA/MA was trained on feeding assistance during NA training.
-The NA/MA did not know if new staff were routinely provided training on how to provide feeding assistance.

Observation of the morning snack on 11/15/16 from 10:15am-10:46am revealed:
-There were a total of thirty-six residents in the dining room; there were ten residents seated at the long table in the center of the dining room.
-There were two staff members present serving pears or applesauce, and coffee and juice.
-Staff assisted residents seated at the center table intermittently in between serving snacks and

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beverages to all residents in the dining room.
-One resident seated at the center table walked out of the dining room after not receiving feeding assistance; the resident did not eat or drink any of her snack.
-Resident #8 was using her fingers to attempt to eat her applesauce; staff did not intervene or assist Resident #8 with eating the snack.

Observation of the lunch meal on 11/15/16 from 12:03pm-12:50pm revealed:
-Residents were served pork loin, mashed potatoes, cauliflower, and a roll.
-There were twelve residents seated at the center (feeding assistance) table.
-There were four NA/PCA staff present in the dining room serving food and assisting residents and one dietary staff serving beverages to the residents.
-There was one staff member seated beside Resident #2 providing feeding assistance.
-Resident #6 and Resident #7 were being fed by one staff member who was standing between the two residents.
-The staff member continued to feed Resident #6 when a second staff member came to assist Resident #7 with feeding assistance; both staff remained standing for the duration of the meal while providing feeding assistance to Resident #6 and Resident #7.

Observation of the supper meal on 11/15/16 from 5:05pm-5:40pm revealed:
-The meal consisted of pizza, salad, and peaches.
-There were twelve residents seated at the center table.
-There were three NA/PCA staff in the dining room serving food and assisting residents and one dietary staff serving beverages to the

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{D 312}	Continued From page 47 residents. -Resident #8 was using her fingers to attempt to eat a pureed meal and had food on her face; there was no staff available to intervene or assist her. -Resident #7 was served her meal and had to wait on staff that were walking around the center table while intermittently provided feeding assistance to Resident #7; staff were standing at all times while assisting Resident #7. -Staff interacted and provided feeing assistance to Resident #6 while standing. Observation of the breakfast meal on 11/16/16 from 08:00am -08:39am revealed: -The breakfast meal was in progress when the observation began. -Residents had pancakes, eggs, sausage, and mixed fruit. -There were ten residents seated at the center table and four NA/PCA staff assisting the residents with eating at the center table. -Resident #8 had a fork in her left hand attempting to eat her pancakes; the pancakes fell off of the fork multiple times before Resident #8 could get the food into her mouth. Resident #8 used her fingers at times to eat. No staff was available to intervene or assist Resident #8 to eat. Interview with a MA on 11/15/16 at 09:27am revealed Resident #8 had to be fed by staff. Observation of the lunch meal on 11/17/16 from 11:58am -12:56pm revealed: -Residents were served sloppy joes, green beans, and pasta salad. -There were thirteen residents seated at the center table and four NA/PCA staff serving the residents meals and providing assistance with feeding/eating and one dietary staff serving drinks	{D 312}		

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to all residents in the dining room.
-One staff was standing to provide feeding assistance to Resident #2.
-Resident #6 was using her fingers to pick up food from her plate and off of the table and place it on her spoon. Some of the food fell from the spoon onto the table, Resident #6 picked up green beans and pasta salad off of the table with her fingers then ate the food; there was no staff available to intervene to provide assistance to Resident #6

Interview with a MA on 11/17/16 at 12:51pm revealed:
-Staff was supposed to feed Resident #6.
-The MA was done giving medications and would go feed Resident #6.

Observation of 11/17/16 at 12:51pm revealed:
-The MA asked Resident #6 "would you like some help? "
-Resident #6 replied "Well yea."
-The MA sat down beside Resident #6 and began to feed Resident #6.

Telephone interview with Resident #6's Power of Attorney (POA) on 11/21/16 at 10:00am revealed:
-Resident #6 had "dementia" and required assistance with "everything."
-Resident #6 required feeding assistance; the staff did a "good job" of providing feeding assistance to Resident #6 as far as the POA knew.

Based on observations, record reviews, and interviews, Resident #8 was not interviewable.

Based on observations, record reviews, and interviews, Resident #2 was not interviewable.

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Telephone interview with Resident #2's POA on 11/16/16 at 2:18pm revealed:
-Resident #2 needed assistance with eating.
-The POA did not know if staff assisted Resident #2 with eating because the POA had not observed Resident #2 at meals recently.

Based ob observations, record reviews, and interviews, Resident #7 was not interviewable.

Telephone interview with Resident #7's POA on/21/16 at 08:20am revealed:
-Resident #7 can feed herself but needed assistance.
-The POA did not have any concerns about the assistance Resident #7 received with eating; Resident #7 "usually" sat at the center table in the dining room and staff were "usually" available to help her.

Interview with the Executive Director (ED) on 11/16/16 at 4:40pm revealed:
-The facility had a lot of residents that required feeding assistance.
-The facility had reviewed the "pros and cons" of changing how the meal service was delivered since the last survey.

Interview with the ED on 11/17/16 at 12:41pm revealed:
-Staff should be sitting when providing feeding assistance to residents.
-"It's a dignity issue."

Interview with the ED on 11/17/16 at 4:17pm revealed:
-All staff attended basic orientation conducted by the Business Office Manager which covered the facility policies and procedures.
-About two months ago, the facility began to use

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computerized training for staff.
-Staff completed the computer training and took a test at the conclusion of the training.
-The ED did not know if the computer training provided staff with teaching on feeding assistance/techniques.

Interview with the ED on 11/17/16 at 8:35pm revealed:
-All floor staff (Nurse Aides and Personal Care Aides) on duty were expected to be in the dining room during meals.
-The floor staff were supposed to serve the food and feed the residents who required assistance.
-The Dietary Aide on duty during meals was supposed to fill drinks and was not supposed to help feed residents.
-The cook was expected to remain in the kitchen during meals.

The failure of the facility to assure residents who required feeding assistance received assistance with eating was detrimental to the welfare of the residents, which constitutes a TYPE B violation.

____

Review of the Plan of Protection submitted by the facility dated 11/17/16 revealed:
-"Immediately" staff would be provided with one on one training regarding the use use of gloves, sitting to assist residents with feeding, and assisting residents to eat in an unhurried manner.
-Each meal would be monitored by management or designee to assure maintenance of residents' dignity and respect.
-A computerized training would be conducted on nutrition and food service for all staff.
-Meals would be monitored by management or designee one time weekly for one month, two times a month for two months, and then once quarterly thereafter.

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{D 338}	10A NCAC 13F .0909 Resident Rights	{D 338}		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations and interviews, the facility failed to ensure residents were treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy related to moving freely in the community dining room at meal times.

The findings are:

Observations on 11/17/16 from 11:55am until 12:33pm revealed:
-There were 15 tables that seated 4 in the main dining room and private dining room making 60 seats total available for meals.
-Five of the 15 tables had been pushed together end to end in the center of the dining room for the residents that required assistance with meals.
-Twenty-two seats were available at the center assistance table for residents and the staff that assisted.
-There were four wheeled walkers, two regular walkers (unfolded), ten regular wheelchairs and four high back oversized Geri-chair type wheel chairs at the tables in the dining room for the lunch meal.
-Ambulatory residents entering or leaving the dining room near the center table had to turn side ways to squeeze through wheelchairs and

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walkers; and step over wheelchair leg rests.
-Staff also had to turn side ways to navigate around the center table to deliver meals and drinks and provide assistance.
-Some staff had to exit the dining room through the 200 hall doorway to walk around and enter the dining room from the doorway on the activity hall to get to residents.
-A list of 13 residents that required assistance with eating their meals was posted in the kitchen.

Interview with a group of four ambulatory residents on 11/17/16 at 12:15pm revealed:
-They chose to sit near the door so they could leave the dining area without impediment.
-The residents did not like having to "crawl" over the wheelchairs and walkers to leave.

Interview with a Dietary Aide on 11/17/16 at 12:26pm revealed:
-Sometimes avoiding the wheelchairs could be a problem while serving meals.
-Tripping or dropping plates while serving residents was a concern.

Interview with a staff member on 11/17/16 at 12:31pm revealed:
-"There just isn't enough room."
-The facility has tried different table arrangements but the congestion was the same.
-The staff member was concerned that a resident or staff member could trip and fall while trying to walk through the dining area.
- Many times residents, sitting in the center of the dining room, would have to wait until wheelchair bound residents had finished their meal and were assisted back to their rooms before they could leave.

Interview with the Executive Director on 11/16/16

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at 5:35pm revealed:
-The facility chose to group the residents who required assistance with meals in the center of the room.
-This would allow staff to concentrate on the residents who required feeding assistance.
-She felt this was the best solution to meet the needs of the residents.
-Facility procedure was that all floor staff, except for the 2 Medication Aides, would be in the dinning room during meals serving and assisting residents with meals.

The failure of the facility to assure a clear route of egress from the dining room for ambulatory residents resulted in ambulatory residents not seated near a doorway having to wait until wheelchair bound residents were removed from the dining room by staff. This non-compliance was detrimental to the welfare of the ambulatory residents and constitutes a TYPE B VIOLATION.

____

Review of the Plan of Protection submitted by the facility dated 11/22/16 revealed:
-A registered dietician would evaluate and assess the feeding and dining room arrangements and meal service delivery to include dining capacity to ensure residents' safety and dining experience.
-Upon recommendations of the dietician, the facility woud implement new processes and/or procedures to include reorganization of meal delivery, training all staff, and oversight of newly established processes.
-The Executive Director (ED)/designee would monitor food service one time weekly for one month, two times monthly for two months and quarterly for six months.

THE CORRECTION DATE OF THIS TYPE B

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{D 338}	Continued From page 54 VIOLATION SHALL NOT EXCEED 01/06/2017.	{D 338}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify orders with the prescribing practitioner for 3 of 5 residents sampled (#2, #4 and #5) for therapeutic diets. The findings are: 1. Review of Resident #4's current FI-2 dated 10/21/16 revealed: -Diagnoses included vascular dementia and recurrent urinary tract infections. -The resident was constantly disoriented. Review of a Physician's Order sheet for Resident #4 signed by the Nurse Practitioner (NP) and dated 10/21/16 revealed Resident #4's diet was listed as pureed with "thickened" liquids with the consistency not specified.	D 344		

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Review of a Resident #4's "Diet Order" sheet signed by the NP and dated 10/21/16 revealed an order for a mechanical soft diet and the thickened liquids were not ordered.

Interview with the Executive Director on 11/15/16 at 2:30pm revealed:
-Any incomplete diet orders were supposed to be clarified by the Medication Aide (MAs) and/or the Memory Care Manager (MCM) with the ordering provider.
-If the DM noticed any incomplete diet orders, the ED would expect the DM to ask the MA to contact the provider to clarify the diet order.

Interview with Resident #4's NP on 11/17/16 at 4pm revealed:
-Resident #4 should be on a mechanical soft diet with nectar thick liquids.
-He expected that the facility to contact him for clarification if there were any questions about his orders.

2. Review of Resident #2's current FL-2 dated 02/17/16 revealed diagnoses included Alzheimer's disease, hypertension, degenerative joint disease, and arthritis.

Review of Resident #2's "Diet Order" dated 10/04/16 revealed:
-Resident #2 was ordered a "mechanical soft" modified diet.
-There was a check mark beside "thickened liquids" to document Resident #2 required modified liquids but the "select consistency" section did not contain any documentation.
-The order was signed by Resident #2's physician and dated 10/19/16.

Interview with the DM on 11/16/16 at 1:55pm

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revealed:
-The DM did not know what process the facility used for diet orders; the MAs just gave the DM a copy of residents' new diet orders "sometimes."
-The DM could not make sure the residents got the correct diet if the MA did not give her a copy of the diet order.

Interview with the Executive Director (ED) on 11/15/16 at 2:30pm revealed:
-Any incomplete diet orders were supposed to be clarified by the Medication Aide (MAs) and/or the Memory Care Manager (MCM) with the ordering provider.
-If the DM noticed any incomplete diet orders, the ED would expect the DM to ask the MA to contact the provider to clarify the diet order.
-Staff would not know what consistency to serve Resident #2 because the order dated 10/19/16 only stated Resident #2 was supposed to get "thickened liquids"; the consistency was not ordered.
-Resident #2's diet order dated 10/19/16 should have been clarified because it was incomplete.
-The MCM was responsible for clarifying Resident #2's diet order.
-The ED would assure Resident #2's physician was notified that day (11/1/5/16) to clarify his modified liquid consistency.

Telephone interview with Resident #2's physician on 11/15/16 at 2:57pm revealed:
-He forgot to mark the consistency on Resident #2's diet order when he signed it on 10/19/16.
-Resident #2's diet order that he signed on 10/19/16 was an incomplete order and it should have been clarified by the facility.
-He expected the facility to clarify Resident #2's diet order with him as soon as possible.
-The facility had never notified him to clarify

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Resident #2's diet.
-The physician would assure Resident #2's diet order was clarified and sent to the facility that day (11/15/16).

Interview with the ED on 11/15/16 at 3:30pm revealed a MA had called Resident #2's physician's office to clarify his diet order.

3. Review of Resident #5's current FL-2 dated 10/27/16 revealed diagnoses included Change in Mental Status and Congestive Heart Failure.

Review of a Rehabilitation facility's discharge instructions to the facility dated 10/6/16 revealed Resident #5 was on a pureed diet with thin liquids and required supervision with meals.

Review of hospital discharge insructions for Resident #5's dated 10/27/16 revealed instructions for a regular diet.

Review of the facility's diet list posted in the kitchen dated 8/10/16 revealed Resident #5 was on a mechanical soft diet.

Review of "Care Notes", "Physician's Order Request" forms and "Medication Clarification" forms dated 10/27/16 through 11/17/16 for Resident #5 revealed there was no documentation of clarification for Resident #5's diet order.

Observation of snacks in the dining room on 11/17/16 at 10:47am revealed:
-Resident #5 was sitting at the feeding assistance table in the dining room in her wheelchair for snack.
-She was served a plate containing tortilla chips, red gelatin and a soft cookie with a bowl of

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popcorn and a cup of milk.
-She ate only the cookie and gelatin without signs of coughing or gagging.

Interview with a Personal Care Aide (PCA) on 11/17/16 at 10:47am revealed:
-Resident #5 was on a soft mechanical diet because she did not have any teeth and had not had teeth for "a long time."
-The resident had problems with coughing and eating after she returned from the hospital approximately one month ago (late September or early October 2016) which lasted for about a week and she had been fine since then.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Observation of the dinner meal on 11/17/16 at 5:25pm revealed Resident #5 was seated at the feeding assistance table and served a dinner plate containing sweet potato fries, cole slaw and a bologna and cheese sandwich which was broken into small bite size pieces.

Interview with a Medication Aide (MA) on 11/17/16 at 4:07pm revealed:
-The MA was not aware of the discharge diet order from the Rehabilitation facility dated 10/6/16.
-Resident #5 coughed if she drank something too fast but not like a "choking cough."
-The former Memory Care Manager (MCM) was responsible for reviewing information sent with discharge instructions and following up with the Primary Care Provider (PCP).
-The MA was going to fax the information to the PCP and see what he wanted to do about Resident #5's diet order.

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D 344	Continued From page 59 Attempted interview with the former MCM on 11/21/16 at 4:52pm was unsuccessful. Telephone interview with the PCP on 11/21/16 at 11:30am revealed: -He could not recall facility staff discussing a therapeutic diet order with him following Resident #5's discharge from the Rehabilitation facility on 10/6/16 or discharge from the hospital on 10/27/16. -It was possible that Resident #5 may have had aspiration pneumonia when she was admitted to the hospital on 9/19/16 especially if she did not receive the therapeutic diet she was supposed to be on. Interview with the Executive Director (ED) on 11/17/16 at 6:42pm revealed: -The ED was not aware of the Rehabilitation facility's discharge instructions for a pureed diet for Resident #5 and that this information had not been communicated to the PCP until 11/17/16. -The MAs were responsible for the initial review of discharge instructions and information, then the MCM was supposed to review and assure things were done and follow up with the PCP. -All staff understood the importance of dysphagia diets including signs of difficulty swallowing and possible aspiration because it was part of their personal care training.	D 344		
{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:	{D 358}		

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(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 A1 VIOLATION
Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 3 of 5 residents (#1,#2, #5) sampled for record review as evidenced by Resident #5 not receiving an antibiotic resulting in hospitalization with diagnosis of sepsis; Resident #5 not receiving a diuretic, a blood pressure medication, an anti-diabetic, and a behavior medication as ordered by the prescriber; Resident #1 not receiving sliding scale insulin per the provider orders; and Resident #2 not receiving a medication for drooling and a medication for vomiting; and 2 of 6 residents (#1, #10) observed during the medication pass including significant errors with an inhaler and a medication used to treat depression.

The findings are:

1. Review of Resident #5's current FL-2 dated 10/27/16 revealed diagnoses included Change in Mental Status and Congestive Heart Failure.

a. Interview with the Primary Care Provider (PCP) on 11/16/16 at 11:11am revealed:
-There was an incident where he had seen Resident #5 at the facility (on 10/19/16) for looking "a little sick" and he prescribed antibiotics for an upper respiratory infection.
-Resident #5's family member was responsible for getting her medications and bringing them to the facility but did not bring the antibiotic for one

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week.
-Facility staff did not notify him that the resident had not received the antibiotic until he returned to the facility (on 10/24/16) for a follow up visit with Resident #5.
-Upon seeing the resident, he found her to be quite sick, not acting like herself, had no verbal response and he therefore admitted her to the hospital where she was diagnosed with Sepsis and required intravenous antibiotics. (Sepsis is a life threatening complication of infection.)
-The PCP expected medications to be given as ordered, prescribed antibiotics to be started within 24 hours and for staff to notify him immediately if staff could not get medications for a resident.

Review of "Physician Order Request" sheet for Resident #5 dated 10/19/16 revealed:
-An order signed by the PCP for Bactrim DS one tablet twice daily for 7 days then one tablet daily for 30 days for an acute and chronic urinary tract infection. (Bactrim is a broad spectrum antibiotic used to treat infections.)
-Staff documented the order had been faxed to a local pharmacy and Resident #5's Power of Attorney (POA) had been called to pick up the medication and deliver to the facility.

Review of Resident #5's October 2016 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Bactrim DS one tablet twice daily for seven days scheduled for 8:00am and 8:00pm.
-Administration documentation included staff initials that were circled from 10/19/16 at 8:00pm through 10/26/16 at 8:00pm except on 10/24/16 at 8:00am where staff initials were not circled.
-Staff documented under exceptions for 10/19/16 at 8:05pm, 10/21/16 at 8:00am and 10/23/16 at

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8:00pm there was a new order; for 10/20/16 at 7:53am and 8:20pm and 10/21/16 at 8:39pm through 10/23/16 at 7:26am the medication was not in the facility.
-According to the eMAR, Resident #5 was given one dose of Bactrim on 10/24/16 at 8:00am.
-Staff documented under "Pass Notes" on 10/21/16 at 8:00am and 10/23/16 at 8:00pm for Bactrim DS that the "family did not provide."

Review of "Care Notes" for Resident #5 revealed:
-On 10/20/16, staff documented the resident was seen 10/19/16 by the PCP and the order for Bactrim was faxed to the pharmacy.
-Staff documented a voice message was left for the POA to pick up and deliver the Bactrim.
-On 10/23/16, staff documented the resident had an antibiotic waiting to be picked up from the pharmacy.
-The resident's POA had been at the facility on 10/23/16 and staff reminded him the resident needed the antibiotic from the pharmacy.
-The POA left the facility and returned on 10/23/16 without the antibiotic and said he would pick it up on 10/24/16.
-On 10/27/16, staff documented the resident had returned from the hospital following admission for Altered Mental Status due to Sepsis from a Urinary Tract Infection.

Review of hospital records dated 10/24/16 through 10/27/16 for Resident #5 revealed:
-Resident #5 had symptoms of an upper respiratory tract infection and a urinary tract infection on 10/19/16, did not receive antibiotic until 10/24/16 and presented on 10/24/16 to the hospital looking septic and was nonresponsive to verbal commands.
-She had chills, malaise, fatigue, diaphoresis, cough, sensory and speech changes and rales in

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her lung sounds.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with Resident #5's POA on 11/17/16 at 2:55pm was unsuccessful.

Interview with a Medication Aide (MA) on 11/17/16 at 4:07pm revealed:
-She had written the care notes on 10/20/16 and 10/27/16 for Resident #5.
-She could not remember all the details between 10/20/16 and 10/27/16 because Resident #5 "gets like that sometimes" where she had a blank stare, sweats and her body would be cold so staff would just send her to the emergency room.
-The MA thought the PCP saw Resident #5 in his office on 10/19/16 and then decided to admit her to the hospital but she was not sure of the date.
-She had left a voice message for Resident #5's family member to get the antibiotic because he picked up her medications from an outside pharmacy and brought them to the facility.
-Staff could not administer medications if they were not at the facility and she could not really say what had been done between 10/20/16 and 10/24/16.
-Staff notified the PCP regarding the resident not receiving antibiotics and appearing more ill on 10/24/16.

Telephone interview with the outside pharmacy's Pharmacist on 11/22/16 at 11:41am revealed:
-The Bactrim originally written on 10/21/16, was received as a transfer order from (another outside pharmacy name) and picked up on 11/3/16 by a family member.
-The Bactrim was ordered for one DS tablet twice daily for 7 days then one tablet daily and had six

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refills available.
-The outside pharmacy was not a backup pharmacy for the facility.

Telephone interview with the facility pharmacy's Pharmacist on 11/22/16 at 1:07pm revealed:
-Resident #5's prescription orders needed to be faxed to the "fill" pharmacy and the facility pharmacy for entry on the eMAR.
-If Resident #5 needed something like an antibiotic medication right away, the pharmacy would fill the order and dispense to the facility if the facility called and requested it.

Interview with the PCP on 11/21/16 at 11:30am revealed:
-He admitted Resident #5 to the hospital on 10/24/16 after seeing that she was "out of it" and learning from staff that she had not received the antibiotic.
-He discussed his concerns about the resident not receiving the antibiotic for four days with a MA on duty and with the Executive Director (ED) on 10/24/16.
-"All it would have took was a phone call and I could have fixed this and helped get her medications."

Interview with the ED on 11/17/16 at 4:19pm revealed:
-Resident #5's medications were obtained by mail from the "VA" once monthly, "unless it's an antibiotic."
-Resident #5's POA got her orders for antibiotics filled and brought them to the facility.
-It took "reminders" to get Resident #5's POA to bring the antibiotics in, "sometimes."
-In the past, the facility would call the POA to "remind" the POA to bring Resident #5's medication; the facility had called the POA on

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more than one occasion and obtained medication for Resident #5 "more than one time" from the back up pharmacy (the ED did not know the dates).
-The ED recalled one incident (unsure of the date) when Resident #5's antibiotics were delayed: the POA took the prescription to one pharmacy and it was too expensive, so the POA wanted to take the prescription to another pharmacy where it was cheaper.
-The ED did not know how long Resident #5's antibiotics had been delayed.
-Resident #5's physician was notified of the delay in getting the antibiotics but the ED was "unsure" how the physician was notified.
-The ED did not know if there was any documentation of the physician being notified.

Interview with the ED on 11/17/16 at 6:42pm revealed:
-She was aware of Resident #5 not receiving an ordered antibiotic from 10/19/16 through 10/23/16 and only receiving one dose on 10/24/16 at 8am prior to being admitted to the hospital on 10/24/16 with a diagnoses of Sepsis.
-The former Memory Care Manager was responsible for monitoring orders at that time.
-The ED expected MAs to contact the PCP if there were any problems with a resident's medications and document all contacts with the PCP in the resident's record.

Review of the facility's "Medication Administration" Policy revealed "Antibiotic: Administration of any medication order for a systemic antibiotic shall be started no later than 9:00am of the following day unless the order is designated by the physician as urgent. All efforts should be made to start antibiotics at the next scheduled dose."

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b. Review of hospital discharge instructions for Resident #5 dated 10/27/16 revealed:
-The discharge diagnoses included Change in Mental Status and Congestive Heart Failure.
-There was documentation under "Patient Instructions" that the Primary Care Provider (PCP) would prescribe Lasix and Lisinopril from the office. (Lasix is a diuretic used to decrease fluid retention caused by congestive heart failure; Lisinopril is an angiotensin-converting enzyme (ACE) inhibitor used to treat heart failure.)

Review of hospital records dated 10/24/16 through 10/27/16 for Resident #5 revealed a BNP (Pro-B type Natriureic Peptide) was done on 10/25/16 at 6:35am with a result of 1829 with a reference of 0-450 for normal. (A BNP level is used to evaluate heart failure and increased level indicates worsened heart failure.)

Review of Resident #5's October and November 2016 electronic Medication Administration Record (eMAR) revealed there was no entry for Lisinopril 5mg daily and Lasix 20mg daily.

Observations of medications on hand for Resident #5 on 11/16/16 at 5:00pm revealed:
-There was an unopened box of Lisinopril 5mg with a pharmacy label that included Resident #5's name, instructions to take one tablet daily and that 30 tablets were dispensed on 10/27/16.
-There was a medication bottle with a pharmacy label that included Resident #5's name, instructions to take Lasix 20mg tablet daily and that 20 tablets were dispensed on 10/27/16.
-There were 20 tablets inside the bottle.

Review of "Interdisciplinary Notes" for Resident #5 dated 11/8/16 revealed:

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-At 11am the resident had a Skilled Nurse (SN) visit and edema of her left hand was noted.
-Staff reported the edema was present since the resident's discharge from the hospital (10/27/16).
-The SN documented notifying the PCP.

Review of "Care Notes" for Resident #5 revealed:
-On 10/27/16, staff documented the resident was returning to the facility from the hospital with three new medication orders for Lisinopril, Lasix and Avelox and the order had been faxed to the pharmacy.
-Staff documented speaking with Resident #5's POA and the medications would be delivered to the facility before the end of the night on 10/27/16.
-On 10/27/16, a second staff documented the resident had returned from the hospital and that Lisinopril, Lasix and Avelox had been received in the facility.

Interview with a Medication Aide (MA) on 11/17/16 at 5:00pm revealed:
-She believed the Lasix and Lisinopril were included in the discharge orders dated 10/27/16.
-She did not know why the orders for Lasix and Lisinopril were not on the eMAR.
-The packages were unopened and did not look like they had been given so they must have been just sitting on the medication cart.

Interview with the MA on 11/17/16 at 6:42pm revealed she had received the prescription orders from the outside pharmacy and was going to fax them to the pharmacy to correct the eMAR.

Review of prescription orders received from an outside pharmacy for Resident #5 on 11/17/16 revealed:
-There was an order for Lisinopril 5mg daily dated

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{D 358}	Continued From page 68 10/27/16. -There was an order for Lasix 20mg daily dated 10/27/16. Telephone interview with the outside pharmacy's Pharmacist on 11/22/16 at 11:41am revealed: -The outside pharmacy was not a backup pharmacy for the facility. -The orders for Lasix and Lisinopril were transferred from another location and picked up by a family member on 10//27/16. -There were 20 Lasix tablets and 30 Lisinopril tablets dispensed on 10/27/16. Telephone interview with the facility pharmacy's Pharmacist on 11/22/16 at 1:07pm revealed: -Facility staff faxed orders to the pharmacy and it was noted in the pharmacy's system if a resident obtained their medications from an outside pharmacy. -Once the order was faxed, the pharmacy entered the order on the eMAR, and in an emergency, facility staff could enter orders on the eMAR. -Resident #5's prescription orders needed to be faxed to the "fill" pharmacy and the facility pharmacy for entry on the eMAR. -The Lisinopril and Lasix were called into an outside pharmacy on 10/27/16 and the facility pharmacy received the order on 11/17/16. Telephone interview with the PCP on 11/21/16 at 11:30am revealed: -The Lasix and Lisinopril should have been started for Resident #5 "to get some of the fluid off." -It would be concerning for the resident not to have had these medications because her blood pressure could have been high and she was at greater risk for a stroke. -He expected these medications to be given	{D 358}		

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saying, "It does not take a lot to check these orders and make sure things were done."

Interview with the Executive Director (ED) on 11/17/16 at 6:42pm revealed:
-The Memory Care Manager (MCM) was responsible for making sure orders were sent to the pharmacy and verified on the eMAR.
-The MCM who was responsible at the time of the Lasix and Lisinopril orders (10/27/16) was no longer at the facility.
-The ED did not know what happened with the orders or why they were missed.
-If a medication arrived in the facility without an order on the eMAR, the ED expected the MAs to administer medications according to the instructions on the label and contact the PCP for the order.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with the former MCM on 11/21/16 at 4:52pm was unsuccessful.

Attempted interview with Resident #5's Power of Attorney (POA) on 11/17/16 at 2:55pm was unsuccessful.

c. Review of "Physician Order Request" sheet for Resident #5 dated 10/19/16 revealed:
-An order signed by the Primary Care provider (PCP) for Bactrim DS one tablet twice daily for 7 days then one tablet daily for 30 days for an acute and chronic urinary tract infection. (Bactrim is a broad spectrum antibiotic used to treat infections.)

Review of Resident #5's current FL-2/hospital discharge instructions dated 10/27/16 revealed

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there was no PCP order to stop or start Bactrim DS.

Review of "Medication Clarification" forms for Resident #5 dated 10/27/16 revealed there was no clarification request for Bactrim DS.

Review of Resident #5's October 2016 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Bactrim DS one tablet daily at 8:00am where staff initials were circled from 10/27/16 through 10/31/16.
-Staff documented under exceptions on 10/27/16 at 9:12am the resident was in the hospital; on 10/28/16 at 7:46am the medication was not in the facility; and on 10/29/16 through 10/31/16 staff documented "new order."

Review of "Care Notes" for Resident #5 revealed:
-On 10/27/16, staff documented the Bactrim had been discontinued and removed from the medication cart.
-On 11/2/16, staff documented the PCP ordered Bactrim DS one tablet daily.
-On 11/3/16, staff documented Resident #5's new order for Bactrim had been received in the facility.

Review of "Physician Order Reguest" forms, "Medication Clarification" forms and prescription orders for Resident #5 dated 10/27/16 through 11/17/16 revealed there were no new orders for Bactrim DS.

Review of Resident #5's November 2016 eMAR revealed:
-There was an entry for Bactrim DS one tablet daily at 8:00am where staff documented administering 11/1/16 through 11/16/16 except on 11/2/16 and 11/3/16.

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-Staff documented under exceptions on 11/2/16 and 11/3/16 that the Bactrim DS was a "new order."
-Staff documented under "Pass Notes" for 11/1/16 and 11/2/16 that the "resident isn't on Bactrim, she is taking (Avelox) 400mg."
-The original order date documented was 10/27/16.

Observations of medications on hand for Resident #5 on 11/16/16 at 5:00pm revealed:
-There was a medication bottle with a pharmacy label that included Resident #5's name, instructions to take Bactrim DS one tablet twice daily for seven days then once daily and that 30 tablets were dispensed on 11/3/16.

Interview with a Medication Aide (MA) on 11/17/16 at 4:30pm revealed:
-Resident #5 continued Bactrim DS starting 11/2/16 when the Avelox was finished.
-The orders were mixed up and the MA had told the former Memory Care Manager (MCM).
-Staying on top of Resident #5's orders was hard because a family member brought medications into the facility and staff had to fax orders to that pharmacy and also fax order to the facility pharmacy to get orders on the eMAR.

Telephone interview with the outside pharmacy's Pharmacist on 11/22/16 at 11:41am revealed the Bactrim for Resident #5 was originally written on 10/21/16, was received as a transfer order from (another outside pharmacy name) and picked up on 11/3/16 by a family member.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with the former MCM on

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11/21/16 at 4:52pm was unsuccessful.

Attempted interview with Resident #5's Power of Attorney (POA) on 11/17/16 at 2:55pm was unsuccessful.

d. Review of Resident #5's current FL-2/hospital discharge instructions dated 10/27/16 revealed medication orders included Depakene 250mg three times daily. (Depakene is used to treat mental and mood issues.)

Observation of medications on hand for Resident #5 on 11/16/17 at 5:00pm revealed:
-There was a bottle of Depakene with a pharmacy label which included Resident #5's name, instructions to take 5ml = 250mg three times daily for dementia and that 473ml (milliliters) was dispensed on 8/22/16 to another facility.
-There was a hand written date of 8/24/16 on the label.
-There was approximately one third of the bottle remaining.

Review of "Care Notes" for Resident #5 revealed:
-On 8/14/16, staff documented the resident was admitted to the hospital for Sepsis and a Urinary Tract Infection.
-On 9/7/16, staff documented the resident returned to the facility from a rehabilitation facility.

Review of a "Medication Clarification" form for Resident #5 dated 9/7/16 revealed:
-Staff requested clarification to continue Depakene 250mg/5ml three times daily.
-The Primary Care Provider (PCP) marked yes, signed and dated the form 9/8/16.

Review of Resident #5's September 2016 eMAR revealed:

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-There was an entry for Depakene 250mg/5ml three times daily at 8:00am, 2:00pm and 8:00pm.
-There were circled staff initials on 9/1/16 at 8:00am through 9/7/16 at 8:00am where under exceptions staff documented the resident was in the hospital; 9/7/16 at 8:00pm staff documented the medication was not in the facility; 9/19/16 at 2:00pm and 9/20/16 at 8:00am through 9/30/16 at 8:00pm staff documented the resident was in the hospital.
-There were a total of 36 doses documented as administered for September 2016 at the facility.

Review of Resident #5's October 2016 eMAR revealed:
-There was an entry for Depakene 250mg/5ml three times daily at 8:00am, 2:00pm and 8:00pm.
-There were circled staff initials on 10/1/16 at 8:00am through 10/6/16 at 8:00am where under exceptions staff documented the resident was in the hospital; and 10/24/16 at 2:00pm through 10/27/16 at 2:00pm staff documented the resident was in the hospital.
-There were a total of 67 doses documented as administered for October 2016 at the facility.

Review of Resident #5's November 2016 eMAR revealed:
-There was an entry for Depakene 250mg/5ml three times daily at 8:00am, 2:00pm and 8:00pm where staff documented administering 11/1/16 through 11/16/16 at 2:00pm.
-There were a total of 47 doses documented as administered for November 2016 at the facility.

Based on interviews and record reviews, Resident #5 received seven days of Depekene 250mg/5ml at the rehabilitation facility from 8/24/16 through 8/31/16 totaling 21 doses; six days at the rehabilitation facility 9/1/16 through

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9/6/16 totaling 18 doses, 36 doses documented on the September 2016 eMAR, 67 doses documented on the October 2016 eMAR and 47 doses documented on the November 2016 eMAR for a total of 189 doses of 5ml or 945ml.

Interview with a Medication Aide (MA) on 11/16/17 at 5:00pm revealed Resident #5 received Depakene three times daily and the bottle with the hand written date of 8/24/16 was the only bottle in the facility.

Telephone interview with an outside pharmacy's Pharmacist on 11/22/16 at 12:07pm revealed:
-The pharmacy did not have record of the facility on file.
-The Depekene was filled for the rehabilitation facility on 8/22/16 where 473ml (milliliters) was dispensed which equaled 31 and a half day's supply.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with the former Memory Care Manager (MCM) on 11/21/16 at 4:52pm was unsuccessful.

Attempted interview with Resident #5's Power of Attorney (POA) on 11/17/16 at 2:55pm was unsuccessful.

e. Review of Resident #5's current FL-2 dated 10/27/16 revealed there was an order to discontinue Glipizide. (Glipizide is used to help control blood sugars.)

Review of a "Medication Clarification" form for Resident #5 dated 10/31/16 revealed:
-Staff documented Glipizide 10mg was to be

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discontinued.
-There was no documented PCP response of yes or no to continue the Glipizide.
-The "Medication Clarification" form was not signed by the PCP.

Review of Resident #5's October 2016 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Glipizide 10mg tablet twice daily at 8:00am and 5:00pm where staff documented administering 10/6/16 through 10/31/16 at 8:00pm except 10/24/16 at 8:00pm through 10/27/16 at 8:00am.
-Staff documented under exceptions that Resident #5 was in the hospital 10/24/16 through 10/27/16.
-Resident #5 received eight doses of Glipizide in October 2016 after the PCP order to discontinue the medication on 10/27/16.

Review of Resident #5's November 2016 eMAR revealed:
-There was an entry for Glipizide 10mg tablet twice daily at 8:00am and 5:00pm where staff documented administering 11/1/16 through 11/16/16 at 8:00am except 11/8/16 and 11/9/16 at 5:00pm.
-Staff documented under exceptions that the medication was not in the facility on 11/8/16 and 11/9/16.
-Resident #5 received 29 doses of Glipizide in November 2016 after the PCP order to discontinue the medication on 10/27/16.

Observation of medications on hand for Resident #5 on 11/16/16 at 5:00pm revealed:
-There were three pharmacy labeled bottles of Glipizide 10mg tablets for Resident #5.
-There was a bottle indicating 180 tablets were

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dispensed on 3/15/16 which was approximately one third full.
-There was a bottle indicating 180 tablets were dispensed on 6/15/16 which was approximately one half full.
-There was a bottle indicating 180 tablets were dispensed on 9/12/16 which was approximately one third full.

Interview with a Medication Aide on 11/17/16 at 5:00pm revealed she just saw that the Glipizide was discontinued and removed it from the medication cart.

Based on observations, interviews and record reviews, Resident #5 was not interviewable.

Attempted interview with the former Memory Care Manager (MCM) on 11/21/16 at 4:52pm was unsuccessful.

Attempted interview with Resident #5's Power of Attorney (POA) on 11/17/16 at 2:55pm was unsuccessful.

Interview with the PCP on 11/16/16 at 11:11am and 11/21/16 at 11:30am revealed he expected orders to be done as written and to be checked to make sure things were done as ordered.

2.Review of Resident #1's current FL-2 dated 03/11/16 revealed diagnoses included Alzheimer type dementia, diabetes mellitus type2 and encephalopathy (acute toxic-metabolic).

Review of current medication orders revealed:
-An order for Novolog 70/30 insulin 16 units to be injected SQ at bedtime.
-An order for fingerstick blood sugars (FSBS) three times per day and dose with sliding scale

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insulin
-An order for Novolog Flexpen insulin as needed per sliding scale of blood sugar (BS) of 200-250 give 2 units; 251-300 give 3 units; 301-350 give 4 units; 351-400 give 5 units; 401-450 give 6 units and call the doctor.

Review of the electronic Medication Administration Record (eMAR) for Resident #1 for September 2016 revealed:
-The FSBS were obtained at 7:30am, 11:30am and 5pm.
-On 09/04/16 the BS was 359 and 4 units of insulin were documented as given.
-On 09/14/16 the BS was 392 and 4 units of insulin were documented as given.
-On 09/15/16 the BS was 339 and 5 units of insulin were documented as given.
-On 09/16/16 the BS was 321 and 3 units of insulin were documented as given.
-On 09/17/16 the BS was 331 and 3 units of insulin were documented as given.
-On 09/18/16 the BS was 307 and 3 units of insulin were documented as given.
-On 09/19/16 the BS was 324 and 3 units of insulin were documented as given .
- On 09/22/16 the BS was 316 and 3 units of insulin were documented as given.
Review of the eMARs for October 2016 revealed:
-On 10/05/16 the BS was 369 and 3 units of insulin were documented as given.
-On 10/09/16 the BS was 358 and 3 units of insulin were documented as given.

Interview with the Executive Director on 11/17/16 at 2:10pm revealed:
-Seven of the 10 mistakes were made by the same Medication Aide (MA) who was no longer employed by the facility.
-The Memory Care Director (MCD), who also was

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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 358}	Continued From page 78 no longer employed at the facility, was responsible for supervision of the MAs. Interview with the prescribing provider on 11/17/16 at 4pm revealed: -He did not remember being notified of a medication error for Resident 1. -Each unit of insulin lowered the BS 50 points, so it was important that correct dosage be given each time. -He expected that his orders to be followed by the facility and to be notified of all medication errors. . 3. Review of Resident #2's current FL-2 dated 02/17/16 revealed diagnoses included Alzheimer's disease, hypertension, degenerative joint disease, and arthritis. A. Observation of Resident #2 on 11/15/16 at 09:35am revealed: -Resident #2 was sitting in his high-backed wheelchair in the hallway. -Resident #2 was drooling. Review of Resident #2's "Physician's Order" sheet dated 10/19/16 at 10:00am revealed: -There was a physician order for Atropine Sulfate 1% solution two drops by mouth every 8 hours with administration times of 06:00am, 2:00pm, and 10:00pm daily. (Atropine drops can be given under the tongue for the treatment of drooling.) -There was a physician order for Atropine Sulfate 1% solution two drops by mouth every 4 hours PRN (as needed) for excessive drooling.	{D 358}		

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{D 358}	Continued From page 79 -The orders were signed by Resident #2's physician. Review of Resident #2's "Physician's Order Request" dated 07/16/15 revealed: -There was documentation of Resident #2 "drooling excessively." -In the physician's response section, there was a physician order for Atropine 1% solution two drops by moth every 8 hours and every 4 hours PRN for excessive drooling. Interview with a Medication Aide (MA) on 11/16/16 at 08:12am revealed Resident #2 drooled "a lot" and was on a medication for the drooling. Observation of Resident #2's medications on hand on 11/16/16 at 10:06am revealed Resident #2 did not have any Atropine drops stocked on the medication cart. Interview with a MA on 11/16/16 at 10:11am revealed: -Resident #2's Atropine was administered by the third shift MA before she got there that day; the third shift MA had not told her Resident #2 was out of Atropine. Observation on 11/16/16 at 10:17am revealed: -Three MAs searched the other medication cart and refrigerator for Resident #2's Atropine; no Atropine was found in stock for Resident #2. -One MA reviewed Resident #2's order for Atropine in the electronic Medication Administration Record (eMAR). -In the eMAR, there was documentation about Resident #2's Atropine which read: "Status: New Rx (prescription) required." -The last filled date for Resident #2's Atropine was not available in the eMAR.	{D 358}		

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{D 358}	Continued From page 80 Interview with a MA on 11/16/16 at 10:20am revealed: -Resident #2's Atropine could not be refilled without a new order. -Resident #2's physician would be there that day (11/16/16); the MA would ask the physician for a new Atropine order that day (11/16/16). Review of Resident #2's September 2016 MAR revealed: -There was an entry for Atropine Sulfate 1% with direction to instill two drops by mouth every 8 hours with administration times of 06:00am, 2:00pm, and 10:00pm. -Atropine was documented as administered to Resident #2 three times daily from 09/01/16-09/30/16 with the following exceptions: on 09/12/16-09/13/16 not given at 06:00am, 2:00pm, and 10:00pm"resident in hospital;" on 09/14/16 at 06:00am and 2:00pm not given, "resident in hospital"; and at 10:00pm "resident out with family;" on 09/15/16 at 06:00am and 2:00pm not given,"resident in hospital ;" on 09/17/16 at 2:00pm not given "new order;" and 09/18/16 at 06:00am not given, "resident in hospital;" and 09/18/16 at 2:00pm not given "new order." -There was an entry for Atropine Sulfate 1% with direction to instill two drops by mouth every 4 hours PRN for excessive drooling. -There was no documentation of Resident #2 receiving PRN Atropine in September 2016. Review of Resident #2's October 2016 MARs revealed: -There was an entry for Atropine Sulfate 1% with direction to instill two drops by mouth every 8 hours with administration times of 06:00am, 2:00pm, and 10:00pm.	{D 358}		

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-Atropine was documented as administered to Resident #2 three times daily from 10/01/16-10/31/16 with the following exceptions: on 10/25/16 and 10/26/16, not administred at 06:00am, "med not in facility."
-There was an entry for Atropine Sulfate 1% with direction to instill two drops by mouth every 4 hours PRN for excessive drooling.
-There was no documentation of Resident #2 receiving PRN Atropine in October 2016.

Review of Resident #2's November 2016 MARs revealed:
-There was an entry for Atropine Sulfate 1% with direction to instill two drops by mouth every 8 hours with administration times of 06:00am, 2:00pm, and 10:00pm.
-Atropine was documented as administered to Resident #2 three times daily from 11/01/16-11/15/16 with the following exceptions: on 11/03/16 and 11/04/16, not administered at 06:00am "med not in the facility;" from 11/08/16-11/15/16, not administered at 6:00am,"med not in facility;" and on 11/14/16 at 10:00pm, not administered "med not in facility."
-There was an entry for Atropine Sulfate 1% with direction to instill two drops by mouth every 4 hours PRN for excessive drooling.
-There was no documentation of Resident #2 receiving PRN Atropine in November 2016.

Interview with a first shift Medication Aide (MA) on 11/16/16 at 10:45am revealed she last administered Atropine to Resident #2 "yesterday" (11/15/16) at 2:00pm.

Attempt to contact the third shift MA by telephone for interview on 11/16/16 at 10:56am was unsuccessful.

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Interview with a MA on 11/17/16 at 4:10pm revealed:
-Drops and cream medications were not on cycle refill and the MAs were responsible for requesting refills from the pharmacy when the stock was "low."
-The medications not on cycle fill had a sticker on the label that the MAs would peel off, put on the pharmacy refill sheet, and then fax the sheet to the pharmacy.

Based on observations, record reviews, and interviews, Resident #2 was not interviewable.

Telephone interview with Resident #2's Power of Attorney (POA) on 11/16/16 at 2:18pm revealed:
-Resident #2 had "streaks" when he would drool.
-As far as the POA knew, Resident #2 got his medications and saw his physician like he was supposed to.
-The POA had not seen Resident #2 drool "ina couple months."

Interview with a Pharmacist at the facility's contracted pharmacy on 11/16/16 at 10:26am revealed:
-The only order the pharmacy had on file for Atropine for Resident #2 was the order dated 07/16/15 for Atropine 1% two drops by mouth every 8 hours and two drops by mouth PRN for excessive drooling.
-The pharmacy did not have Resident #2's Atropine order dated 10/19/16 on file.
-The pharmacy required medication order renewals yearly; Resident #2's Atropine was not available for refill because the last physician order on file was dated 07/16/15, which was greater than a year old.
-The dispensing history for Resident #2's Atropine was as follows: on 07/16/15, the pharmacy

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{D 358}	Continued From page 83 dispensed 5mls (milliliters) of Atropine for Resident #2; on 08/24/15, the pharmacy dispensed 15mls of Atropine for Resident #2; on 03/09/16, the pharmacy dispensed 15mls of Atropine for Resident #2. -The pharmacy had not refilled Resident #2's Atropine since 03/09/16. -The pharmacy required the facility to request refills for Resident #2's Atropine because it was not on cycle fill. -A 15ml supply of Atropine would last Resident #2 "about 50 days" if he was only given the scheduled doses and no PRN doses. Interview with the Executive Director (ED) on 11/15/16 at 4:40pm revealed: -Resident #2's scheduled 6:00am dose of Atropine would be administered by the third shift MA. -Upon review of Resident #2's November 2016 MARs, the ED had no explanation why Atropine was documented as not given due to the medication not being in the facility by the third shift MA on multiple dates in November 2016, but was documented as given by the first and second shift MAs on the same dates. -"It does not make sense" that Atropine would be documented as given on multiple dates when it was documented as not being in the facility by the third shift MA. -The only explanation the ED had was maybe Resident #2 was sleeping when the 6:00am dose of Atropine was due so the third shift MA did not give the Atropine. -The MA might have "marked the wrong thing" on the MAR. -The ED would talk to the third shift MA and check to see if the morning administration time needed to be changed.	{D 358}		

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{D 358}	Continued From page 84 Interview with the ED on 11/16/16 at 3:00pm revealed: -Annual medication order renewals were supposed to be faxed to the pharmacy by the MAs or Memory Care Manager (MCM) upon receipt. -The ED expected medications to be administered to all residents per the provider orders. Interview with the ED on 11/17/16 at 4:19pm revealed: -The ED did not have an explanation why Resident #2's Atropine was documented for months as being administered if the medication had not been in stock or refilled. -There was not enough supply of Atropine dispensed from the pharmacy to account for what was documented as being administered to Resident #2. Interview with Resident #2's physician on 11/16/16 at 11:15am revealed: -Resident #2 had been on hospice and his original Atropine order (dated 07/16/15) had been written by the hospice physician. -Resident #2 was no longer on hospice (physician could not recall the date Resident #2 was removed from hospice). -The physician did not recall renewing Resident #2's Atropine order on 10/19/16. -The physician expected all residents in the facility to receive their medications as ordered and to be notified of any problems with resident's medications. -The facility had not contacted the physician about any problems with Resident #2's medications. B. Review of a hospital discharge summary dated	{D 358}		

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08/30/16 for Resident #2 revealed Resident #2 was evaluated in the emergency department for vomiting.

Review of a hospital discharge prescription order for Resident #2 dated 08/30/16 revealed an order for Metoclopramide 10mg. take one every six hours,"quantity 30 (thirty)" with zero refills. (Metoclopramide is used to treat nausea and vomiting).

Review of the "Physician's Order Request" for Resident #2 dated 09/20/16 revealed:
-Under the "issue/problem/clarification"section, there was documentation that Resident #2 had no refills left of Metoclopramide 10mg. "May we have a new hard script for this medication? "
-There was a signed physician order for Metoclopramide 10mg. take one tablet every six hours.

Review of Resident #2's September 2016 MARs revealed:
-There was an entry for Metoclopramide 10mg. take one tablet every 6 hours with administration times of 12:00am, 06:00am, 12:00pm, and 6:00pm.
-Metoclopramide 10mg. was documented as administered to Resident #2 every 6 hours (four times daily) from 09/01/16-09/11/16.
-Metoclopramide 10mg. was documented as not given to Resident #2 on 09/12/16-09/14/16, "resident in hospital."
-Metoclopramide 10mg. was documented as not given on 09/15/16 at 12:00am, 06:00am, and 12:00pm "resident in hospital," at 6:00pm, "med not in facility."
-Metoclopramide 10mg. was documented as not given to Resident #2 on 09/16/16 at 12:00am and 06:00am with"new order" as the reason, at

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12:00pm and 6:00pm "med not in facility."
-Metoclopramide 10mg. was documented as not given to Resident #2 on 9/17/16 at 12:00am, 06:00am, and 12:00pm, "new order;' Metoclopramide 10mg. was documented as given to Resident #2 at 6:00pm.
-Metoclopramide 10mg. was documented as not given to Resident #2 on 09/18/16 at 12:00am "new order;" at 06:00am, "resident in hospital;" at 12:00pm"new order;" and 6:00pm "resident refused."
-Metoclopramide 10mg. was documented as not given to Resident #2 at 12:00pm "med not in facility."
-Metoclopramide 10mg. was documented as not given to Resident #2 on 09/20/16 at 12:00am, 06:00am, and 12:00pm "new order;" Metoclopramide 10mg. was documented as given at 6:00pm.
-Metoclopramide 10mg. was documented as not given to Resident #2 at all on 09/21/16, "new order."
-Metoclopramide 10mg. was documented as not administered to Resident #2 on 09/22/16 at 6:00pm, due to "new order."

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/22/16 at 08:35am revealed:
-The pharmacy first dispensed Metoclopramide for Resident #2 on 08/31/16, (from the hospital prescription order dated 08/30/16), which was less than an 8 day supply of Metoclopramide.
-The pharmacy did not receive a new order for Metoclopramide for Resident #2 until 09/21/16 at 08:31am (the physician order dated 09/20/16).
-Resident #2 would have run out of Metoclopramide prior to 09/20/16 because the pharmacy had only dispensed 30 tablets (less than an 8 day supply) on 08/31/16.

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Based on observations, record reviews, and interviews, Resident #2 was not interviewable.

Telephone interview with Resident #2's Power of Attorney (POA) on 11/16/16 at 2:18pm revealed as far as the POA knew, Resident #2 got his medications like he was supposed to.

Interview with the Executive Director (ED) on 11/16/16 at 3:00pm revealed the ED expected medications to be administered to all residents per the provider orders.

Interview with Resident #2's physician on 11/16/16 at 11:15am revealed the physician expected medications to be administered as ordered

4. Based on observations, interviews, and record reviews, the Medication Pass error rate was 4% as evidenced by two significant medication errors out of 44 opportunities on 11/16/16 between 7:53am and 9:15am including errors with an asthma control inhaler (#1) and an antidepressant (#10) as related to both medications not being available on the medication cart to be administered.

A. Review of Resident #1's current FL-2 dated 03/11/16 revealed diagnoses included Alzheimer type dementia, diabetes mellitus type 2 and encephalopathy (acute toxic-metabolic).

Review of a Physician's Order sheet dated 08/01/16 revealed an order for Advair Diskus 250/50, inhale 1 puff into the lungs twice a day. (Advair is used to control symptoms of Asthma and Chronic Obstructive Pulmonary Disease.)

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Observation of the medication pass and Resident #1's electronic Medication Administration Record (eMAR) Screen on 11/16/16 at 8:25am revealed the resident was scheduled to receive an Advair inhaler at 8:00am but did not receive it with her morning medications because there was no Advair inhaler on the medication cart.

Interview with the Medication Aide (MA) on 11/16/16 at 8:25am and 9:15am revealed:
-Resident #1 was out of Advair and the MA had sent a refill request for it to the pharmacy on 11/16/16.
-The MA had just administered the Advair on 11/15/16 but did not know what happened to the inhaler because it was no longer on the medication cart.

Review of Resident #1's Electronic Medication Administration Record (eMAR) revealed:
-An entry for Advair Diskus 250/50 AER, inhale 1 puff into the lungs twice a day.
-The times for administration were 8am and 8pm.
-The starting date for the medication was 08/01/16.
-The Advair was administered as ordered for the month of September 2016.
-One dose of Advair was not given during October 2016 on 11/02/16 at 8pm.
-The documented reason for the missed dose was the "medication was not in the facility."
-Documentation on the eMAR revealed that the Advair was given during the month of November 2016 as ordered until the 11/16/16 8am dose.

Interview with Resident #1 on 11/16/16 at 3:02pm revealed that she thought the last time she had received the Advair was "yesterday"(11/15/16).

Telephone interview with a Pharmacist at the

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{D 358}	Continued From page 89 facility's contracted pharmacy on 11/16/16 at 3:53pm revealed: -The Advair was filled for the first time on 08/02/16. -Refills were sent 09/01/16, 10/03/16 and 11/16/16 at the facility request. -The Advair was not on automatic refill. -Each Advair container was a closed system (only one complete dose is administered at a time) and contained 60 doses. -If the medication was ordered twice a day, one Advair Diskus would last 30 days. -If the first dose of the 10/03/16 refill was started at 8am, the 60th dose would have been given on 11/01/16. -The Pharmacist could not explain how an extra 28 doses could have been given with the amount of the medication that had been sent to the facility. Confidential staff interview revealed: -Any MA could reorder medications. -Medications that were not on automatic refill should be ordered by the MA who recognized the supply was low. -The Advair Diskus had a countdown feature so staff know when only a few doses remained. -If a refill was requested by 2pm, it was delivered that night. -Occasionally, it would take 24 to 48 hours to receive the medication from the pharmacy. - "Third shift does not reorder medications like they should, each MA is responsible for ordering medications." Interview with the Executive Director at 9:43am on 11/17/16 revealed: -She could not explain where the extra 28 doses of Advair were obtained. -No one at the facility reviewed the eMARs for	{D 358}		

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errors or discrepancy.

Interview with the prescribing provider on 11/17/16 at 4pm revealed that he expected medication orders to be followed and to be notified if clarification was needed or problems developed.

B. Review of Resident #10's current FL-2 dated 4/19/16 revealed:
-Diagnoses included Dementia, Coronary Artery Disease, Hyperlipidemia, Hypertension and Muscular Degeneration.
-Medication orders included Zoloft 25mg daily.

Review of a subsequent order for Resident #10 dated 10/24/16 revealed an order for Zoloft 50mg daily.

Observation of the Medication Pass and Resident #10's electronic Medication Administration Record (eMAR) Screen on 11/16/16 at 7:53am revealed the resident was scheduled to receive Zoloft 50mg at 8:00am but did not because there was no Zoloft for Resident #10 on the medication cart.

Interview with the Medication Aide (MA) on 11/16/16 at 7:53am revealed Resident #10 was out of Zoloft and the facility was waiting for a family member to bring the medication.

Review of Resident #10's November 2016 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Zoloft 50mg daily at 8:00am and staff documented administering 11/1/16 through 11/11/16.
-On 11/12/16 through 11/16/16 staff initials were circled and under exceptions staff documented

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the medication was not in the facility.

Attempted interview with the Responsible Person for Resident #10 on 11/21/16 at 3:48pm was unsuccessful.

Interview with a Medication Aide (MA) on 11/17/16 at 5:25pm revealed:
-The MAs were responsible for ordering refills for medications which was supposed to be done when the medication was down to a week's supply.
-If a medication was needed that day, the MA was supposed to request it from the back up pharmacy.
-The only reason a medication would be out for five days would be if a new prescription was needed.
-If a new prescription was needed the MA should call the Primary Care Provider (PCP).

Telephone interview with the PCP nurse on 11/21/16 at 4:32pm revealed:
-Resident #10 was seen by the PCP on 8/23/16.
-The facility faxed medication reviews and any refill requests to the PCP who would sign them and fax them back to the facility.
-Copies of the medication reviews and prescription refill orders were not kept in the PCP's office.
-The Zoloft should not be stopped abruptly to avoid worsening symptoms.

The failure of the facility to assure 3 of 5 sampled residents received medications in accordance with their provider's orders resulted in Resident #5 not receiving an antibiotic for five days, being hospitalized with diagnoses of Sepsis, Congestive Heart Failure, and Urinary Tract Infection, and requiring intravenous antibiotics. This

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{D 358}	Continued From page 92 non-compliance constitutes a TYPE A1 violation for serious physical harm and neglect. (Sepsis is a life threatening complication of infection.) ________________________________ Review of the facility's Plan of Protection dated 11/16/16 revealed: -Designated MAs will immediately complete a medication cart audit for both medication carts where Primary Care Provider (PCP) orders will be compared against physical counts. -Any medications not on the medication carts will be ordered beginning 11/16/16. -Staff will be retrained on the"Bucket System " for processing PCP orders on 11/21/16. -Two MAs will be designated to ensure all PCP orders are processed as ordered. -A medication pass observation will be conducted by the Executive Director designee weekly for one month, then twice monthly for two months and then quarterly thereafter. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 12/22/16.	{D 358}		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record	D 392		

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D 392	Continued From page 93 reviews, the facility failed to maintain an accurate and readily retrievable record of controlled drugs resulting in inaccurate records for Clonazepam and Temazepam for 1 of 2 residents (#3) with orders for controlled substances. The findings are: Review of Resident #3's current FL-2 dated 9/28/16 revealed: -Diagnoses included Alzheimer's Dementia, Unspecified Contact Dermatitis, Constipation, Essential Hypertension, Enlarged Prostate without Symptoms, Hyperlipidemia and Insomnia. -Medication orders included Clonazepam 0.5mg twice daily and Temazepam 15mg daily at bedtime. (Clonazepam is a benzodiazepine used to treat anxiety and Temazepam is a benzodiazepine used to treat insomnia.) A. Review of pharmacy dispensing records for Resident #3 revealed 60 tablets of Clonazepam 0.5mg were dispensed on 9/6/16, 10/3/16 and 11/2/16. Review of Resident #3's September 2016 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Clonazepam 0.5mg that staff documented administering twice daily at 8:00am and 8:00pm except from 8:00pm on 9/3/16 through 8:00pm 9/6/16. -Staff documented under exceptions that the resident was in the hospital on 9/3/16; that there was a new order from 9/4/16 at 10:39am through 9/6/16 at 9:17am; and that the "med was not in the facility" on 9/6/16 at 8:19pm. -There were 48 doses documented as administered from 9/7/16 at 8:00am through 9/30/16 at 8:00pm.	D 392		

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Review of Resident #3's "Inventory History" sheet for Clonazepam revealed there was no record available for 9/1/16 through 9/30/16 leaving 60 tablets of Clonazepam 0.5mg unaccounted for. (The "Inventory History" sheet is the electronic controlled drug record.)

Review of Resident #3's October 2016 eMAR revealed:
-There was an entry for Clonazepam 0.5mg that staff documented administering twice daily at 8:00am and 8:00pm except seven doses from 10/1/16 at 8:00am through 10/3/16 at 8:00pm and 10/17/16 at 8:00pm.
-The boxes for 10/1/16 and 10/2/16 at 8:00am and 8:00pm and 10/3/16 at 8:00am were blank.
-On 10/3/16 at 8:37pm staff documented under exceptions for Clonazepam "new order."
-There were 55 doses documented as administered 10/4/16 at 8:00am through 10/31/16 at 8:00pm.

Review of Resident #3's "Inventory History" sheet for Clonazepam dated 10/1/16 through 10/31/16 revealed:
-There was no record for 10/1/16 through 10/3/16 at 3:07pm, where staff document a reconciliation with zero tablets remaining.
-On 10/3/16 at 11:56pm staff documented receiving a delivery of 60 capsules leaving a remaining count of 60 tablets.
-On 10/8/16 at 7:08am staff document a reconciliation with 58 tablets remaining.
-The next entry was on 10/8/16 at 9:16am, where staff documented removing one capsule for the "med pass" leaving 61 tablets.
-There was no documentation that three additional tablets were received or returned to the count.

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-On 10/8/16 at 8:36pm and again on 10/9/16 at 1:48am, staff documented removing one tablet each time for the "med pass".
-According to the "Inventory History" sheet, two 0.5mg tablets were removed for the "med pass" 5 hours and 12 minutes apart between 10/8/16 at 8:36pm and 10/9/16 at 1:48am.
-On 10/10/16 at 9:12pm, 10/10/16 at 10:52pm and again on 10/10/16 at 11:27pm staff documented removing one tablet each time for the "med pass".
-According to the "Inventory Sheet" three 0.5mg tablets were removed for the "med pass" 2 hours and 15 minutes apart between 10/10/6 at 9:12pm and 10/10/16 at 11:27pm.
-On 10/17/16 at 5:45pm staff documented that two tablets were disposed leaving 39 remaining tablets.
-On 10/17/16 at 9:05pm staff documented that one tablet was removed for the "med pass". (According to the October 2016 eMAR, Resident #3 refused his 10/17/16 administration of Clonazepam for 8:00pm.)
-There was no documentation that the Clonazepam removed on 10/17/16 at 9:05pm was returned to the count or disposed of.

Review of Resident #3's Clonazepam dispensing record, September and October 2016 eMARs and "Inventory History" sheets for 9/1/16 through 10/31/16 revealed:
-There was no documentation that 12 of the 60 tablets dispensed on 9/6/16 were administered or removed from the inventory.
-There were three additional tablets documented on 10/8/16 with no documentation of new inventory.
-There were three additional doses documented as administered on 10/9/16 at 1:48am, 10/10/16 at 10:52pm and 10/10/16 at 11:27pm.

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D 392	Continued From page 96 -Two tablets were disposed of on 10/17/16 at 5:45pm prior to Resident #3 refusing the 8pm dose on 10/17/16. -There was no documentation of disposal or return to the count for the Clonazepam removed on 10/17/16 at 9:05pm which the resident refused. -There were a total of 9 Clonazepam inaccurately accounted for in October 2016 for Resident #3. Attempts to interview the Medication Aide (MA), a former MA, and the former Memory Care Manager (MCM); who documented the discrepancies were unsuccessful on 11/16/16 and 11/21/16. Review of Resident #3's November 2016 eMAR revealed: -There was an entry for Clonazepam 0.5mg that staff documented administering twice daily at 8:00am and 8:00pm except 11/2/16, 11/3/16 and 11/4/16 at 8:00pm. -Staff documented under exceptions that the resident refused on 11/2/16 and the Clonazepam was held per Primary Care Provider (PCP) orders on 11/3/16 and 11/4/16. -There were 28 doses documented as administered 11/1/16 through 11/16/16. Review of Resident #3's "Inventory History" sheet for Clonazepam dated 11/1/16 through 11/17/16 revealed the remaining count on 11/17/16 at 7:51am was 41 tablets. Observations of medications on hand for Resident #3 on 11/16/16 at 5:10pm revealed: -There was a bubble pack with a pharmacy label with Resident #3's name for Clonazepam 0.5mg with instructions to take twice daily. -The pack indicated 30 capsules were dispensed	D 392		

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on 11/2/16 and 43 tablets remained.

Review of Resident #3's dispensing records from 9/6/16, 10/3/16 and 11/2/16, the September, October and November 2016 eMARs and medications on hand revealed:
-There was a total of 180 Clonazepam dispensed and a total of 131 tablets documented as administered leaving 49 tablets.
-There were 43 tablets on hand resulting in 6 tablets unaccounted for.

B. Review of pharmacy dispensing records for Resident #3 revealed 30 capsules of Temazepam 15mg was dispensed on 9/13/16, 10/17/16 and 11/12/16.

Review of Resident #3's September 2016 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Temazepam 15mg at bedtime that staff documented administering daily at 8:00pm except on 9/3/16, where it was noted under exceptions that the resident was in the hospital.
-There were 17 doses administered from 9/14/16 through 9/30/16.

Review of Resident #3's October 2016 eMAR revealed:
-There was an entry for Temazepam 15mg at bedtime that staff documented administering daily at 8:00pm except on 10/17/16, where it was noted under exceptions that the resident refused at 9:05pm.
-There were 30 doses documented as administered 10/1/6 through 10/31/16.

Review of Resident #3's "Inventory History" sheet for Temazepam dated 9/13/16 through 10/31/16

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revealed:
-On 9/13/16 at 11:43pm staff documented receiving 30 tablets with a remaining count of 33 capsules.
-On 10/8/16 at 7:08am staff documented a reconciliation of the count as 9 capsules remaining.
-On 10/8/16 at 8:36pm staff documented removing one capsule for the "med pass" leaving 11 capsules.
-There was no documentation that two additional capsules were received or returned to the count.
-On 10/9/16 at 1:48pm staff documented removing one capsule for the "med pass" leaving 10 capsules.
-According to the "Inventory History" sheet, two 15mg capsules were removed for the "med pass" 5 hours and 12 minutes apart between 10/8/16 at 8:36pm and 10/9/16 at 1:48pm.
-On 10/10/16 at 9:12pm and again on 10/10/16 at 11:27pm staff documented removing one capsule each time for the "med pass".
-According to the "Inventory Sheet" two 15mg capsules were removed for the "med pass" 2 hours and 15 minutes apart between 10/10/6 at 9:12pm and 10/10/16 at 11:27pm.

Review of Resident #3's October 2016 eMAR and Temazepam "Inventory History" sheet revealed:
-There were two additional tablets documented on 10/8/16 with no documentation of new inventory.
-There were two additional doses documented as administered on 10/9/16 at 1:48am and 10/10/16 at 11:27pm.
-There were a total of 4 Temazepam inaccurately accounted for in October 2016 for Resident #3.

Attempts to interview the Medication Aide (MA), a former MA, and the former Memory Care

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Manager (MCM); who documented the discrepancies were unsuccessful on 11/16/16 and 11/21/16.

Review of Resident #3's November 2016 eMAR revealed:
-There was an entry for Temazepam 15mg at bedtime that staff documented administering daily at 8:00pm except on 11/2/16, 11/3/16, 11/4/16, 11/10/16, 11/11/16 and 11/12/16.
-Staff documented under exceptions that the resident refused on 11/2/16; the Temazepam was held per Primary Care Provider (PCP) orders on 11/3/16 and 11/4/16; and that there was a new order on 11/10/16, 11/11/16 and 11/12/16.
-There were 9 doses documented as administered from 11/1/16 through 11/15/16.

Review of Resident #3's "Inventory History" sheet for Temazepam dated 11/1/16 through 11/16/16 revealed:
-On 11/9/16 at 8:02pm staff documented removing one capsule for the "med pass" leaving 10 capsules remaining.
-The next entry on the "Inventory History" sheet was on 11/12/16 at 9:28pm where staff documented receiving a delivery of 30 capsules leaving a remaining count of 30 capsules.
-According to Resident #3's November 2016 eMAR, he did not receive Temazepam on 11/10/16, 11/11/16 and 11/12/16 leaving 10 capsules unaccounted for.
-The remaining count on 11/16/16 at 9:44pm was 26 tablets.

Observations of medications on hand for Resident #3 on 11/16/16 at 5:10pm revealed:
-There was a bubble pack with a pharmacy label with Resident #3's name for Temazepam 15mg with instructions to take daily at bedtime.

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-The pack indicated 30 capsules were dispensed on 10/17/16. There were 4 capsules remaining.
-There was a second bubble pack with a pharmacy label with Resident #3's name for Temazepam 15mg with instructions to take daily at bedtime.
-The pack indicated 30 capsules were dispensed on 11/12/16. There were 30 capsules remaining.

Based on review of Resident #3's Temazepam "Inventory History" sheet and observation of medications on hand, there were 9 tablets on hand that were not accounted for on the "Inventory History" sheet.

Review of Resident #3's dispensing records from 9/6/16, 10/3/16 and 11/2/16, the September, October and November 2016 eMARs and medications on hand revealed there was a total of 90 Temazepam dispensed and a total of 56 tablets documented as administered leaving 34 tablets.

Attempts to interview the MA on 11/16/16 at 11:56am, who documented the dose administered on 11/9/16 and the doses not administered on 11/11/16 and 11/12/16, were unsuccessful.

Interview with a MA on 11/16/16 at 4:55pm revealed:
-The count for controlled drugs was incorrect a lot.
-The eMAR did not always subtract from the count when a medication was given.
-For this reason, the MA signed the bubble pack for each controlled drug she removed from the pack.
-The MA did not know why the eMAR system did not always subtract from the count but thought it

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might be that sometimes the MAs did not "click on" the medication when it was on the screen properly.
-Controlled drugs were removed from the bubble pack, administered to the resident and then the MA electronically signed by clicking on the medication and verifying the count.

Interview with a second MA on 11/22/16 at 12:44pm revealed:
-The notation of reconciliation on the "Inventory History" sheet indicated staff conducted a count of controlled drugs on the medication cart.
-Staff were supposed to count all controlled drugs on the medication cart every shift.
-Controlled drugs were delivered to the facility on 2nd shift and the MA on duty added the amount received to the inventory on the electronic record.
-There would only be additional removals of a medication if there was a PRN (as needed) order from the Primary Care Provider (PCP).
-Refused or dropped controlled drugs were entered on count sheets and recorded as disposed on the eMAR.

Review of PCP orders for Resident #3 revealed there were no subsequent orders for additional or PRN orders for Clonazepam or Temazepam.

The facility count sheets were not available for review.

Interview with the Executive Director (ED) on 11/17/16 at 10:15am and 3:55pm revealed:
-The controlled drug records were kept on the electronic medication administration system and there were no written controlled drug logs.
-Staff were expected to alert the Memory Care Manager (MCM) or the ED if the electronic controlled substance count did not reconcile.

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-The MCM or the ED would check if the controlled substance count was off due to showing up under a missed medication related to not being "clicked off" appropriately during the medication pass.
-The electronic medication administration system had a dash board the ED or the MCM checked every morning for alerts on missed medications.
-If there were any discrepancies in the electronic controlled drug counts or missed medications, the ED or the MCM would talk to the MA on duty to resolve it.
-The ED or the MCM could also suspend orders in the electronic medication administration system for residents who were hospitalized to minimize documentation errors.

Confidential interview with a staff on 11/17/16 revealed:
-There had been a problem with Oxycodone going missing from the facility which occurred around Halloween 2016. (Oxycodone is an Opioid used to treat pain.)
-The Oxycodone was kept in a locked cabinet in the medication room for return to the pharmacy.
-There had been a video camera in the medication room but the recorder box was intentionally broken within the same 24 hour period the Oxycodone went missing by a MA that no longer worked at the facility.
-There was a second MA who appeared to be under the influence of narcotics while at work.
-The MA would be mean and rude to coworkers and residents when she wasn't "high" and talkative and nice when she was high.
-The ED was aware of the missing Oxycodone, the broken video recorder box and the allegations of the MA working while under the influence of narcotics.

Confidential interview with a second staff on

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11/21/16 revealed:
-Staff had witnessed a MA (the same MA reported by 1st confidential interviewee) not administer controlled drugs to Resident #3 as well as several other residents on many occasions.
-Staff had witnessed the MA say she administered a controlled drug but had never gone down to the resident's room.
-The MA would come to work "high on drugs ...chatty and nice" and when she was not "high" she was mean.
-Residents had complained to the ED of not receiving pain medications and about being in pain after receiving pain medications.
-Many other staff knew the MA was taking controlled drugs off the medication cart.
-Staffs concerns about this MA had been reported to the ED many times but the staff felt it needed to be reported to someone else because nothing was being done about it.

Interview with the ED on 11/17/16 at 5:59pm revealed:
-There was an incident involving missing controlled drugs for one resident.
-The ED could not recall who the resident was, what controlled drug it was, how the incident came to her attention and when the incident occurred except that it was before the former MCM left the facility (early November 2016).
-She reported discussing concerns with the pharmacy regarding increased PRN (as needed) usage of a controlled drug for one resident.
-She could not recall whether the facility contacted the pharmacy or the pharmacy contacted the facility.
-She did not think she was alerted by the dash board on the electronic medication administration system because it would only show up on the dash board if it was a missed medication.

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-She thought she may have become aware of the incident because there was concern the resident was having more pain, and an eMAR audit was done by the MCM who reviewed medications on the cart and compared that to inventory lists and the eMAR.
-Excess controlled drugs and those for return to pharmacy were stored in a locked cabinet in the medication room.
-MAs had a key to the medication room and the locked cabinet.
-Controlled drugs that were kept in the medication room cabinet were not counted by staff, only the controlled drugs on the medication carts were counted each shift.
-She was not aware of any complaints from residents or family members regarding not receiving pain medications or having uncontrolled pain.
-There were cameras in the facility but a former MA reported the recorder box had been broken by a resident who threw water on it approximately two weeks ago (early November 2016) on 2nd or 3rd shift.
-Discrepancies on the electronic count were reported to the Corporate Nurse by the ED and followed up with staff to resolve.
-She was not aware of any suspicious behavior of staff related to possible substance abuse at work.
-The facility policy was to conduct a urine drug screen upon hire at the facility; and for suspicious behavior at work and with all workers compensation incidents employees were sent to a third party and accompanied by a facility department head.

The facility controlled drug return sheets were not available for review.

Telephone interview with the Pharmacist on

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D 392	Continued From page 105 11/22/16 at 1:07pm revealed: -The pharmacy dispensed Clonazepam and Temazepam for Resident #3. -The pharmacy had access to the facility's eMAR and would not dispense controlled drugs unless there were less than eight day's supply remaining. -She did not know what the system showed the facility when the controlled drug count was off but the count was definitely off on the Temazepam by 10 tablets on 11/9/16. -The pharmacy return sheets were not exclusive to controlled drugs, they included all drug returns and would therefore not readily identify errors. -There were dispenses on 8/22/16 and 9/23/16 for another resident for a controlled drug that were not recorded on the inventory on the eMAR which was strange. -Facility staff was responsible for adding inventory to the eMAR system upon receiving delivery from pharmacy. The ED was not available for interview on 11/21/16 and 11/22/16. ______________________________ Review of the facility's Plan of Protection dated 11/22/16 revealed: -A Registered Nurse and the Interim Administrator will immediately conduct a narcotic count and compare to the electronic count. -A temporary policy will be implemented requiring two signatures for any narcotic administered. -The pharmacy will conduct a pharmacy review and cart audit. -The Divisional Care Manager will conduct a narcotic administration review for the last 90 days. -The facility will conduct weekly medication cart audits to compare medications administered to medications on hand.	D 392		

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D 392	Continued From page 106 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 01/06/2017.	D 392		
{D 465}	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Non-compliance continues with increased severity resulting in detriment to the residents. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of the residents in the Special Care Unit (SCU) for 9 of 9 shifts sampled from 09/23/16-09/25/16, 3 of 9 shifts sampled from 10/16/16-10/18/16, and 5 of 9 shifts sampled from 11/01/16-11/03/16. The findings are: Confidential staff interview revealed: -Residents were supposed to be showered every other day and given a sponge bath on non-shower days. -There was not enough staff on duty to provide	{D 465}		

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the care the residents needed, especially on the weekends.

Confidential interview with a second staff member revealed:
-There were usually two or three staff members in the dining room serving and feeding residents during meal times while the Dietary Aide served the drinks.
-There was not enough staff to feed the residents at the center table; some staff had to feed more than one resident at a time.

Confidential interview with a third staff member revealed:
-Twelve residents required feeding asistance and there was usually only two staff to feed them.
-There was not enough staff to get the residents' two hour brief checks completed or shower the residents.

Confidential interview with a fourth staff member revealed:
-On first shift, there was usually two Personal Care Aides (PCAs) assisgned to each of the 100 and 200 halls and one MA assigned to each hall, for a total of six staff on first shift.
-"Sometimes" there was a "floater" PCA who worked both halls on first shift, for a total of seven staff on first shift.
-There was sometimes not enough staff to meet the residents needs.
-The staff did not know how many staff were routinely sceduled on the other shifts.

Interview with a PCA on 11/17/16 at 7:17pm revealed:
-PCAs were responsible for feeding residents who were seated at the middle table for each meal.

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-There were a lot of residents who needed feeding assistance and not enough PCAs.

Review of Daily Census Reports (DCRs) dated 09/23/16-09/25/16 revealed the facility census was 60 from 09/23/16-09/25/16, requiring 60 hours of staff time on first and second shifts and 48 hours of staff time on third shift.

Review of the "Punch Detail" Report (PDR) dated 09/23/16 revealed the facility was short in staffing hours on all three shifts: only 56.19 staff hours were provided on first shift, 56.75 hours were provided on second shift, and 38.22 hours were provided on third shift.

Review of the PDR dated 09/24/16 revealed the facility was short in staffing hours on all three shifts: only 51.85 staff hours were provided on first shift, 54.35 hours were provided on second shift, and 46.25 hours were provided on third shift

Review of the PDR dated 09/25/16 revealed the facility was short in staffing hours on all three shifts: 52.01 staff hours were provided on first shift, 59.03 hours were provided on second shift, and 38.82 hours were provided on third shift.

Review of DCR dated 10/16/16 revealed the facility census was 57, requiring 57 hours of staff time on first and second shifts and 45.6 hours of staff time on third shift.

Review of the PDR dated 10/16/16 revealed the facility was short in staffing hours on all three shifts: 51.87 staff hours were provided on first shift, 39.02 hours were provided on second shift, and 29.85 hours were provided on third shift

Review of the DCRs and PDRs dated

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{D 465}	Continued From page 109 10/17/16-10/18/16 revealed the facility provided the minimum staffing hours on all three shifts from 10/17/16-10/18/16. Review of DCRs dated 11/01/16-11/03/16 revealed the facility census was 56 from 11/01/16-11/03/16, requiring 56 hours of staff time on first and second shifts and 44.8 hours of staff time on third shift. Review of the PDR dated 11/01/16 revealed the facility was short in staffing hours on second shift with only 43.07 hours provided. Review of the PDR dated 11/02/16 revealed the facility was short in staffing hours on second and third shifts: 53.25 staff hours were provided on second shift, and 42.71 staff hours were provided on third shift. Review of the PDR dated 11/03/16 revealed the facility was short in staffing hours on second and third shifts: 46.58 hours were provided on second shift, and 41.85 hours were provided on third shift. Observation of the supper meal on 11/15/16 from 5:05pm-5:40pm revealed: --There were twelve residents seated at the center table. -There were three NA/PCA staff in the dining room serving food and assisting residents and one dietary staff serving beverages to the residents. -Resident #8 was using her fingers to attempt to eat a pureed meal and had food on her face; there was no staff available to intervene or assist her. Observation of the breakfast meal on 11/16/16	{D 465}		

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from 08:00am -08:39am revealed:
-There were 10 residents seated at the center table and 4 staff assisting the residents with eating at the center table.
-Resident #8 was using her left hand attempting to eat her pancakes; the pancakes fell off of the fork multiple times before Resident #8 could get the food into her mouth. There was no staff available to intervene or assist Resident #8 to eat.

Observation on 11/17/16 at 12:10pm revealed a urine odor was detectable at a distance of three feet from Resident #8 in the dining room during the lunch meal.

Interview with a MA on 11/15/16 at 09:27am revealed Resident #8 had to be fed by staff and required incontinent care by staff.

Observations on 11/16/16 at 11:53am and 11/17/16 at 10:51am and 5:12pm revealed Resident #3 was wearing the same blue jeans, red plaid shirt and blue jacket.

Observations on 11/17/16 from 12:01pm until 1:30pm revealed:
-Resident #3 was in his room lying on his bed fully dressed, sleeping.
-A PCA entered Resident #3's room at 1:24pm and asked "Are you okay? Did you eat today?"
-The PCA did not have a plate of food or drink to offer and encourage the resident to eat and drink.
-The PCA returned at 1:30pm with a MA, who gave the resident his medications.

Confidential staff interview revealed:
-Personal care for the residents at the facility was a concern on 2nd and 3rd shift and all shifts on the weekends because there was not enough staff to take care of the residents.

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-The 2nd shift usually had one MA and four PCAs for approximately 55 residents.
-PCAs were responsible for assisting residents in the dining room with meals and assisting residents who stayed in their room for meals.
-There was not enough staff to assist all the residents who needed assistance and that was why residents like Resident #3 were forgotten about in their rooms.
-The PCAs did the best they could for the residents and usually did not receive help from other staff except for one MA who consistently helped with personal care tasks when she was not administering medications.

Confidential interview with a family member revealed:
-The family member visited the facility weekly and would find the resident in the same clothes from the week before which were filthy and smelled bad.
-The family member had asked staff about showering the resident and staff would tell the family member clean clothes were laid out for the resident each day and the resident was independent with showering.
-The family member was told by staff they could not make him shower.
-The family member expected staff to coach and help the resident to bath and put on clean clothes each day.
-The resident had never had problems with taking a shower, did not have a history of refusing and just needed assistance.
-The family member had discussed concerns with the Executive Director (ED) a few times in the last few months and nothing was done about making sure the resident was showered and shaved.

Confidential telephone interview with a second

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family member/Power of Attorney (POA) revealed:
-The POA did not have any concerns about the resident's personal care until the "last couple of months."
-The resident was taken to the hospital in November 2016.
-The POA "couldn't believe" what the resident looked like upon arriving at the hospital; the POA could not believe how dirty the resident was and how bad the resident smelled.
-"Apparently, they weren't bathing" the resident.
-The resident "stunk", had dried food on their mouth, had "filthy" feet, and the resident's teeth were so dirty the POA "was gagging" when cleaning them.
-The POA called the ED regarding the concerns about one week later (unsure of the date in November 2016), because the POA "needed to calm down."
-The POA told the ED the resident had been "neglected" before going to the hospital; the ED was "unaware of any of it."
-The ED never called the POA back; the POA expected a return call from the ED after the ED found out about it.

Interview with the ED on 11/17/16 at 7:00pm revealed:
-She was covering the MCM position which meant handling concerns related to resident care and medical issues.
-She was not aware of any recent complaints related to personal care and expected staff to provide personal care for residents according to their care plan and as needed.

The ED was not available for interview on 11/21/16 and 11/22/16.

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{D 465}	Continued From page 113 The failure of the facility to assure the minimum number of staff were present at all times to provide feeding assistance, assist residents with bathing, dressing, oral care, shaving, and other personal care was detrimental to the health and welfare of the residents. This non-compliance constitutes a TYPE B violation. ______________________________ Review of the facility's Plan of Protection dated 11/22/16 revealed: -The facility would immediately review staffing for all shifts to ensure shifts were staffed according to state guidelines. -The ED/designee would review the daily assignment sheets to review staff coverage. -Staff scheduled would not be allowed to leave the facility at the end of their shift until their relief had arrived or until a manager had relieved him/her of their shift. -There would be a manager on duty on the weekends to assure all shifts were adequately staffed. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 01/06/2017.	{D 465}		
{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	{D912}		

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review, the faciliy failed to assure each resident received care and services which were adequate, appropriate, and in substantial compliance with the rules and statues as related to nutrition and food services, controlled substances, special care unit staffing, and residents' rights.

The findings are:

1. Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served to 4 of 5 residents sampled (#2, #3, #5, #8,) who had orders for therapeutic diets, thickened liquids, and dietary supplements. [Refer to Tag D310, 10A NCAC 13F. 0904 (e)(4) Nutrition and Food Service (Type Unabated B Violation)].

2. Based on observations and interviews, the facility failed to assure residents were provided feeding assistance in manner which promoted dignity and respect and staff sat to feed residents who required assistance for 4 of 4 meals and 1 of 1 snack observed. [Refer to Tag D312, 10A NCAC 13F .0904 (f)(2) Nutrition and Food Service (Type Unabated B Violation)].

3. Based on observations and interviews, the facility failed to ensure residents were treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy related to moving freely in the community dining room at meal times. [Refer to Tag D338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)].

4. Based on observations, interviews and record reviews, the facility failed to maintain an accurate and readily retrievable record of controlled drugs resulting in inaccurate records for Clonazepam

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	HAL071015	A. BUILDING: ______ B. WING ______	R-C 11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

(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
{D912}	Continued From page 115 and Temazepam for 1 of 2 residents (#3) with orders for controlled substances. [Refer to Tag D465, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of the residents in the Special Care Unit (SCU) for 9 of 9 shifts sampled from 09/23/16-09/25/16, 3 of 9 shifts sampled from 10/16/16-10/18/16, and 5 of 9 shifts sampled from 11/01/16-11/03/16. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)].	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record review, the faciliy failed to assure each resident was free of neglect related to healthcare, medication administration, and management of the facility. The findings are: 1 .Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider of acute health care needs of 3 of 5 sampled residents (#1, #2 and #5) where one resident did not receive a prescribed antibiotic resulting in hospitalization with a diagnoses of Sepsis (#5); for a second resident with eleven	D914		

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D914	Continued From page 116	D914		

finger stick blood sugar results greater than 401 (#1); and for a third resident who needed a two-day follow up evaluation after a hospital visit (#2). [Refer to Tag D273, 10A NCAC 13F. 0902(b) Health Care (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 3 of 5 residents (#1,#2, #5) sampled for record review as evidenced by Resident #5 not receiving an antibiotic resulting in hospitalization with diagnosis of sepsis; Resident #5 not receiving a diuretic, a blood pressure medication, an anti-diabetic, and a behavior medication as ordered by the prescriber; Resident #1 not receiving sliding scale insulin per the provider orders; and Resident #2 not receiving a medication for drooling and a medication for vomiting; and 2 of 6 residents (#1, #10) observed during the medication pass including significant errors with an inhaler and a medication used to treat depression. [Refer to Tag D358, 10A NCAC 13F. 1004 Medication Administration (Type A1 Violation)].

3. Based on observations, interviews and record reviews, the Administrator failed to assure the management, operations, and policies/procedures of the facility were implemented to ensure and maintain each residents' rights as evidenced by failing to maintain substantial compliance with the rules and statutes regarding medication administration, health care, nutrition and food services, Special Care Unit staffing hours, controlled substances, and residents' rights, all of which are the responsibility of the Administrator. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)].

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D980	G.S. § 131D-25 Implementation	D980		

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 A1 VIOLATION

Based on observations, interviews and record reviews, the Administrator failed to assure the management, operations, and policies/procedures of the facility were implemented to ensure and maintain each residents' rights as evidenced by failing to maintain substantial compliance with the rules and statutes regarding medication administration, health care, nutrition and food services, Special Care Unit staffing hours, controlled substances, and residents' rights, all of which are the responsibility of the Administrator.

The findings are:

Non-compliance was identified in the following areas:
1 .Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider of acute health care needs of 3 of 5 sampled residents (#1, #2 and #5) where one resident did not receive a prescribed antibiotic resulting in hospitalization with a diagnoses of Sepsis (#5); for a second resident with eleven finger stick blood sugar results greater than 401 (#1); and for a third resident who needed a

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D980	Continued From page 118	D980		

two-day follow up evaluation after a hospital visit (#2). [Refer to Tag D273, 10A NCAC 13F. 0902(b) Health Care (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 3 of 5 residents (#1,#2, #5) sampled for record review as evidenced by Resident #5 not receiving an antibiotic resulting in hospitalization with diagnosis of sepsis; Resident #5 not receiving a diuretic, a blood pressure medication, an anti-diabetic, and a behavior medication as ordered by the prescriber; Resident #1 not receiving sliding scale insulin per the provider orders; and Resident #2 not receiving a medication for drooling and a medication for vomiting; and 2 of 6 residents (#1, #10) observed during the medication pass including significant errors with an inhaler and a medication used to treat depression. [Refer to Tag D358, 10A NCAC 13F. 1004 Medication Administration (Type A1 Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served to 4 of 5 residents sampled (#2, #3, #5, #8,) who had orders for therapeutic diets, thickened liquids, and dietary supplements. [Refer to Tag D310, 10A NCAC 13F. 0904 (e)(4) Nutrition and Food Service (Type Unabated B Violation)].

4. Based on observations and interviews, the facility failed to assure residents were provided feeding assistance in manner which promoted dignity and respect and staff sat to feed residents who required assistance for 4 of 4 meals and 1 of 1 snack observed. [Refer to Tag D312, 10A NCAC 13F .0904 (f)(2) Nutrition and Food

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D980	Continued From page 119	D980		

Service (Type Unabated B Violation)].

5. Based on observations and interviews, the facility failed to ensure residents were treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy related to moving freely in the community dining room at meal times. [Refer to Tag D338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)].

6. Based on observations, interviews and record reviews, the facility failed to maintain an accurate and readily retrievable record of controlled drugs resulting in inaccurate records for Clonazepam and Temazepam for 1 of 2 residents (#3) with orders for controlled substances. [Refer to Tag D465, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

7. Based on observations, interviews, and record reviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of the residents in the Special Care Unit (SCU) for 9 of 9 shifts sampled from 09/23/16-09/25/16, 3 of 9 shifts sampled from 10/16/16-10/18/16, and 5 of 9 shifts sampled from 11/01/16-11/03/16. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)].

The Administrator's failure to assure policies and procedures were implemented to provide appropriate care and services maintained within substantial compliance of the state rules and statutes resulted in a delay in Resident #5 receiving antibiotics, a delay in Resident #5's physician being notified, and an in-patient hospitalization requiring intravenous antibiotic treatment for diagnosis of sepsis. This

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D980	Continued From page 120 non-compliance constitutes a TYPE A1 violation for serious harm and neglect. ______________________ Review of the Plan of Protection submitted by the facility dated 11/18/16 revealed: -The current Administrator would be provided onsite supervision by Regional Director who is a licensed Administrator or qualified designee to ensure systematic re-implementation of facility processes to include but not limited to nutrition and food services, medication administration, health care referral and follow up, and recruiting and training a qualified Memory Care Manger (MCM). -A temporary qualified MCM would be designated until a permanent MCM was assigned. -New processes and procedures would be developed and implemented to include audits, oversight, as defined daily, weekly, monthly, and/or quarterly by a corporate representative, clinical support specialist, and quality assurance nurse. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 12/22/2016.	D980		