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D 000	Initial Comments The Adult Care Licensure Section and the Craven County Department of Social Services conducted an annual survey and complaint investigation on March 29 - 31, 2017. The complaint investigation was initiated by the Craven County Department of Social Services on March 6, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure walls, ceilings, and floors were kept clean and in good repair for 5 of 5 common resident bathrooms, residents' bedrooms, the hallway, and the chapel. Observation of the bathroom in Resident Room #6 on the blue hall on 03/29/17 at 10:36 a.m. revealed: -There was missing paint behind the handrail near the toilet and on the wall behind the sink. -There were 2 pieces of metal on the wall below the handrail with missing paint around the 2 metal pieces. -The metal pieces appeared to be brackets for a toilet paper holder. -There was no toilet paper holder in the bathroom. -There was a roll of toilet paper on top of the handrail propped against the wall.	D 074		

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D 074	Continued From page 1 Interview with a resident who lived in Room #6 on 03/29/17 at 10:36 a.m. revealed: -She had lived in the facility for about 6 years. -There was a toilet paper holder in the bathroom but it fell off the wall over a year ago. -She propped the toilet paper roll on the handrail against the wall. Interview with the Maintenance Technician on 03/29/17 at 3:40 p.m. revealed: -He was not aware of missing paint or the toilet paper holder in Resident Room #6. -He had not seen a work order for it. -The issue was things were not reported and if not reported, there would not be a work order. -Staff were supposed to report any issues or concerns to the Administrator. Observation of the bedroom and bathroom in Resident Room #7 on the blue hall on 03/29/17 at 10:46 a.m. revealed: -There were strips and pieces of popcorn ceiling hanging down around the edges of the bedroom that had peeled away from the ceiling. -There was an area of white paint with 2 holes on the wall beside the mirror that was about 2 feet long and 1 foot wide. -There were multiple small holes and missing paint on the wall below the handrail near the toilet. -There was no toilet paper holder in the bathroom. -There was a roll of toilet paper on top of the handrail propped against the wall. Interview with the two residents residing in Room #7 on 03/29/17 at 10:57 a.m. revealed: -They have lived at the facility from 1 to 2 years. -The holes on the wall had always been that way.	D 074		

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-They never had a toilet paper holder on the wall in the bathroom since they moved in.
-They prop the toilet paper roll on the handrail against the wall.
Observation of Resident Room #8 on the blue hall on 03/29/17 at 4:08 p.m. revealed there was an area of popcorn ceiling above the resident's bed that was missing paint and peeling.

Interview with the resident in Room #8 on 03/29/17 at 4:08 p.m. revealed:
-The ceiling had flaked off and landed on her bed for approximately 3 months.
-She had informed the prior Administrator approximately 3 months ago but the ceiling had not been repaired.

Observation of Resident Room #29 on the blue hall on 03/29/17 at 4:06 p.m. revealed the wall had a broken outlet cover with a connector cord hanging out of the cover.

Observation of the ceiling of Resident Room #42 on the green hall on 03/29/17 at 4:45 p.m. revealed peeling paint around the air vent.

Observation of the air condition unit in Resident Room #67 on the green hall on 03/29/17 at 10:50 a.m. revealed:
-There was visible sunlight shining through the right side of the unit, where the unit was not flush with the wall.
-The largest part of the hole was about 1/4 of a inch.
-There was no caulking or molding around the unit.

Interview with the resident that lived in Room #67 on 03/29/17 at 10:50 a.m. revealed:
-The resident was moved to Room #67 about 3

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months ago.
-The air conditioning unit had a hole in the wall around it since he moved in.
-The resident was worried that a snake could fit between the hole and come in.

Observation of the floor of Resident Room #70 on the green hall on 03/29/17 at 3:40 p.m. revealed the linoleum was peeling up at the entranceway to the bathroom.

Interview with the resident on 03/29/17 at 3:40 p.m. revealed:
-She was previously in another room that was damaged during a storm at the end of last year (2016).
-She was moved to room #70 so they could repair her old room.
-The floor in the bathroom had been peeling up since she moved to the room.
-The floor was new and needed something to connect the linoleum bathroom floor to the flooring in the bedroom.
-She had never tripped because of the floor peeling.

Observation in the hallway outside of Resident Room #61 on 03/29/17 at 4:29 p.m. revealed a non-functioning wall heater that was dusty with rusted slats.

Observation of the common shower room on the green hall beside Resident Room #51 on 03/29/17 at 4:30 p.m. revealed the metal divider walls for the toilet stall were rusted and had missing paint.

Observation of the common tub room on the green hall beside Resident Room #50 on 03/29/17 at 4:33 p.m. revealed:

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D 074	Continued From page 4 -The bottom of the wall beside the toilet had a 3 foot long scuff of missing paint horizontal to the floor. -The metal divider walls for the toilet stall were rusted and had missing paint. Observation of the shower room beside Resident Room #43 on the green hall on 03/29/17 at 4:39 p.m. revealed: -There was missing paint behind the paper towel holder on the wall behind the sink. -There were 2 pieces of metal on the wall beside the paper towel holder, what appeared to be an old towel rod. Observation of the common bath and spa room beside Room #5 on the blue hall on 03/29/17 at 11:04 a.m. revealed: -The metal divider walls for the toilet stall were rusted and had missing paint. -There was a puddle of water about 2 feet in diameter in the middle of the bathroom floor near the metal floor drain. -The floor was not level where the puddle had formed, preventing the water from going down the metal floor drain. -The ceiling vent was rusted. -The one inch molding at the top of the wall near the ceiling was missing on the wall near the shower and the wall near the toilet, exposing the wooden board underneath. Interview with Maintenance Technician on 03/29/17 at 4:40 p.m. revealed: -It appeared the floor had sunk near the middle of the floor and was preventing the water from flowing to the metal drain. -He was not aware the water was not draining properly. -Wheelchairs running into the metal walls of the	D 074		

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toilet stall caused the paint to chip and the walls to rust.
-They needed painting and he had not seen that task on any work orders.
-He did not know why the molding on the wall near the ceiling had been removed.
-He showed it to his boss a couple of weeks ago and they plan to put the molding back up.

Observation of the common bath and spa room beside Room #4 on the blue hall on 03/29/17 at 11:19 a.m. revealed:
-There was an area on the wall that was about 6 inches wide and 12 inches long with missing paint and holes.
-It was located beside a paper towel holder and appeared to be an area where another paper towel holder had been installed previously.

Interview with Maintenance Technician on 03/29/17 at 4:45 p.m. revealed:
-He was not aware of the missing paint and holes in the wall
-The wall needed patching and painting.

Observation of the facility's chapel on the blue hall on 03/29/17 at 10:21 a.m. revealed:
-There were 3 ceiling vents that were rusted and had black stains.
-One of the rusted ceiling vents had brown stains on the ceiling around the vent in multiple areas.
-The second rusted ceiling vent had areas of missing textured paint (popcorn ceiling) around it where white plaster had been applied.
-The third rusted ceiling vent had areas of missing textured paint and the underlying gray material could be seen around the vent.
-There were strips and pieces of popcorn ceiling hanging down around the edges of the room that had peeled away from the ceiling.

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-There was an electrical outlet on the back wall near the entrance door that had a faceplate underneath it that was broken off at the bottom leaving about ½ inch hole in the wall.

Interview with a personal care aide on 03/29/17 at 10:27 a.m. revealed:
-She had worked at the facility for about 20 years.
-She did not come in the chapel often so she had not noticed the peeling ceiling or the rusted ceiling vents with stained or missing paint.
-She did not know how long it had been that way or if there were any plans to repair it.

Interview with the Maintenance Technician on 03/29/17 at 3:25 p.m. revealed:
-The ceiling in the chapel had been that way since he started working at the facility about 9 months ago.
-He had not been asked to do any repairs to the chapel and he had not done any yet.
-He would take down the ceiling vents, sand them, paint them, and put them back up.
-He was not aware of the broken faceplate cover on the wall in the chapel.
-The faceplate covered an empty electrical box with no wires and he would repair it.
-The popcorn ceiling was peeling off in some area probably because of moisture.

Interview with the Maintenance Technician on 03/29/17 at 3:25 p.m. revealed:
-He had been working at the facility for about 9 months.
-The facility's corporation used an electronic system to generate work orders.
-The Administrator submitted any needed repairs into the electronic system to the Maintenance Technician's boss.
-He would get electronic work orders from his

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D 074	Continued From page 7 boss. -He would then decide which work orders to do first and do the needed repairs. -He was not allowed to make any repairs that were not on work orders. -Everything had to go through the Administrator and then into the electronic work order system in order to account for their working time. -He would sometimes do a walk-thru of the facility to look for needed repairs. -He had recently been busy working on leaks, broken items and catching up on maintenance repairs that were outstanding when he started this job. Interview with the Administrator on 03/29/17 at 6:30 p.m. revealed: -She did a walk-thru of the facility every day and it was her responsibility to identify any maintenance issues. -The Maintenance Technician also did a walk-thru when he was at the facility once a week. -The housekeeping staff should report any environmental issue to her. -Their corporation used an electronic reporting system to submit any needed repairs. -Once submitted, the needed repairs would be put on a work order and could be done by the Maintenance Technician. -The facility recently had a state construction survey so they had been working on making corrections from that survey.	D 074		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency	D 150		

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D 150	Continued From page 8 (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 5 staff sampled (A and D) who provided personal care to residents had successfully completed an 80-hour personal care training and competency evaluation program. The findings are: A.Review of the personnel record for Staff A revealed: -Staff A was hired on 12/28/15 as a Medication Aide (MA). -There was no documentation of personal care training. Observation of Staff A on 03/30/17 at 9:37 a.m. revealed: -Staff A physically assisted a resident to sit up in	D 150		

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bed and physically helped the resident stay in an upright position while the resident took his medications.
-After the resident took his medications, Staff A physically assisted the resident to lay back down on the bed.
-Staff A held onto the resident's upper body as he laid back down and Staff A moved the resident's legs onto the bed from a sitting position to a lying position.

Interview with Staff A on 03/30/17 at 10:20 am revealed:
-She had worked at the facility since 12/2015.
-She worked as a MA.
-She had never worked at the facility as a Personal Care Aide (PCA).
-She had not completed any personal care training.
-She would occasionally help feed residents or push them in a wheelchair.
-She was not aware she needed to have personal care training if she was a Medication Aide.

Refer to interview with the Business Office Manager on 03/30/17 at 9:15 am.

Refer to interview with the Administrator on 03/30/17 at 10:15 am.

B.Review of the personnel record for Staff D revealed:
-Staff D was hired on 12/22/16 as a Personal Care Aide (PCA).
-There was no documentation of personal care training.

Observation on 03/29/17 at 5:05 pm during the dinner meal service revealed Staff D was sitting at a table, feeding a resident.

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D 150	Continued From page 10 Interview with Staff D on 03/29/17 at 4:00 pm revealed he worked at the facility as a PCA. Interview with the Business Office Manager on 03/30/17 at 10:00 am revealed: -Staff D was enrolled now in a personal care training course. -Staff D was hired as a Personal Care Aide and was in the process of training to become a Medication Aide. Refer to interview with the Business Office Manager on 03/30/17 at 9:15 am. Refer to interview with the Administrator on 03/30/17 at 10:15 am. Interview with the Business Office Manager on 03/30/17 at 9:15 am revealed: -She was responsible for personnel records. -She scheduled the necessary trainings for staff. -She was not aware that Medication Aides were required to have personal care training. -She thought that because the Medication Aides did not perform personal care to the residents, then they did not need the training. -She would schedule the personal care training for those that needed it. Interview with the Administrator on 03/30/17 at 10:15 am revealed: -She had worked at the facility for less than a month. -When she started, she was informed that the Business Office Manager was responsible for the staff's personnel records and scheduling trainings. -She was not aware that Medication Aides were	D 150		

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D 150	Continued From page 11 required to have personal care training. -She thought that since the Medication Aides did not perform personal care, they did not need the training. -She did not realize that feeding and assistance with ambulation was considered a personal care task.	D 150		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) who was known to be disoriented, had been ordered to wear a Wanderguard, was known to remove the Wanderguard and had wandered away from the facility. The findings are: Review of Resident #1's current FL2 dated 2/2/17 revealed: -Diagnoses included hypertension, lipedema, Alzheimer's dementia, and lower extremity edema. -"Intermittently" was marked under "Disoriented". -"Wanderer" was marked under "Inappropriate	D 270		

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Behavior".
-"Ambulatory" was marked under "Ambulatory Status".
-There was a note of "Treatment: Wanderguard for safety".

Review of Resident #1's Resident Register revealed an admission date of 2/7/14.

Review of an Accident Report dated 3/8/17 for Resident #1 revealed:
-The Activity Director "reported that the resident was at the grocery store".
-The report had been completed by the Executive Director.
-The time of the incident was 4:00 pm.
-The legal guardian of the resident was notified at 5:29 pm.

Attempted interviews on 3/29/17, 3/30/17 and 3/31/17 with the Activity Director revealed she was not available.

Interview with a Medication Aide on 3/30/17 at 10:07 am revealed:
-Medication Aides usually checked Wanderguards during the times indicated on the electronic MAR.
-Resident #1 rarely had her Wanderguard on but as long as she was in the building, Medication Aides made an entry that the Wanderguard was checked.
-She had not observed Resident #1 trying to exit the facility.
-The Medication Aides had been informed by the previous Executive Director to do this since the resident had continuously taken her Wanderguard off.
-She was not aware of whether the Primary Physician for the resident had been notified that

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the resident had been taking her Wanderguard off.
-Due to a staff shortage, she had been working different shifts so she must have accidentally entered that she checked the residents Wanderguard earlier than she should have.

Interview with the Executive Director on 3/30/17 at 9:52 am revealed:
-She had completed an investigation on 3/10/17 regarding how Resident #1 had been able to get out of the facility and how long she had been out of the facility.
-The resident was out of the facility for approximately 35 minutes.
-A Personal Care Aide saw the resident in the lobby at approximately 3:15 pm.
-The Activity Director was waved down by a resident at approximately 3:50 pm.
-Another resident had seen Resident #1 in the parking lot of a shopping center down the street from the community and stopped her because she knew Resident #1 was not supposed to leave the building.
-The Activity Director walked Resident #1 back to the facility and notified the Resident Care Manager.
-Supervision of Resident #1 had been increased to 15 minute checks when she returned to the facility.
-Prior to the resident eloping from the facility, the resident was checked every 2 hours, the same as the other residents.
-The residents Wanderguard was put on the resident when she returned to the facility.
-The staff had assumed that the resident had taken her Wanderguard off.

A second interview with the Executive Director on 3/30/17 at 10:44 am revealed:

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-There was only 1 camera in the facility that worked and it displayed the Medication Room.
-She had no way of knowing when Resident #1 left the facility on 3/8/17.

Observation of the distance from the facility to the grocery store revealed it was approximately one tenth of a mile.

Telephone interview with Resident #1's legal representative on 3/30/17 at 9:18 am revealed:
-She had been notified by facility staff on 3/8/17 that the resident had been found outside the facility.
-She had not been informed exactly where the resident was located but had been under the impression that she was right outside the property.
-She had not been informed how long the resident had been missing but had gotten the impression that the resident was located immediately after she exited the doors.
-She had not been informed that the resident did not have her Wanderguard on when she left the building.
-She had never been informed that the resident refused to wear the Wanderguard or had taken it off.
-Within a month of the resident being admitted to the facility, the staff had requested permission to put a Wanderguard on the resident.
-According to the staff the resident had been exit seeking and repeatedly threatened to leave the facility since admission.

Telephone interview with Resident #1's Primary Care Physician on 3/30/17 at 10:12 am revealed:
-He had been made aware that the resident eloped from the facility on 3/8/17.
-He had not been made aware that the resident

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had been taking her Wanderguard off or refusing to wear it.
-If he had been made aware of this, he would have considered changing the level of care for the resident to a Special Care Unit.
-The Wanderguard was requested by the facility after admission because the resident had been verbally threatening to leave and exit seeking.

Review of Resident #1's Nurse's Notes revealed there were no entries between 2/2/17 and 3/9/17.

Based on observations, interview and record review, Resident #1 was not interviewable.

Observation of Resident #1's room on 3/29/17 at 11:02 am revealed:
-The room was the farthest room from the medication room.
-The room was located beside an exit door that exited into an unsecured part of the facility property.
-The exit door was locked, alarmed when pushed and had a 15 second delayed release.

Observation during the initial tour of survey on 03/29/17 at 10:30 am revealed:
-The exit door beside Resident #1's room was pushed open.
-After 15 seconds of holding the door handle, the door opened and an alarm sounded.
-The door opened into an enclosed area.
-There was another unlocked door that went to the back of the facility.
-The back of the facility was not enclosed and would allow access to the road in front of the facility.
-The road in front of the facility was a two lane road.
-At 10:44 am, a laundry staff responded to the

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alarm, punched in a code and the alarm stopped sounding.
-The staff went through both the doors to the outside and then turned around and came back inside.

Interview with the laundry staff on 03/29/17 at 11:45 am revealed:
-He worked in the laundry department.
-He happened to hear the alarm and came down to deactivate it.
-He did not see anyone outside.
-He was not sure how long the alarm had been sounding.

Observation on 03/29/17 at 3:51 pm revealed:
-There was a shift change and the staff were different.
-The exit door beside Resident #1's room was pushed open at 3:51 pm.
-After 15 seconds of holding the door handle, the door opened and an alarm sounded.
-At 3:54 pm, another resident came out of his room, typed in a code on the key pad by the alarming door and the alarm stopped sounding.
-The Administrator was walking down the hall when the resident deactivated the alarm.
-The staff did not go in Resident #1's room.

Interview on 03/29/17 at 4:00 pm with the resident that deactivated the alarm revealed:
-He had lived at the facility for "a long time".
-He had a job and worked during the day outside of the facility.
-He usually worked Monday - Friday and was gone from the facility until about 3:00 pm.
-He was given the door code by a staff person "a long time ago".
-He used the code to go out of that door.
-It was quicker to go out of that door to get to the

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other side of the building.
-He was in his room and heard the alarm sounding so he punched in the code to turn it off.
-He had deactivated the alarm before.
-He did not tell anyone when he deactivated the alarm.

Confidential interview with staff revealed:
-There was a resident that had the door code.
-That resident had the door code when they started working at the facility.
-The staff were not aware of a policy that required them to do a resident check when the door alarm was activated.
-The door alarms went off a lot because they did not work properly.
-The alarms would sound if the wind was blowing hard.

Interview with the Executive Director on 3/30/17 at 9:25 am revealed:
-She had checked the electronic MAR to verify the times that the Medication Aides checked Resident #1's Wanderguard on 3/8/17.
-There was an entry at 5:30 am for the 12:00 am to 6:59 am shift.
-There was an entry at 5:30 am for the 6:00 am to 2:59 pm shift.
-There was an early entry at 12:40 pm for the 3:00 pm to 10:59 pm shift.
-She had not been aware that the Medication Aides were not checking Wanderguards as ordered.
-She had not been aware that the electronic MAR system allowed Medication Aides to make entries prior to 1 hour before the order was scheduled.

Observation of Resident #1 on 3/30/17 at 10:42 am revealed the resident was sitting in the front lobby and was wearing a Wanderguard around

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D 270	Continued From page 18 her ankle. Interview with the Executive Director on 3/31/17 at 9:30 am revealed: -She was not aware why Resident #1 had an order for a Wanderguard. -She had been at the facility approximately a month and had not gotten to know the residents or their history yet. -There was no system in place to ensure Wanderguards and their batteries were operating properly. -The facility had no Wanderguard policy in place. Interview with the Clinical Support Specialist on 3/31/17 at 11:05 am revealed: -The number code to the exit doors had been changed on 3/31/17. -She was not aware why a resident with a Wanderguard would be moved into a room beside an exit door in the very back of the building. The failure of the facility to provide supervision in accordance with Resident #1's assessed needs, care plan and history of wandering behavior resulted in neglect and substantial risk of serious injury to Resident #1 due to the fact that Resident #1 wandered away from the facility and was discovered one tenth of a mile from the facility by another oriented resident. This non-compliance constitutes a Type A2 Violation for neglect. Review of the Plan of Protection provided by the facility on 03/31/17 revealed: -Immediately, a list of identified wanders who required a transmitter would be developed and available in the nurse's station. -The Executive Director (ED) with support of the	D 270		

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D 270	Continued From page 19 Clinical Support Staff would in-service staff on which resident's required additional supervision and documentation on safety checks. -Safety checks would include verification that the transmitters are in place and not expired; expiring devices would be replaced before the expiration date. -Expiration dates would be tracked by the ED. -Door codes would be changed immediately to prevent cognitive residents form allowing cognitively impaired residents to exit without supervision. -Staff would be in-serviced on importance of responding to door alarms quickly and on visual check at the time they check the door to ensure identified wanderers are present and accounted for. -The ED and the Resident Care Manager would assess residents to identify any safety and supervision needs to ensure they are addressed. -Each shift the Medication Aides would complete a count of all resident with wanderguards. -The ED would conducted training with support of the Clinical Support Staff to all staff on the correct procedure for ensuring residents are in the community and steps to take if any are to be identified as missing. CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED APRIL 30, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 20 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to obtain healthcare for 3 of 5 sampled residents (#2, #4, #5) regarding one resident with second degree burns for 3 days (Resident #2), one resident who did not receive Foley catheter care for 2 months and was diagnosed with a urinary tract infection (Resident #5), and one resident who missed doses of heart / blood pressure medications after a hospitalization and was readmitted to the hospital 6 days later with symptoms of chest pain and heart failure (Resident #4). The findings are: 1. Review of Resident #4's current FL-2 dated 03/22/17 revealed a diagnoses of coronary artery disease. Review of a hospital discharge report for Resident #4 dated 03/15/17 revealed: -The resident was admitted on 03/08/17 with complaints of chest pain and leg pain, and weakness. -The resident's blood pressure on admission to emergency room was 219/87. -The resident was last hospitalized on 02/03/17 and had a stress test that was negative for ischemia or infarct. -The resident had a history of coronary heart disease with bypass grafting and stent placement, chronic heart failure, hypertension, and chronic kidney disease. -The resident's discharge diagnoses included coronary artery disease of autologous bypass graft, chronic combined systolic and diastolic	D 273		

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congestive heart failure; acute kidney injury superimposed on chronic kidney disease, chest pain, and uncontrolled hypertension.
-The resident was discharged on 03/15/17.
-There was a new medication order for Plavix 75mg daily. (Plavix is used to prevent blood clots.)
-There was a new medication order for Hydralazine 50mg every 8 hours. (Hydralazine is used to treat high blood pressure and heart failure.)
-There was a new medication order for Bystolic 10mg twice daily. (Bystolic is used to treat high blood pressure.)
-There was a new medication order for Nifedipine ER 30mg 3 tablets daily. (Nifedipine ER is used to treat high blood pressure and chest pain.)

Review of a nurses' note for Resident #4 dated 03/15/17 revealed:
-Staff faxed discharge orders with new FL-2 to the facility's primary pharmacy.
-Staff faxed allergy information to the primary pharmacy in order to release new medications.

Review of a nurses' note for Resident #4 dated 03/15/17 revealed staff faxed a copy of FL-2 to the primary pharmacy that was in the resident's hospital folder due to some medications were still not showing on the electronic MAR.

Review of a nurses' note for Resident #4 dated 03/17/17 revealed:
-Staff called the primary pharmacy to reorder medications for the resident but the pharmacy indicated their records showed the resident used another pharmacy.
-The resident had been using the primary pharmacy but the resident's face sheet had to be changed to the primary pharmacy and it was

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faxed to them.

Review of a form faxed to the primary pharmacy dated 03/17/17 revealed staff noted the fax would serve as written proof for Resident #4's medications to be filled by the primary pharmacy.

Review of Resident #4's March 2017 medication administration record (MAR) revealed:
-There was an entry for Bystolic 10mg 1 tablet twice daily with an original order date of 03/15/17.
-Bystolic was not documented as administered from 03/16/17 - 03/20/17 due to "awaiting pharmacy delivery".
-There was an entry for Plavix 75mg 1 tablet daily with an original order date of 03/15/17.
-Plavix was not documented as administered from 03/15/17 - 03/16/17 (no reason) and on 03/17/17 and 03/20/17 due to "awaiting pharmacy delivery".
-There was an entry for Hydralazine 50mg 1 tablet every 8 hours with an original order date of 03/15/17.
-Hydralazine was not documented as administered from 03/16/17 - 03/20/17 due to "awaiting pharmacy delivery".
-There was an entry for Nifedipine ER 30mg 3 tablets (90mg) daily with an original order date of 03/15/17.
-Nifedipine ER was not documented as administered from 03/15/17 - 03/16/17 (no reason) and on 03/17/17 and 03/20/17 due to "awaiting pharmacy delivery".

Review of nurses' notes for Resident #4 dated 03/18/17 - 03/21/17 revealed:
-There was no documentation the primary pharmacy was contacted again about obtaining medications for the resident.
-There was no documentation that Resident #4's

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primary care provider (PCP) or cardiologist were notified the resident was not receiving the new heart / blood pressure medications prescribed when the resident was discharged from the hospital on 03/15/17.

Telephone interview with a pharmacist from the facility's primary pharmacy on 03/30/17 at 10:07 a.m. revealed:
-She thought when they first got Resident #4's information in December 2016, they supplied some medications for her but someone at the facility told the pharmacy that the resident got her medications from a local pharmacy.
-Someone from the facility contacted them last week (the week of 03/20/17) to get medications for Resident #4.

Review of primary pharmacy dispensing records for Resident #4 dated 12/30/16 - 03/30/17 revealed Plavix, Hydralazine, Bystolic, and Nifedipine were all dispensed on 03/20/17 with original order dates of 03/15/17.

Interview with a medication aide on 03/31/17 at 1:10 p.m. revealed:
-Resident #4 had always used the facility's primary pharmacy.
-The facility faxed a face sheet to the pharmacy for Resident #4 to use the primary pharmacy.
-She was not sure when the face sheet was faxed.
-She was not sure why there was a delay in getting the medications after that.
-She did not know if Resident #4's physician was aware of the missed doses of medications.

Interview with the Administrator on 03/31/17 at 12:35 p.m. revealed:
-The facility sent all orders for Resident #4 from

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the hospitalization ending 03/15/17 to the primary pharmacy.
-The primary pharmacy indicated that Resident #4 was not one of their patients.
-The facility faxed documentation of a face sheet indicating Resident #4 used the primary pharmacy.
-She did not know when they faxed the information to the pharmacy and she could not find any documentation in her notes.
-She was not aware there was a delay in getting the medications after the form was faxed to the pharmacy.
-The medication aides were supposed to let the Administrator, Resident Care Coordinator (RCC), or the nurse know if medications did not come in from the pharmacy.
-She did not know if Resident #4's PCP or cardiologist were aware of the missed doses of medications.

Interview with the facility's Licensed Health Professional Support (LHPS) nurse on 03/31/17 at 12:55 p.m. revealed:
-She faxed the orders from Resident #4's hospitalization ending 03/15/17 to the primary pharmacy on 03/15/17.
-Staff had not reported to the nurse that they had not been unable to get medications for Resident #4 after her hospitalization ending 03/15/17.
-She was not aware the resident had missed the doses of medications.

Interviews with Resident #4 on 03/30/17 at 4:50 p.m. and 03/31/17 at 8:40 a.m. revealed:
-She had been hospitalized at least twice recently for congestive heart failure.
-She had heart trouble since 1993 and she had congestive heart failure.
-She did not know if she was getting medications

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like she was supposed to.
-She had missed some medications for 2 or 3 days because they did not come in from the pharmacy.
-She could not recall when this happened or which medications.
-Her blood pressure sometimes ran high.
-The facility staff ordered her medications from the facility's primary pharmacy.
-She did not get medications from any other pharmacy.

Review of a nurses' note for Resident #4 dated 03/21/17 revealed the resident was sent out for chest pain.

Review of a hospital discharge report for Resident #4 dated 03/22/17 revealed:
-The resident was admitted and released less than two weeks ago for similar symptoms.
-The resident was admitted on 03/21/17 with severe midsternal chest pressure and shortness of breath.
-The chest pressure radiated to her back, left jaw, left arm, and was accompanied by nausea.
-The resident's blood pressure was 178/81.
-The resident's blood pressure was "likely driving the congestive heart failure exacerbation".
-The resident's blood pressure seemed "poorly controlled" despite being on several medications.
-The resident's discharge diagnoses included chest pain, non-cardiac; acute on chronic combined systolic and diastolic heart failure, mild; and chronic renal disease, stage 4.
-The resident was discharged on 03/22/17.
-There was a list of medications for the resident to continue taking with no changes.
-The list included Plavix 75mg daily, Hydralazine 50mg every 8 hours, Bystolic 10mg twice daily, and Nifedipine ER 30mg 3 tablets daily.

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D 273	Continued From page 26 Interview with the facility's corporate Clinical Support Specialist on 03/31/17 at 12:25 p.m. revealed: -She was not aware Resident #4's new medications ordered when she was discharged from the hospital on 03/15/17 were unavailable and not started prior to the re-hospitalization on 03/21/17. -The Resident Care Coordinator (RCC) was also supposed to help review orders and MARs to make sure medications orders were implemented. -The facility had been short staffed and the RCC was currently working as a medication aide on night shift for about 2 months. -The RCC had not been able to perform routine monitoring tasks during this time since she was working as a medication aide. Telephone interview with a nurse at the PCP's office for Resident #4 on 03/31/17 at 1:25 p.m. revealed: -They were aware Resident #4 had some recent hospitalizations. -The resident missing the heart medications could have contributed to the resident being re-hospitalized on 03/21/17. -They had not been notified of Resident #4 missing the doses of medications prior to being hospitalized on 03/21/17. Telephone interview with a nurse at the cardiologist's office for Resident #4 on 03/31/17 at 2:35 p.m. revealed: -The cardiologist was with a patient and unavailable to come to the phone. -They were not aware Resident #4 had missed dosages of heart medications and Plavix between her most recent hospitalizations in March 2017.	D 273		

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-She discussed the missed doses with the PCP and the PCP stated the missed doses of heart medications could have contributed to Resident #4's symptoms and re-hospitalization.
-The PCP was especially concerned about the resident missing doses of Bystolic because it helps control heart rate and medications in that class of drugs should not be stopped abruptly.
-The resident was taking Bisoprolol prior to the order for Bystolic. (Bisoprolol and Bystolic are both beta blockers and abrupt cessation of beta blockers may cause an acute exacerbation of cardiac disease.)
-The PCP was also concerned that missing doses of Plavix could cause one of the resident's cardiac stents to clot.

2. Review of the current FL2 for Resident #5 dated 1/21/17 revealed:
-Diagnoses included urinary tract infection with carbapenem resistant organisms, diabetes, dementia, autonomic dysfunction, neurogenic bladder, interstitial lung disease, chronic kidney disease stage 2 to 3, chronic anemia, gastroesophageal reflux disease and malignant hypertension.
-"Intermittently" was marked under "Disoriented".
-There was no notation that Resident #5 had a foley catheter.

Review of Resident #5's Resident Register revealed an admission date of 8/17/16.

Review of Home Health Comprehensive Adult Assessment dated 8/21/16 revealed:
-The assessment was completed by a Registered Nurse.
-The assessment was not signed by a Primary Care Provider.
-The plan of care included a foley catheter.

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D 273	Continued From page 28 -The foley catheter was to be changed every month. -"Understands only basic conversations or simple, direct phrases" was marked under "Understanding of Verbal Content". -"Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener" was marked under "Speech and Oral Expression of Language". Review of Resident #5's Care Notes revealed: -There was an entry dated 11/22/16 by home health "catheter change". -There was an entry dated 12/6/16 by the Resident Care Manger "spoke with home health nurse and she will be here sometime tonight to see resident for funny colored urine." -There was an entry dated 12/6/16 by home health "assessment of catheter and urine drained from bag." -There was an entry dated 12/7/16 by a Medication Aide "called home health to report the resident has blood in his catheter tubing." -There was an entry dated 12/7/16 by home health "assess blood from Foley catheter but no blood observed." -There was an entry dated 12/26/16 by home health "visit due to leaking catheter which was changed with no issues." -The last documented catheter change was 12/26/16. Review of Resident #5's Referral Form dated 1/23/17 revealed: -A referral for hospice services was completed by the Primary Physician due to decline in overall health. -Hospice opened a case to evaluate the resident on 1/24/17 and denied admission.	D 273		

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Review of Resident #5's home health records revealed:
-The resident was being discharged from home health on 1/24/17.
-Resident #5 was referred to hospice service and could not receive home health and hospice at the same time.

Review of Resident #5's record revealed:
-There was no documentation of an order, or clarification for an order for the foley catheter.
-There was no documentation of home health after 1/24/17, when it was discontinued to hospice services.
-There was no documentation of hospice services other than an initial evaluation which denied admission.
-There was no documentation of the catheter being changed from 12/26/16 until 3/6/17.
-The 12/26/16 catheter change was performed by Home Health because the catheter was leaking.
-The 3/6/17 catheter was replaced by the emergency room because Resident #5 had a fall that pulled out his catheter.

Review of Resident #5's Clinical Discharge Instructions from the local hospital dated 3/24/17 revealed:
-The resident went to the emergency room.
-The reason for the visit was documented as an acute urinary tract infection.
-The resident was discharged with a prescription for an antibiotic.

Observation on 3/29/17 at 5:00 pm revealed:
-Resident #5 was in his room, in bed.
-There was a urine drainage bag, with a catheter, coming from Resident #5.
-The bag was filled with pink urine.

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Interview with the 2nd shift Medication Aide on 3/29/17 at 5:40 pm revealed:
-Resident #5 was on an antibiotic for the blood in his urine.
-The blood in his urine started yesterday, 3/28/17.
-She Primary Care Provider was not notified because the resident was already on an antibiotic.

Interview with the same 2nd shift Medication Aide on 3/29/17 at 6:25 pm revealed:
-She had observed blood in Resident #5's urine approximately 30 minutes ago and had notified the Administrator.
-The Administrator had instructed her to immediately call 911.
-The resident had not had blood in his urine until today.
-She had observed the residents' physical health deteriorating the past month leaving the resident no longer able to do anything for himself.
-She was unsure of why Resident #5's health had deteriorated.

Observation on 3/29/17 at 6:25 pm revealed Emergency Management Services leaving the facility with Resident #5.

Review of Resident #5's Clinical Discharge Instructions from the local hospital dated 3/29/17 revealed:
-The reason for the visit was hematuria and urinary tract infection.
-Resident #5 was prescribed a different antibiotic.

Telephone interview with Resident #5's primary physician on 3/30/17 at 10:35 am revealed:
-The resident had been admitted to the facility with a Foley catheter.
-The Foley catheter required routine daily

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cleaning and emptying and should be changed monthly.
-A home health agency had been changing the catheter monthly until January 2017.
-He was told by facility staff on 3/28/17 that home health had not been to the facility since January 2017 (unknown date) and hospice had denied services to the resident.

Interview with the Executive Director on 3/30/17 at 4:30 pm revealed:
-She was not aware that Resident #5 was denied hospice services.
-The Resident Care Manager should have notified the physician and home health that hospice services were denied.
-The Resident Care Manager was working as a Medication Aide due to a shortage of staff.

3. Review of the current FL2 for Resident #2 dated 11/8/16 revealed:
-Diagnoses included hypertension, carpel tunnel, chronic pain, constipation, dementia, degenerative joint disease, gastroesophageal reflux disease and hallucinations.
-"Intermittently" was circled under "Disoriented".
-"Total Care" was circled under "Personal Care Assistance."

Review of Resident #2's Resident Register revealed an admission date of 11/10/16.

Review of Resident #2's current Care Plan dated 11/19/16 revealed:
-"Non-ambulatory" was checked under ambulation.
-"Limited strength" was checked under upper extremities.
-"Daily incontinence" was checked under bladder.
-"Sometimes disoriented" was checked under

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orientation.
-"Forgetful - needs reminders" was checked under memory.
-An entry of "Extensive" was under bathing, dressing, mobility, toileting and eating.

Interview with the LHPS nurse on 3/30/17 at 2:14 pm revealed:
-The LHPS nurse had assessed Resident #2 on 3/3/17 as part of her quarterly LHPS assessment and saw no sign of skin issues.
-She had been asked by a Medication Aide on 3/6/17 to assess the resident regarding blisters on her neck and right shoulder as her primary physician was not scheduled to visit her until 3/7/17.
-After she had assessed the resident, she informed the Executive Director that the resident needed to be evaluated at the hospital.

Interview with the Clinical Support Specialist on 3/30/17 at 2:22 pm revealed:
-The LHPS nurse had assessed Resident #2 on 3/3/17 and saw no sign of skin issues.
-On 3/4/17, she had received a telephone call from a Medication Aide who informed her that the resident had skin breakdown.
-She instructed the Medication Aide to fax the primary physician and to begin two hour checks for the resident.
-The LHPS nurse assessed the resident on 3/6/17 and recommended that the resident be evaluated at the local hospital.
-The resident was transported to the local hospital by Emergency Medical Services.

Review of Care Notes dated 3/6/17 revealed Resident #2 "was sent out to the hospital to be checked for possible shingles."

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D 273	Continued From page 33 Review of local hospital discharge information dated 3/6/17 revealed: -Resident #2 arrived at the hospital on 3/6/17 at approximately 11:00 am. -The resident "presented to the hospital with complaints of pain and right shoulder blister-like wounds with unknown contact or exposure." -An initial assessment revealed the "skin was dry and very thin with blisters noted on the neck and shoulder." -Upon a "focused exam the skin on the right shoulder upper arm has a blister wound with blister roof sloughing." -The resident had "a second degree superficial burn to the right shoulder with skin sloughing and multiple blisters intact." Observation of Resident #2 on 3/6/17 at 5:50 pm revealed there was an area of approximately 1 inch of blisters of various sizes on the neck and right shoulder of the resident and an area of approximately 1 inch where the blisters had burst. Interview with a Personal Care Aide (PCA) on 3/6/17 at 5:55 pm revealed: -She was not surprised that the resident had gotten burned from the heater. -She had notified the Medication Aide on 3/4/17 that Resident #2 had something wrong with her skin. -The family of Resident #2 complained during every facility visit that the resident was cold. -She had assisted with pushing the bed against the heater shortly after the resident was admitted to the facility due to complaints received that the resident had been cold. -The resident had routinely moved herself in the bed until she was lying on the heater. -The PCA's moved the resident off the heater so she would not get burned every night by sliding	D 273		

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the sheets.
-The family of the resident had asked for the heat to be left on high at all times.
-The bed was moved away from the heater on 3/6/17 when the resident returned from the hospital with a diagnosis of second degree burns.

Interview with a Medication Aide on 3/30/17 at 2:35 pm revealed:
-A PCA had informed her on 3/4/17 that there was something wrong with the skin on Resident #2's neck and right shoulder.
-She had assessed the skin and observed the area to be red and blistered.
-She had thought that the resident lying on her pillows with her pillows on the heater might have caused the skin to blister.
-She had called the Clinical Support Specialist and informed her that the resident had either skin breakdown or burns.
-She was instructed by the Clinical Support Specialist to fax the primary physician to notify him of the skin issue, make a care note of her observations, and to make sure the resident was checked and turned hourly.
-She had observed the skin again on 3/5/17 when a different Personal Care Aide asked her to assess the resident.
-She had observed the skin to be the same as the previous day other than some of the blisters had burst.
-She had not notified anyone of the burst blisters on 3/5/17 because she had previously notified the Clinical Support Specialist on 3/4/17.
-She had seen the family in the facility on 3/4/17 but had not talked to them about the resident because she had not wanted to upset them.

A second interview with the same Medication Aide on 3/30/17 at 3:49 pm revealed:

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-She had thought about it and needed to make corrections to her previous interview.
-When she called the Clinical Support Specialist on 3/4/17 she had not mentioned anything about a burn but had said that Resident #2 had skin breakdown.
-She had never seen skin breakdown and was not familiar with how it looked.
-She had not described the skin to the Clinical Support Specialist.

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

Telephone interview with Resident #2's legal representative on 3/6/17 at 4:00 pm revealed:
-He had visited the resident on 3/4/17 and observed an area of approximately 2 inches of blisters on her neck and right shoulder.
-The resident had not verbally complained of pain but winced when the area was touched.
-He asked a PCA what had happened and she replied that she did not know whether the blisters were skin tears or a burn but she would report this to the Medication Aide.
-The PCA informed him that for the past week the resident had been found numerous times lying on the heater.
-The resident was evaluated at the local hospital on 3/6/17 and was diagnosed with second degree burns.
-On 3/6/17, the Licensed Health Professional Support (LHPS) nurse informed him that she had assessed the resident on 3/3/17 and the blisters were not present and must have occurred overnight.

Interview with the Executive Director on 3/14/17 at 2:45 pm revealed:
-She had initiated an investigation as to how

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Resident #2 received burns on 3/6/17 and completed the investigation on 3/14/17.
-She learned that the resident had been lying on her pillows with the pillows lying on the heat unit.
-The staff had repositioned the resident numerous times and the resident had resumed her previous position.
-She determined that the burns were a result of the resident lying on her pillows over the heat unit.
-The bed was moved away from the heat unit when the resident returned from the local hospital with a diagnosis of second degree burns on 3/6/17.

Record review on 3/30/17 revealed:
-There was confirmation of a fax sent to Resident #2's primary physician on 3/4/17 with a request for him to assess skin breakdown in several spots.
-There was a return fax from the primary physician on 3/7/17 indicating that he had the resident on the schedule to see later in the day.

Telephone interview with Resident #2's primary care physician on 3/14/17 at 9:05 am revealed:
-He had not been informed skin issues were discovered on 3/4/17 until 3/7/17.
-His expectation would have been for the resident to be sent out immediately when the blisters were observed.

The facility's failure to assure appropriate health care referral and follow up for 3 of 5 sampled residents resulted in Resident #2's second degree burns without physician notification for 3 days after being discovered; Resident #5 who had no foley catheter care for 2 months which resulted in an emergency room visit with a diagnosis of acute urinary tract infection; and

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D 273	Continued From page 37 Resident #4's PCP and cardiologist were not notified of the resident missing doses of 4 new heart / blood pressure medications from 03/15/17 - 03/20/17, resulting in the resident being readmitted to the hospital on 03/21/17 with severe chest pain and shortness of breath and being diagnosed with acute on chronic congestive heart failure. The facility's failure to provide adequate health care referral and follow up for three residents resulted in serious neglect and substantial risk of physical harm which constitutes a Type A2 Violation. Review of the Plan of Protection provided by the facility on 03/31/17 revealed: -The facility would immediately contact residents Primary Care Provider (PCP) to request an order for home health for catheter care and the contact and request would be documented and filed in the residents' chart. -Staff would be educated by the Registered Nurse in coordination with the Executive Director (ED), Resident Care Manager (RCM) and Clinical Support Staff on complete, thorough, detailed reporting of any resident change or illness to include skin issues. -A chart review would be conducted to ensure health care referral and follow up needs are being met internally or by a supporting agency. Any discrepancies would be referred to the PCP for review and follow up orders. -The ED and RCM would coordinate with the Registered Nurse to ensure any health care needs that require a licensed health professional would be referred out to supporting agencies. Documentation would be filed in the chart. -Any resident admitted or a new order for a catheter would be immediately referred to Home Health. -All referrals for additional healthcare needs	D 273		

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D 273	Continued From page 38 would be received by the medication room and the Mediation Aides would fax to the appropriate healthcare or supporting agency. -The ED/RCM would follow up on referrals to ensure start of care. -Agencies would be notified to document care provided in the care note section. -The ED/RCM and Clinical Support Staff would follow up on orders received. CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED APRIL 30, 2017.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to protect 1 of 5 sampled residents (Resident #2) from neglect which resulted in second degree burns on the neck and shoulder because staff pushed the residents' bed agaisnt the heater and allowed the resident to lie on the heater. The findings are: Review of the current FL2 for Resident #2 dated 11/8/16 revealed: -Diagnoses included hypertension, carpel tunnel,	D 338		

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chronic pain, constipation, dementia, degenerative joint disease, gastroesophageal reflux disease and hallucinations.
-"Intermittently" was circled under "Disoriented".
-"Total Care" was circled under "Personal Care Assistance."
-"Normal was circled under "Skin".

Review of Resident #2's Resident Register revealed an admission date of 11/10/16.

Review of Resident #2's current Care Plan dated 11/19/16 revealed:
-"Non-ambulatory" was checked under ambulation.
-"Limited strength" was checked under upper extremities.
-"Daily incontinence" was checked under bladder.
-"Sometimes disoriented" was checked under orientation.
-"Forgetful - needs reminders" was checked under memory.
-An entry of "Extensive" was under bathing, dressing, mobility, toileting and eating.

Observation of Resident #2 on 3/6/17 at 5:50 pm revealed there was an area of approximately 1 inch of blisters of various sizes on the neck and right shoulder of the resident and an area of approximately 1 inch where the blisters had burst.

Review of Care Notes dated 3/6/17 revealed Resident #2 "was sent out to the hospital to be checked for possible shingles."

Observation of Resident #2 on 3/29/17 at 10:00 am revealed:
-She was in the lobby, in a wheelchair, slouched over.
-Her right arm was bent at the elbow and wrist

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and was against her chest.
-She propeled the wheelchair using her left foot only.

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

Interview with the Clinical Support Specialist on 3/30/17 at 2:22 pm revealed:
-The Licensed Health Professional Support (LHPS) nurse had assessed Resident #2 on 3/3/17 as part of her quarterly LHPS assessment and saw no sign of skin issues.
-On 3/4/17, she had received a telephone call from a Medication Aide who informed her that the resident had skin breakdown.
-She instructed the Medication Aide to fax the primary physician and to begin two hour checks on the resident.
-The LHPS nurse assessed the resident on 3/6/17 and recommended that the resident be evaluated at the local hospital.
-The resident was transported to the local hospital by Emergency Medical Services.

Interview with the LHPS nurse on 3/30/17 at 2:14 pm revealed:
-She had assessed Resident #2 on 3/3/17 and saw no sign of skin issues.
-She had been asked by a Medication Aide on 3/6/17 to assess the resident regarding blisters on her neck and right shoulder as her primary physician was not scheduled to visit her until 3/7/17.
-After she had assessed the resident, she informed the Executive Director that the resident needed to be evaluated at the hospital.

Review of local hospital discharge information dated 3/6/17 revealed:

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D 338	Continued From page 41 -Resident #2 arrived at the hospital on 3/6/17 at approximately 11:00 am. -The resident "presented to the hospital with complaints of pain and right shoulder blister-like wounds with unknown contact or exposure." -An initial assessment revealed the "skin was dry and very thin with blisters noted on the neck and shoulder." -Upon a "focused exam the skin on the right shoulder upper arm has a blister wound with blister roof sloughing." -The resident had "a second degree superficial burn to the right shoulder with skin sloughing and multiple blisters intact." Interview with a Personal Care Aide on 3/6/17 at 5:55 pm revealed: -She was not surprised that Resident #2 had gotten burned from the heater. -Resident #2 required total assistance with activities of daily living. -Resident #2 required total assistance with transfers. -She had notified the Medication Aide on 3/4/17 that Resident #2 had something wrong with her skin. -The resident was "stubborn and would not move or listen to the staff". -The family of Resident #2 complained during every facility visit that the resident was cold. -The had assisted with pushing the bed against the heater shortly after the resident was admitted to the facility due to complaints received that the resident had been cold. -The resident had routinely moved in the bed until she was lying on the heater. -The PCA's moved the resident off the heater so she would not get burned every night by sliding the sheets. -The family of the resident had asked for the heat	D 338		

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to be left on high at all times.
-The bed was moved away from the heater on 3/6/17 when the resident returned from the hospital with a diagnosis of second degree burns.

Interview with a Medication Aide on 3/30/17 at 2:35 pm revealed:
-A Personal Care Aide had informed her on 3/4/17 that there was something wrong with the skin on Resident #2's neck and right shoulder.
-She had assessed the skin and observed the area to be red and blistered.
-She had thought that the resident lying on her pillows with her pillows on the heater might have caused the skin to blister.
-She had called the Clinical Support Specialist and informed her that the resident had either skin breakdown or burns.
-She was instructed by the Clinical Support Specialist to fax the primary physician to notify him of the skin issue, make a care note of her observations, and to make sure the resident was checked and turned hourly.
-She had observed the skin again on 3/5/17 when a different Personal Care Aide asked her to assess the resident.
-She had observed the skin to be the same as the previous day other than some of the blisters had burst.
-She had not notified anyone of the burst blisters on 3/5/17 because she had previously notified the Clinical Support Specialist on 3/4/17.
-She had seen the family in the facility on 3/4/17 but had not talked to them about the resident because she had not wanted to upset them.

A second interview with the same Medication Aide on 3/30/17 at 3:49 pm revealed:
-She had thought about it and needed to make corrections to her previous interview.

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-When she called the Clinical Support Specialist on 3/4/17 she had not mentioned anything about a burn but had said that Resident #2 had skin breakdown.
-She had never seen skin breakdown and was not familiar with how it looked.
-She had not described the skin to the Clinical Support Specialist.

Telephone interview with Resident #2's legal representative on 3/6/17 at 4:00 pm revealed:
-He feels the resident "has been neglected".
-He had visited the resident on 3/4/17 and observed an area of approximately 2 inches of blisters on her neck and right shoulder.
-The resident had not verbally complained of pain but winced when the area was touched.
-He asked a Personal Care Aide (PCA) what had happened and she replied that she did not know whether the blisters were skin tears or a burn.
-The PCA thought the blisters might have been burns caused by the resident sleeping all night on the heater.
-The PCA informed him that for the past week the resident had been found numerous times lying on the heater.
-The Legal Representative asked the PCA why the resident had not been checked during the night.
-He had discussed with the previous Administrator the need for the resident to be checked every 30 minutes due to her diagnosis of dementia and she had agreed.
-According to the PCA, the resident had not been checked on routinely at night while she was in bed.
-The resident was evaluated at the local hospital on 3/6/17 and was diagnosed with second degree burns.
-On 3/6/17, the Licensed Health Professional

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Support (LHPS) nurse informed him that she had assessed the resident on 3/3/17 and the blisters were not present and must have occurred overnight.

Interview with the Executive Director on 3/14/17 at 2:45 pm revealed:
-She had completed an investigation as to how Resident #2 received burns.
-She learned that the resident had been lying on her pillows with the pillows lying on the heat unit.
-The staff had repositioned the resident numerous times and the resident had resumed her previous position.
-She determined that the burns were a result of the resident lying on her pillows over the heat unit.
-The bed was moved away from the heat unit when the resident returned from the local hospital with a diagnosis of second degree burns.

Interview with the Clinical Support Specialist on 3/16/17 at 9:44 am revealed:
-Resident #2 required more care that originally thought at admission.
-The resident should have been admitted to a nursing facility rather than an adult care home.

Observation of Resident #2 on 3/30/17 at 8:59 revealed:
-The resident was sitting in a wheelchair in the lobby of the facility.
-The resident was leaning forward with her head almost touching her knees.
-The right arm and hand of the resident appeared to be contracted.

Interview with the Executive Director on 3/30/17 at 3:00 pm revealed:
-She was not aware of why the resident was

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contracted on her right side.
-She had been aware that the two hour check lists for the resident had not been completed as ordered by the Clinical Support Specialist.
-She had trained some staff regarding checks on 3/13/17.
-The training had included the importance of completing two hour checks on all residents, reporting issues to Medication Aides, documentation of issues discovered and Medication Aides reporting issues to the Resident Care Manager or the Executive Director.

The facility failed to ensure residents were free from neglect for 1 of 5 sampled residents (#2). The failure of the facility to ensure Resident #2 was free from neglect resulted in an emergency room visit as a result of second degree burns obtained from staff positioning the resident to close to a heating unit. The failure of the facility to ensure the resident was free from neglect resulted in the injury of a resident and constitutes a Type A1 Violation.

Review of the Plan of Protection provided by the facility on 03/31/17 revealed:
-Immediately the facility would reinforce and educate staff of Residents Rights.
-Room checks would be completed to ensure there were no environmental hazards that could put resident in harm's way.
-The Executive Director (ED) would conduct facility rounds weekly to ensure there were no environmental hazards to residents and act accordingly.
-The Ombudsman would be contacted regarding scheduling of Residents Rights training to include Elder Abuse and Neglect.
-Staff would be educated on the importance of

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D 338	Continued From page 46 immediately reporting to the ED anything that could pose a hazard, cause harm, abuse or neglect to a resident. -Staff would be in-serviced regarding proper placement of furniture in rooms by the ED. -The ED and Clinical Support Staff would ensure the Resident Relations Hotline is posted to ensure concerns can be voiced. -The housekeeping department would be educated on possible environmental hazards, proper furniture placement at time of hire by the ED and coordinated with the Environmental Services Supervisor. -Staff would receive education regarding skin issues, what constitutes breakdown verses other skin concerns, proper reporting steps and actions to take when injuries occur. -Training would be conducted the Registered Nurse in coordination with the ED, Resident Care Manager and Clinical Support Staff. -Resident Rights and safety training would be provided to existing and new employees to include any hazards that may result in harm, abuse or neglect. CORRECTION DATE THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 30, 2017.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

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D 358	Continued From page 47 and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 9 residents (#7, #8) observed during the medication pass, including errors with insulin, an antipsychotic, a pain reliever, and a laxative and for 3 of 5 residents (#3, #4, #5) sampled for review including errors with insulins, an antibiotic for infection, heart / blood pressure medications, a medication to prevent blood clots, and an antidepressant. The findings are: 1. The medication error rate was 12% as evidenced by the observation of 4 errors out of 31 opportunities during the 4:00 p.m. - 5:00 p.m. medication pass on 03/29/17 and the 8:00 a.m. medication pass on 03/30/17. A. Review of Resident #7's current FL-2 dated 04/27/16 revealed: -The resident's diagnoses included Type 2 diabetes mellitus, cortical blindness, bilateral hearing loss, left breast cancer / mastectomy, mental retardation, asthma, and heart murmur. -There was an order for Humalog insulin 5 units 3 times a day before meals. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before eating a meal.) Review of the March 2017 medication administration record (MAR) revealed:	D 358		

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D 358	Continued From page 48 -There was an entry for Humalog inject 5 units 3 times daily before meals. -Humalog was scheduled to be administered at 7:30 a.m., 11:30 a.m., and 4:30 p.m. -The resident's blood sugar ranged from 59 - 350 from 03/01/17 - 03/29/17. Observation during the medication pass on 03/29/17 revealed: -Resident #7 was in her room and she was eating two orange crackers with peanut butter (afternoon snack). -The medication aide (MA) checked Resident #7's blood sugar at 3:54 p.m. and it was 97. -The MA administered 5 units of Humalog insulin to the resident at 3:58 p.m. Observation of Resident #7 on 03/29/17 revealed the resident was served supper at 5:10 p.m., 1 hour and 12 minutes after receiving Humalog, a rapid-acting insulin. Interview with the MA on 03/29/17 at 6:00 p.m. revealed: -Supper was usually served around 5:00 p.m. -She had about 6 diabetic residents to check blood sugars and / or administer insulin to before supper. -She usually started the medication pass around 3:45 p.m. - 4:00 p.m. so she could get it completed in the one hour time frame allowed. -She tried not to administer insulin after the residents were eating because eating food would alter the residents' blood sugars. -She had diabetes training by the facility's nurse when she started working here about 3 weeks ago but she could not recall if they discussed the onset times for different insulins. -She was not sure of the facility's policy for insulin administration.	D 358		

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D 358	Continued From page 49 Interview with Resident #7 on 03/31/17 at 9:45 a.m. revealed: -She was diabetic and got insulin every day. -Her blood sugar ran low and high sometimes. -She had to wait "a while" (could not give timeframe) to get her meal sometimes after she received insulin. -Her stomach sometimes felt "funny" while she was waiting for her meal. -She felt tired, anxious, and sleepy when her blood sugar was low. Interview with the Administrator on 03/30/17 at 10:50 a.m. revealed: -The MAs have been trained on how to administer insulin by the facility's Licensed Health Professional Support (LHPS) nurse. -The facility's policy was to administer insulin within 30 minutes of the meal. Interview with the Licensed Health Professional Support (LHPS) nurse on 03/31/17 at 12:55 p.m. revealed: -She had trained the MAs on diabetes and insulin administration, including the onset of action of the different types of insulin. -The MAs were trained to administer the rapid and short acting insulins within 30 minutes of the meal. Telephone interview with a medical assistant at Resident #7's primary care physician's (PCP) office on 03/31/17 at 10:26 a.m. revealed: -The PCP was unavailable for interview. -Resident #7 was supposed to get Humalog insulin 5 units before meals. -Humalog should usually not be administered more than 30 minutes prior to the meal.	D 358		

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D 358	Continued From page 50 B. Review of Resident #8's current FL-2 dated 01/24/17 revealed the resident's diagnoses included schizophrenia, chronic back pain, hypertension, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. a.) Review of Resident #8's current FL-2 dated 01/24/17 revealed: -There was an order for Clozapine 100mg along with 50mg (to equal 150mg) twice daily. (Clozapine is an antipsychotic.) -There was an order for Clozapine 25mg 2 tablets (50mg) along with 100mg (to equal 150mg) every morning. Review of Resident #8's March 2017 medication administration record (MAR) revealed: -There was an entry for Clozapine 100mg take 1 tablet twice daily along with 50mg to equal 150mg and it was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -There was an entry for Clozapine 25mg take 2 tablets (50mg) every morning with 100mg to equal 150mg and it was scheduled to be administered at 8:00 a.m. Review of Resident #8's physician's order and progress notes revealed no documentation the physician had been contacted to clarify the Clozapine order. Observation of the 8:00 a.m. medication pass on 03/30/17 revealed: -The medication aide (MA) administered one Clozapine 100mg tablet and one Clozapine 25mg tablet to Resident #8 at 8:22 a.m. -The resident was administered 125mg of Clozapine instead of 150mg as ordered. Interview with the MA on 03/30/17 at 9:52 a.m.	D 358		

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revealed:
-She pulled out both Clozapine bubble cards from the medication cart, one for the 100mg tablets and the other for the 25mg tablets.
-At first, she stated the resident got 1 tablet of each strength.
-Then she read the label and stated the resident usually got 2 of the 25mg Clozapine tablets.
-She forgot to administer 2 of the Clozapine 25mg tablets that morning on 03/30/17.
-She had not noticed the discrepancy in the orders for Clozapine 100mg and 25mg.
-Resident #8 did not have auditory or visual hallucinations to her knowledge.
-Resident #8 sometimes seemed depressed and she "moped" around and talked down about herself.
-Resident #8 would sometimes burst into tears if another resident would not talk to her.

Interview with the Administrator on 03/30/17 at 10:50 a.m. revealed:
-The MAs have been trained to read the MARs and the medication labels.
-If a MA was passing medication and something was unclear or did not match, the MA should get clarification.
-The MA should notify the RCC or the Administrator if they did not know how to proceed with administering a medication.
-They would contact Resident #8's physician to clarify the Clozapine order.

Telephone interview with a medical assistant for Resident #8's primary care provider (PCP) on 03/31/17 at 10:26 a.m. revealed:
-The facility contacted their office for clarification of the Clozapine dosage today.
-The PCP wanted to continue the Clozapine as the resident had been receiving it at the facility

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since she had been stable on that dosage.
-The resident should continue to get Clozapine 50mg in the morning and 100mg twice a day.

Review of a clarification order dated 03/31/17 revealed the physician ordered to continue Clozapine 100mg twice a day and 25mg (2 tablets) every morning.

b.) Review of Resident #8's current FL-2 dated 01/24/17 revealed there was an order for Lactulose 10gm/15ml take 30ml once daily. (Lactulose is a laxative used to treat constipation.)

Review of Resident #8's March 2017 medication administration record (MAR) revealed there was an entry for Lactulose 10gm/15ml take 30ml every day and it was scheduled to be administered at 8:00 a.m.

Observation of the 8:00 a.m. medication pass on 03/30/17 revealed:
-The medication aide (MA) used a graduated 30ml medication cup to measure Resident #8's Lactulose.
-The MA poured and administered 15ml of Lactulose to Resident #8 at 8:23 a.m. instead of 30ml as ordered.

Interview with the MA on 03/30/17 at 9:52 a.m. revealed:
-She usually gave the resident 15ml of Lactulose.
-She pointed to the 15ml listed in the strength of Lactulose (10gm/15ml) printed on the MAR.
-When asked about the directions on the MAR to take 30ml daily, the MA realized she was looking at the wrong information.
-She had not noticed the directions on the MAR and the medication label was for 30ml.

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-She mistakenly looked at the 15ml listed in the strength of the Lactulose.
-The resident had not complained of having constipation to the MA.

Interview with the Administrator on 03/30/17 at 10:50 a.m. revealed:
-The MAs have been trained to read the MARs and the medication labels.
-The MAs were supposed to administer the medication according to the order.

Interview with Resident #8 on 03/30/17 at 4:50 p.m. revealed:
-Sometimes when she received Lactulose in the plastic medication cup, it was half full and sometimes the medication cup was full.
-She was currently constipated and she only had one small bowel movement yesterday.

c.) Review of Resident #8's current FL-2 dated 01/24/17 revealed there was an order for Tylenol 325mg 2 tablets every 6 hours as needed. (Tylenol is used to treat pain.)

Review of a physician's order dated 02/13/17 revealed a standing order for Tylenol 500mg 1 tablet every 4 hours as needed for headache or minor discomfort.

Review of Resident #8's March 2017 medication administration record (MAR) revealed:
-There was an entry for Tylenol 325mg take 2 tablets (650mg) every 6 hours as needed.
-There was an entry for the standing order for Tylenol 500mg 1 tablet every 4 hours as needed for headache or minor discomfort.
-No Tylenol had been documented as administered in March 2017.

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D 358	Continued From page 54 Observation of the 8:00 a.m. medication pass on 03/30/17 revealed: -Resident #8 came out of the dining room and walked up to the medication aide (MA) at the medication cart. -The MA began preparing Resident #8's morning medications. -Resident #8 asked the MA for some Tylenol for pain. -The MA asked the resident where she was hurting. -The resident stated she had pain in her back radiating down her leg. -The MA continued preparing the resident's morning medications. -The MA administered Resident #8's morning medications from 8:22 a.m. to 8:25 a.m. -The MA did not administer any Tylenol to the resident when she administered the resident's morning medications. -The MA did not document any Tylenol as being administered to the resident. -The MA then continued to the next resident on the medication pass. Interview with the MA on 03/30/17 at 9:52 a.m. revealed: -Resident #8 had Tylenol available in the facility. -She did not administer Tylenol to the resident because the resident had a scheduled pain patch that she was wearing. -She thought the pain patch would help the resident's pain. Observation of medications on hand for Resident #8 on 03/30/17 revealed: -There was no Tylenol 325mg tablets for Resident #8. -There was a house stock bottle of Tylenol 500mg in the medication cart.	D 358		

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D 358	Continued From page 55 Interview with the MA on 03/30/17 at 9:55 a.m. revealed the MA was not aware there was no Tylenol 325mg tablets on hand for Resident #8. Interview with Resident #8 on 03/30/17 at 4:50 p.m. revealed: -She had not received any Tylenol today. -Tylenol usually helped her back pain more than the pain patch she wore every day. -She was currently still having some back and leg pain. Interview with the Administrator on 03/30/17 at 10:50 a.m. revealed: -The MAs should administer a "prn" (as needed) medication when the resident asked for it. -Resident #8's Tylenol should have been administered when requested by the resident. -The MA could have administered the standing order of Tylenol 500mg since the resident did not have any Tylenol 325mg tablets on hand. 2. Review of Resident #4's current FL-2 dated 03/22/17 revealed a diagnoses of coronary artery disease. Review of a nurses' note for Resident #4 dated 03/07/17 at 9:05 p.m. revealed: -The resident complained of chest pain and took a Nitroglycerin pill about 8:15 p.m. (Nitroglycerin is used to treat chest pains.) -The resident threw up afterwards and the chest pain started again and her lower jaw was hurting. -The resident was sent to the emergency room. Review of a local hospital discharge report for Resident #4 dated 03/15/17 revealed: -The resident was admitted on 03/08/17 with complaints of chest pain and leg pain, and	D 358		

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weakness.
-The resident's blood pressure on admission to emergency room was 219/87.
-The resident was last hospitalized on 02/03/17 and had a stress test that was negative for ischemia or infarct.
-The resident had a history of coronary heart disease with bypass grafting and stent placement, chronic heart failure, hypertension, and chronic kidney disease.
-The chest pain was relieved by Nitroglycerin.
-The resident's discharge diagnoses included coronary artery disease of autologous bypass graft, chronic combined systolic and diastolic congestive heart failure; acute kidney injury superimposed on chronic kidney disease, chest pain, and uncontrolled hypertension.
-The resident was discharged on 03/15/17.
-There was a new medication order for Plavix 75mg daily. (Plavix is used to prevent blood clots.)
-There was a new medication order for Hydralazine 50mg every 8 hours. (Hydralazine is used to treat high blood pressure and heart failure.)
-There was a new medication order for Bystolic 10mg twice daily. (Bystolic is used to treat high blood pressure.)
-There was a new medication order for Nifedipine ER 30mg 3 tablets daily. (Nifedipine ER is used to treat high blood pressure and chest pain.)

Review of a nurses' note for Resident #4 dated 03/15/17 revealed:
-Staff faxed discharge orders with new FL-2 to the facility's primary pharmacy.
-Staff faxed allergy information to the primary pharmacy in order to release new medications.

Review of a nurses' note for Resident #4 dated

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D 358	Continued From page 57 03/15/17 revealed staff faxed a copy of FL-2 to the primary pharmacy that was in the resident's hospital folder due to some medications were still not showing on the electronic MAR. Review of a nurses' note for Resident #4 dated 03/17/17 revealed: -Staff called the primary pharmacy to reorder medications for the resident but the pharmacy indicated their records showed the resident used another pharmacy. -The resident had been using the primary pharmacy but the resident's face sheet had to be changed to the primary pharmacy and it was faxed to them. Review of a form faxed to the primary pharmacy dated 03/17/17 revealed: -Staff noted the fax would serve as written proof for Resident #4's medications to be filled by the primary pharmacy. Review of Resident #4's March 2017 medication administration record (MAR) revealed: -There was an entry for Bystolic 10mg 1 tablet twice daily with an original order date of 03/15/17. -Bystolic was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -Bystolic was not documented as administered from 03/16/17 - 03/19/17 due to "awaiting pharmacy delivery". -Bystolic was not documented as administered from 03/20/17 - 03/22/17 due to the resident being out of the facility and in the hospital. Review of Resident #4's March 2017 MAR revealed: -There was an entry for Plavix 75mg 1 tablet daily with an original order date of 03/15/17. -Plavix was scheduled to be administered at 8:00	D 358		

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D 358	Continued From page 58 a.m. -Plavix was not documented as administered on 03/15/17 and 03/16/17 with no reason for the omission documented. -Plavix was not documented as administered on 03/17/17 and 03/20/17 due to "awaiting pharmacy delivery". -Plavix was documented as administered on 03/18/17 and 03/19/17. -Plavix was not documented as administered on 03/21/17 and 03/22/17 due to the resident being out of the facility and in the hospital. Review of Resident #4's March 2017 MAR revealed: -There was an entry for Hydralazine 50mg 1 tablet every 8 hours with an original order date of 03/15/17. -Hydralazine was scheduled to be administered at 6:00 a.m., 2:00 p.m., and 10:00 p.m. -Hydralazine was not documented as administered from 03/16/17 - 03/20/17 due to "awaiting pharmacy delivery". -Hydralazine was not documented as administered from 03/21/17 - 03/22/17 due to the resident being in the hospital. Review of Resident #4's March 2017 MAR revealed: -There was an entry for Nifedipine ER 30mg 3 tablets (90mg) daily with an original order date of 03/15/17. -Nifedipine ER was scheduled to be administered at 8:00 a.m. -Nifedipine ER was not documented as administered on 03/15/17 and 03/16/17 with no reason for the omission documented. -Nifedipine ER was not documented as administered on 03/17/17 and 03/20/17 due to "awaiting pharmacy delivery".	D 358		

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D 358	Continued From page 59 -Nifedipine ER was documented as administered on 03/18/17 and 03/19/17. -Nifedipine was not documented as administered on 03/21/17 and 03/22/17 due to the resident being out of the facility and in the hospital. Review of nurses' notes for Resident #4 dated 03/18/17 - 03/21/17 revealed: -There was no documentation the primary pharmacy was contacted again about obtaining medications for the resident. -There was no documentation that Resident #4's primary care provider (PCP) or cardiologist were notified the resident was not receiving the new heart / blood pressure medications prescribed when the resident was discharged from the hospital on 03/15/17. Telephone interview with a pharmacist from the facility's primary pharmacy on 03/30/17 at 10:07 a.m. revealed: -Their pharmacy just started servicing the facility as the primary pharmacy either on 12/01/16 or 01/01/17. -She thought when they first got Resident #4's information in December 2016, they supplied some medications for her but someone at the facility told the pharmacy that the resident got her medications from a local pharmacy. -She did not know which staff person from the facility reported that information to the pharmacy. -Someone from the facility contacted them last week (the week of 03/20/17) to get medications for Resident #4. -They were having problems with their computer system today and she could not access all information in the computer. -She was unable to access some of the dispensing information but she would try to generate a report and fax to the facility.	D 358		

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D 358	Continued From page 60 Review of primary pharmacy dispensing records for Resident #4 dated 12/30/16 - 03/30/17 revealed: -Thirty Plavix 75mg tablets were dispensed on 03/20/17 with an original order date of 03/15/17. -Ninety Hydralazine 50mg tablets were dispensed on 03/20/17 with an original order date of 03/15/17. -Sixty Bystolic 10mg tablets were dispensed on 03/20/17 with an original order date of 03/15/17. -Ninety Nifedipine ER 30mg tablets were dispensed on 03/20/17 with an original order date of 03/15/17. Telephone interview with a pharmacist at a local pharmacy on 03/30/17 at 11:38 a.m. revealed they had not dispensed any medications for Resident #4. Review of medications on hand on 03/31/17 for Resident #4 revealed: -There was a supply of Plavix 75mg tablets dispensed by the facility's primary pharmacy on 03/20/17 and 21 of 30 tablets were left in the bubble card. -There was a supply of Hydralazine 50mg tablets dispensed by the facility's primary pharmacy on 03/20/17 and 70 of 90 tablets were left in the bubble card. -There was a supply of Bystolic 10mg tablets dispensed by the facility's primary pharmacy on 03/20/17 and 42 of 60 tablets were left in the bubble card. -There was a supply of Nifedipine ER 30mg tablets dispensed by the facility's primary pharmacy on 03/20/17 and 59 of 90 tablets were left in the bubble card. Interview with a medication aide on 03/31/17 at	D 358		

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D 358	Continued From page 61 1:10 p.m. revealed: -They have had some problems getting medications from the primary pharmacy. -Resident #4 had always used the facility's primary pharmacy. -The primary pharmacy told the facility in March 2017 (could not recall date) that Resident #4's face sheet indicated the resident used a local pharmacy. -The facility faxed a face sheet to the pharmacy for Resident #4 to use the primary pharmacy. -She could not recall what date it was faxed to the pharmacy. -A copy of the fax was filed in the resident's record. -She was not sure why there was a delay in getting the medications after that. Interview with the Administrator on 03/31/17 at 12:35 p.m. revealed: -The facility sent all orders for Resident #4 from the hospitalization ending 03/15/17 to the primary pharmacy. -The primary pharmacy indicated that Resident #4 was not one of their patients. -They faxed documentation of a face sheet indicating Resident #4 used the primary pharmacy. -She did not know when they faxed the information to the pharmacy and she could not find any documentation in her notes. -She was not aware there was a delay in getting the medications after the form was faxed to the pharmacy. -The medication aides were supposed to let the Administrator, Resident Care Coordinator (RCC), or the nurse know if medications did not come in from the pharmacy. Interview with the facility's Licensed Health	D 358		

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Professional Support (LHPS) nurse on 03/31/17 at 12:55 p.m. revealed:
-She faxed the orders from Resident #4's hospitalization ending 03/15/17 to the primary pharmacy on 03/15/17.
-She put the orders in the facility's "bucket" system.
-The Administrator or RCC were supposed to check the "bucket" to assure medications orders were implemented.
-Staff had not reported to the nurse that they had not been unable to get medications for Resident #4 after her hospitalization ending 03/15/17.
-She was not aware the resident had missed the doses of medications.

Interviews with Resident #4 on 03/30/17 at 4:50 p.m. and 03/31/17 at 8:40 a.m. revealed:
-She had been hospitalized at least twice recently for congestive heart failure.
-She had heart trouble since 1993 and she had congestive heart failure.
-She did not know if she was getting medications like she was supposed to.
-She had missed some medications for 2 or 3 days because they did not come in from the pharmacy.
-She could not recall when this happened or which medications.
-Her blood pressure sometimes ran high.
-The facility staff ordered her medications from the facility's primary pharmacy.
-She did not get medications from any other pharmacy.

Review of a nurses' note for Resident #4 dated 03/21/17 revealed the resident was sent out for chest pain.

Review of a hospital discharge report for

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D 358	Continued From page 63 Resident #4 dated 03/22/17 revealed: -The resident was admitted on 03/21/17 with severe midsternal chest pressure and shortness of breath. -The chest pressure radiated to her back, left jaw, left arm, and was accompanied by nausea. -The resident's blood pressure was 178/81. -The resident's blood pressure was "likely driving the congestive heart failure exacerbation". -The resident's blood pressure seemed "poorly controlled" despite being on several medications. -The resident was admitted and released less than two weeks ago for similar symptoms. -The resident's pain was relieved by Nitroglycerin paste and a diuretic. -The resident's discharge diagnoses included chest pain, non-cardiac; acute on chronic combined systolic and diastolic heart failure, mild; and chronic renal disease, stage 4. -The resident was discharged on 03/22/17. -There was a list of medications for the resident to continue taking with no changes. -The list included Plavix 75mg daily, Hydralazine 50mg every 8 hours, Bystolic 10mg twice daily, and Nifedipine ER 30mg 3 tablets daily. Interview with the facility's corporate Clinical Support Specialist on 03/31/17 at 12:25 p.m. revealed: -They got medications on a cycle fill and on demand from the primary pharmacy. -Sometimes it was difficult for staff to know which medications had to be ordered and which ones would come in the cycle fill batch each month. -Medication orders sent to the primary pharmacy by 12:00 noon would be delivered that same night. -Medication orders sent to the primary pharmacy after 12:00 noon would be delivered the next night.	D 358		

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D 358	Continued From page 64 -If a medication was ordered and not received by the facility, the medication aides were supposed to let the nurse or the Administrator know about it. -The Administrator printed exception reports from the electronic MARs which would show documentation of unavailable medications. -She was not aware Resident #4's new medications ordered when she was discharged from the hospital on 03/15/17 were unavailable and not started prior to the re-hospitalization on 03/21/17. -The Resident Care Coordinator (RCC) was also supposed to help review orders and MARs to make sure medications orders were implemented. -The facility had been short staffed and the RCC was currently working as a medication aide on night shift for about 2 months. -The RCC had not been able to perform routine monitoring tasks during this time since she was working as a medication aide. -They were in the process of trying to hire new staff. Telephone interview with a nurse at the PCP's office for Resident #4 on 03/31/17 at 1:25 p.m. revealed: -They were aware Resident #4 had some recent hospitalizations. -The resident missing the heart medications could have contributed to the resident being re-hospitalized on 03/21/17. -They had not been notified of Resident #4 missing the doses of medications prior to being hospitalized on 03/21/17. Telephone interview with a nurse at the cardiologist's office for Resident #4 on 03/31/17 at 2:35 p.m. revealed: -The cardiologist was with a patient and	D 358		

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unavailable to come to the phone.
-They were not aware Resident #4 had missed dosages of heart medications and Plavix between her most recent hospitalizations in March 2017.
-She discussed the missed doses with the PCP and the PCP stated the missed doses of heart medications could have contributed to Resident #4's symptoms and re-hospitalization.
-The PCP was especially concerned about the resident missing doses of Bystolic because it helps control heart rate and medications in that class of drugs should not be stopped abruptly.
-The resident was taking Bisoprolol prior to the order for Bystolic. (Bisoprolol and Bystolic are both beta blockers and abrupt cessation of beta blockers may cause an acute exacerbation of cardiac disease.)
-The PCP was also concerned that missing doses of Plavix could cause one of the resident's cardiac stents to clot.

3. Review of Resident #5's current FL-2 dated 1/21/17 revealed:
-The resident's diagnoses included urinary tract infection with carbapenem resistant organisms, diabetes, dementia, autonomic dysfunction, neurogenic bladder, interstitial lung disease, chronic kidney disease stage 2-3, chronic anemia, malignant hypertension and gastroesophageal reflux disease.
-The resident was intermittently oriented.

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 8/17/16.

Review of Resident #5's Clinical Discharge Instructions from the hospital dated 3/24/17 revealed:
-The reason for the visit was acute urinary tract

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D 358	Continued From page 66	D 358		

infection.
-There was an order for Levofloxacin 750 milligrams, take 1 tablet by mouth every 24 hours for 5 days. (Levofloxacin is an antibiotic used to treat infection).

Review of Resident #5's electronic Medication Administration Record for March 2017 revealed:
-There was an order for Levofloxacin 750 milligrams, take 1 tablet by mouth every day for 5 days added on 3/29/17.
-There was an entry indicating the medication had been administered on 3/29/17.
-There was an entry of "awaiting pharmacy delivery" on 3/30/17.

Observation of medications on hand for Resident #5 on 3/29/17 revealed there was no Levofloxacin available.

Observation on 3/29/17 at 5:25 pm revealed Emergency Management Services leaving with Resident #5.

Interview with a 2nd shift Medication Aide on 3/29/17 at 5:25 pm revealed:
-She had observed blood in Resident #5's urine approximately 30 minutes ago and had notified the Administrator.
-The Administrator had instructed her to immediately call 911.
-The resident had not had blood in his urine until today.
-She had observed the residents physical health deteriorating the past month leaving the resident no longer able to do anything for himself.

Review of Resident #5's Clinical Discharge Instructions from the hospital dated 3/29/17 revealed:

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D 358	Continued From page 67 -The reason for the visit was hematuria and urinary tract infection. -There was an order to discontinue Levofloxacin. -There was an order for Doxycycline 100 milligrams, take 1 capsule by mouth twice a day. Telephone interview with the attending physician at the hospital on 3/30/17 at 9:29 am revealed: -He had not been aware that Resident #5 had not been administered Levofloxacin as ordered on 3/24/17. -With the residents health conditions, not treating a urinary tract infection could "easily lead to sepsis". Telephone interview with the pharmacy that maintains the electronic Medication Administration Records for the facility on 3/30/17 at 9:00 am revealed they had received the order for Resident #5's Levofloxacin on 3/29/17 and updated the Medication Administration Record the same day. Telephone interview with the dispensing pharmacy for Resident #5 on 3/30/17 at 10:02 am revealed they had not received an order for Levofloxacin for the resident. Telephone interview with a 1st shift Medication Aide on 3/30/17 at 12:05 pm revealed: -She had not administered Levofloxacin to Resident #5 on 3/29/17. -She had not been aware that the resident had been ordered the medication. -She had not made the entry on 3/29/17 indicating that she had administered the medication and she was not aware of who made the entry. Telephone interview with a 2nd shift Medication	D 358		

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D 358	Continued From page 68 Aide on 3/30/17 at 12:45 pm revealed: -She had faxed Resident #5's order for Levofloxacin to the pharmacy that maintains the electronic Medication Administration Records on 3/24/17. -She had forgotten that the resident used a different pharmacy to dispense his medications and she had not sent the order to the dispensing pharmacy. Interview with the Administrator on 3/30/17 at 12:58 pm revealed: -She had not been aware that Resident #5 had not been administered Levofloxacin. -The Resident Care Manager was responsible for checking behind the Medication Aides to ensure all physician orders were followed. -The Resident Care Manager had been working as a Medication Aide for several weeks due to a shortage of staff. 4. Review of Resident #3's current FL-2 dated 2/22/17 revealed: -The resident diagnosis included hypoglycemia with history of diabetes, dyslipidemia, history of cerebrovascular accident, history of peripheral neuropathy, history of coronary obstructive pulmonary disease, history of mood disorder, history of gastroesophageal disease and tobacco abuse. -A physician's order for Novolog insulin - 2 units subcutaneously three times a day before meals, hold if resident is not eating. (Novolog is a rapid acting insulin used to treat diabetes). -A physician's order for Levemir insulin - 20 units subcutaneously daily at bedtime. (Levemir is a long acting insulin used to treat diabetes). Review of the Resident Register revealed Resident #3 was admitted on 12/16/09.	D 358		

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D 358	Continued From page 69 Review of a subsequent physician's order on a Medication Discharge Report from the local hospital emergency room for Resident #3 dated 3/24/17 revealed: -Discontinue Novolog - 2 units subcutaneously three times a day before meals. -Discontinue Levemir - 20 units subcutaneously as bedtime. -There was a physician's signature and was dated 3/24/17. Review of the fax confirmation provided revealed: -The paper read "transmission verification report". -The paper was dated 03/24/17 at 12:16 am. -There was hand writing with the word "pharmacy" at the top of the paper. -The fax number corresponded with the facility contracted pharmacy. -The fax transmission verification report was attached to the physician's order for the discontinuation of Novolog insulin and Levemir insulin for Resident #3. Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2017 revealed: -Novolog insulin - 2 units subcutaneously three times daily before meals, "hold if not eating". -Levemir insulin - 20 units subcutaneously at bedtime. -On 03/25/17 at 9:16 am - Novolog was documented as "resident refused". -On 03/25/17 at 11:30 am - Novolog 2 units was documented as administered. -On 03/25/17 at 8:00 pm - Levemir 20 units was documented as administered. -On 03/26/17, 03/27/17, 03/28/17 at 7:00 am, 11:30 am, 4:30 pm - Novolog 2 units was documented as administered.	D 358		

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D 358	Continued From page 70 -On 03/26/17 at 9:20 pm - Levemir was documented as "resident refused". -On 03/27/17 at 8:00 pm - Levemir 20 units was documented as administered. -On 03/29/17 at 7:00 am and 11:30 am - Novolog 2 units was documented as administered. -On 03/29/17 at 4:24 pm - Novolog was documented as not administered, "awaiting provider clarification". -On 03/29/17 at 9:11 pm - Levemir was documented as "withheld per doctor orders". -On 03/30/17 at 7:00 am - Novolog 2 units was documented as administered. -Novolog 2 units was administered 14 times after the order was discontinued. -Levemir 20 units was administered 2 times after the order was discontinued. Review of Resident #3's March 2017 Finger Stick Blood Sugar (FSBS) results revealed: -The residents FSBS was checked three times a day at 7:30 am, 11:30 am and 4:30 pm. -The results ranged from 50 mg/dL - 579 mg/dL. Interview with a 1st shift Medication Aide on 03/30/17 at 10:00 am revealed: -She faxed any new physician's orders to the pharmacy when she received them. -Whichever Medication Aide that was on duty was responsible for faxing their own orders. -This would include any type of order. -The Medication Aide would then make a note in the chart to indicate that the order had been faxed. -She then placed the order in the file attached to the wall. -She did not check the order again. -It was the Resident Care Managers and the Administrators responsibility to verify if the order was placed on the eMAR and sign it off.	D 358		

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D 358	Continued From page 71 -She had administered the Novolog insulin to Resident #3 on 03/27/17 and 03/29/17 because there was an order on the eMAR. -She had no reason to think the order on the eMAR was not correct. Interview with the Administrator on 03/30/17 at 11:50 am revealed: -The Medication Aide (MA) on duty was responsible for faxing all new orders to the pharmacy. -There was a fax confirmation that the pharmacy received the order to discontinue the Novolog insulin and the Levemir insulin on 03/24/17 at 12:17 am for Resident #3. -When a physician's order was input or changed by the pharmacy on the eMAR, the Administrator or the Resident Care Manager would have to approve it. -When it was after hours or on the weekend, the MA was supposed to call the Administrator or the Resident Care Manager to come and approve the physician's orders on the eMAR. -There was no record that she nor the Resident Care Manager had been contacted. -She was not sure why the physician's order for Resident #3 was not discontinued on the eMAR. -She was not aware that Resident #3 was still receiving the Levemir insulin and the Novolog insulin. Telephone interview with the Pharmacist at the facility pharmacy on 03/30/17 at 3:40 pm revealed: -When physician's orders were faxed from the facility, it went into an electronic system. -She knew the pharmacy received an order for 2 new medications that were not insulin on 03/25/17 when they opened that morning. -She did not see in the computer system that the	D 358		

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D 358	Continued From page 72	D 358		

insulin discontinue order was received until 03/28/17.
-There was always a chance that something could have been over looked.
-The facility should always verify medication orders in the eMAR by the physician's order at the facility.

Telephone interview with the Medical Assistant at the Primary Care Providers (PCP) office on 03/31/17 at 10:36 am revealed:
-The facility would notify the PCP's office when a resident went to the hospital.
-The facility would fax over any new orders that they received from the hospital when the resident returned.
-The PCP was aware that Resident #3 had been to the hospital on 03/24/17.
-The PCP was not aware that the physician at the emergency room had discontinued Resident #3's insulin.
-The PCP was not in the office, but she would make him aware and see Resident #3 on Tuesday, April 04, 2017.
-She was unable to say if Resident #3's diabetes could be managed without insulin.

The facility failed to administer medications as ordered to 2 of 9 residents (#7, #8) observed during the medication pass and 3 of 5 residents (#3, #4, #5) sampled. Resident #4 did not receive 4 new heart / blood pressure medications on hospital discharge orders dated 03/15/17 and the resident was readmitted to the hospital on 03/21/17 with severe chest pain and shortness of breath and was diagnosed with acute on chronic congestive heart failure. Resident #5 was discharged from the hospital on 03/24/17 with an

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D 358	Continued From page 73 acute urinary tract infection (UTI) with an order for an antibiotic that was never administered resulting in the resident being sent to the emergency room on 03/29/17 with blood tinged urine in his catheter bag and being diagnosed with a UTI with an order for another antibiotic. Resident #3 continued to receive 14 doses of a rapid-acting insulin and 2 doses of a long-acting insulin after the insulins were discontinued on 03/24/17. Resident #7 received a rapid-acting insulin 1 hour and 12 minutes prior to the supper meal on 03/29/17. Resident #8 received wrong dosages of an antipsychotic and a laxative and did not receive pain medication as requested for back and leg pain on 03/30/17. The failure of the facility to administer medications as ordered resulted in substantial risk of serious physical harm or death to residents and constitutes a Type A2 Violation. Review of the Plan of Correction provided by the facility on 03/31/17 revealed: -The facility would immediately audit physician orders from the last 30 days and compare to the medication administration record for accuracy. -The Primary Care Provider (PCP) would be notified of any discrepancies and would request they review and sign physician's order. -The facility would follow through with any further recommendations from the PCP. -Medication Administration Records to cart audits would be conducted immediately to ensure no medcations have expired. -The Registered Nurse would provide additional education o diabetes, insulin administration and proper medication administration techniques to the medication administration staff. -All staff would be re-trained on the "bucket	D 358		

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D 358	Continued From page 74 system" (ordering process) by the clinical support staff and enforced by the Executive Director (ED) and the Resident Care Manager (RCM). -The facility would identify a lead qualified Supervisor in Charge that would be able to approve orders in the absence of the ED/RCM. -The ED/RCM would follow up on any order processes by the lead SIC to ensure accuracy. -The ED/RCM would initial the order as confirmation the order was received for proper processing to include approval on the Electronic Medication Administration Record (eMAR). -On the weekend/after hours the facility would use CVS pharmacy as the back up for the facility pharmacy. -One the medication was received and the order was on the eMAR, the ED, RCM or lead SIC would initial nest to each medication on the physician orders as verification that each order was processed. -The Registered Nurse would compete staff training, regarding eMAR documentation, specifically, proper dosage, proper milligrams and comparing the eMAR to the medication labels. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 30, 2017.	D 358		
D 387	10A NCAC 13F .1007 (b) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (b) Medications, excluding controlled medications that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of.	D 387		

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This Rule is not met as evidenced by:
Based on record reviews, observations and interviews, the facility failed to assure expired medications were stored separately from active medications for 1 of 5 sampled residents (#3).

The findings are:

Review of Resident #3's FL-2 dated 2/22/17 revealed:
-Diagnosis included hypoglycemia with history of diabetes, dyslipidemia, history of cerebrovascular accident, history of peripheral neuropathy, history of coronary obstructive pulmonary disease, history of mood disorder, history of gastroesophageal disease and tobacco abuse.
-A physician's order for Novolog insulin - 2 units subcutaneously three times a day before meals, hold if resident is not eating. (Novolog is a rapid acting insulin used to treat diabetes).

Review of the Resident Register revealed Resident #3 was admitted on 12/16/09.

Review of a subsequent physician's order on a Medication Discharge Report from the local hospital emergency room for Resident #3 dated 3/24/17 revealed:
-Discontinue Novolog - 2 units subcutaneously three times a day before meals.
-Discontinue Levemir - 20 units subcutaneously as bedtime.
-There was a physician's signature and was dated 3/24/17.

Observation on 03/30/17 at 10:10 am of the medications available for administration for Resident #3 revealed the following expired

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medication stored with the active medication:
-Novolog insulin - 2 units subcutaneously three times a day before meals, hold if resident is not eating.
-The opened date on the Novolog insulin was 02/28/17.
-The expiration date on the Novolog insulin was 03/28/17.
-There was a pharmacy sticker that indicated the insulin expired 28 days after opening.

Review of the Manufactors instructions for Novolog insulin indicates the insulin could be kept for 28 days after opening.

Review of the March 2017 Electronic Medication Administration Record (eMAR) for Resident #3 revealed:
-Novolog 2 units was administered on 03/29/17 at 7:00 am and 11:30 am.
-Novolog 2 units was administered on 03/30/17 at 7:00 am.

Interview with a Medication Aide on 03/30/17 at 10:08 am revealed:
-She had worked at the facility as a Medication Aide since 12/2015.
-She had not administered the Novolog insulin to Resident #3 today (03/30/17) because the order had changed.
-She was not aware the Novolog insulin had expired.
-She was aware that insulin was usually only good for 28 days after opening.
-She was taught as a Medication Aide to date the bottle of insulin when you first open in.
-She would reorder insulin if she noticed it was expired.
-She thought the Resident Care Manager did cart audits to check for expired medications.

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D 387	Continued From page 77 -She did know the Resident Care Manager was responsible for returning medication to the pharmacy that had been discontinued. -She was not sure when the last time medications had been returned to the pharmacy because the Resident Care Manager had been working as a Medication Aide. Telephone interview with the Pharmacist at the Facility's Pharmacy on 03/30/17 at 11:08 am revealed: -Novolog insulin could be kept for 28 days after opening. -She was unsure if the insulin was effective after 28 days, there was not clinical data to validate. -The expired insulin should be removed from the medication cart immediately and reordered if needed. The Resident Care Manager was not available for interview.	D 387		
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, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related	D912		

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D912	Continued From page 78 to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 9 residents (#7, #8) observed during the medication pass, including errors with insulin, an antipsychotic, a pain reliever, and a laxative and for 3 of 5 residents (#3, #4, #5) sampled for review including errors with insulins, an antibiotic for infection, heart / blood pressure medications, a medication to prevent blood clots, and an antidepressant. [Refer to Tag D358 10A NCAC 13F .1004 (a) Medication Administration (Type A2 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 reviews the facility failed to assure residents were free of neglect as related to supervision, health care and residents rights. The findings are: 1.Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) who was known to be disoriented, had been ordered to wear a Wanderguard, was known to remove the Wanderguard nd had wandered away from the facility. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2	D914		

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D914	Continued From page 79 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to obtain healthcare for 3 of 5 sampled residents (#2, #4, #5) regarding one resident with second degree burns for 3 days (Resident #2), one resident who did not receive Foley catheter care for 2 months and was diagnosed with a urinary tract infection (Resident #5), and one resident who missed doses of heart / blood pressure medications after a hospitalization and was readmitted to the hospital 6 days later with symptoms of chest pain and heart failure (Resident #4). [Refer to Tag D273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to protect 1 of 5 sampled residents (Resident #2) from neglect which resulted in second degree burns on the neck and shoulder because staff pushed the residents' bed agaisnt the heater and allowed the resident to lie on the heater. [Refer to Tag D338, 10A NCAC 13F .0909 Residents Rights (Type A1 Violation)].	D914		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025035	A. BUILDING: _____ B. WING _____	03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BERN HOUSE	2915 BRUNSWICK AVENUE NEW BERN, NC 28562

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D934	Continued From page 80	D934		

glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled Medication Aides (Staff C and E) had received the annual state mandated infection control training.

The findings are:

A. Review of Staff C's personnel record revealed:
-Staff C was hired as a Resident Care Manager on 08/27/08.
-Staff C had completed the medication clinical skills checklist on 12/30/16.
-Staff C had passed the state medication exam on 11/12/09.
-There was documentation Staff C had completed the state mandated infection control training on 03/07/16.

Review of the staff schedule provided by the facility revealed Staff C worked as a Medication Aide (MA) on 03/29/17 from 11:00 pm - 7:00 am.

Staff C was not available for interview.

Interview with the Business Office Manager on 03/30/17 at 9:15 am revealed:
-Staff C was hired as a Resident Care Manager (RCM) on 08/27/08.
-The RCM position could also function as a

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D934	Continued From page 81 Medication Aide at the facility. -Staff C had been working as a MA for the last few weeks because the facility was short staffed. Refer to interview with the Business Office Manager on 03/30/17 at 9:15 am. Refer to interview with the Administrator on 03/30/17 at 10:15 am. B. Review of Staff E's personnel record revealed: -Staff E was hired as a MA on 04/07/14. -There was documentation Staff E had completed the state mandated infection control training on 03/07/16. Interview with Staff E on 03/29/17 at 5:05 pm revealed she worked at the facility as a MA. Refer to interview with the Business Office Manager on 03/30/17 at 9:15 am. Refer to interview with the Administrator on 03/30/17 at 10:15 am. Interview with the Business Office Manager on 03/30/17 at 9:15 am revealed: -She was responsible for personnel records. -She scheduled the necessary trainings for staff. -She had the annual infection control training scheduled for Medication Aides on 04/07/17. -She knew the Medication Aides needed the annual infection control training. -She had other trainings that needed to be completed, so she scheduled those first. Interview with the Administrator on 03/30/17 at 10:15 am revealed: -She had worked at the facility for less than a month.	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025035	A. BUILDING: _____ B. WING _____	03/31/2017

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D934	Continued From page 82 -When she started, she was informed that the Business Office Manager was responsible for the staff's personnel records and scheduling trainings.	D934		