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

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{D 000}	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted a follow-up survey on July 12-14, 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 and interviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair for 12 resident rooms and 4 common bathrooms on the West Hall and 10 resident rooms and a common living room on the East Hall of the facility. The findings are: Observation of the West Hall on 07/12/17 from 10:50 a.m. - 12:02 p.m. revealed: -There was a hole about 3 inches in diameter on the bottom left corner of the closet door in Resident Room #114. -There were broken pieces of wood sticking out around the hole in Resident Room #114. -The ceiling exhaust fan vent cover had a thick layer of dust with strings of dust hanging down in the women's common bathroom beside Resident Room #112. -There were multiple areas of brownish black	{D 074}		

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stains with smears on the floor near the bed and near the mini-refrigerator in Resident Room #117.
-There was an area of carpet about 1 and ½ feet long that was ripped near the threshold of the door in Resident Room #115.
-There was an area of white stains about 12 by 24 inches on the carpet near the wall on the left side of the room in Resident Room #115.
-There were purple and brown stains on the floor on the right side of the bed in Resident Room #113.
-There was a dingy gray build-up of stains on the floor throughout the room in Resident Room #113.
-There was a torn area of carpet about 6 inches long that was unraveling on the left side of the threshold in Resident Room #109.
-There were multiple brownish black stains with smears on the floor throughout the room in Resident Room #107.
-The corner of the outside wall of the closet had missing paint and sheetrock near the bottom of the walls and the baseboard was peeling away from the wall in Resident Room #107.
-The overhead vent near the bathroom was covered in thick dust in Resident Room #110.
-There was black staining with smears that covered 2 floor tiles on the floor beside of the headboard of the bed near the window in Resident Room #110.
-There was a leak in the upper back corner on the right side of the room that had paint peeling from the wall with discolored streaks running down the wall in Resident Room #102.
-There were multiple rust colored stains on the floor that covered approximately six floor tiles on the edge of the floor near the wall in Resident Room #102.
-There was a hole in the closet door at waist level that was approximately 4 inches in diameter in

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{D 074}	Continued From page 2 Resident Room #102. -There were orange/rust colored stains on multiple floor tiles in Resident Room #100. -There were black scrapes 8-10 inches in length on the wall with blackened area on the floor beneath the scrapes in Resident Room #98. The overhead vents in two common hallway bathrooms between Resident Rooms #99 and #101 were covered in thick dust. -The closet door had an area approximately 4 inches in diameter that had been patched halfway between the floor and midway of the door in Resident Room #103. -The floor had 2 tiles near the window that had a black stain with smears in Resident Room #103. Interview with the resident who resided in Room #114 on 07/12/17 at 10:50 a.m. revealed: -She did not know what happened to the closet door. -The hole in the closet door had "been there" but she could not say how long. Interview with the resident in who resided in Room #117 on 07/12/17 at 11:15 a.m. revealed: -The stains on the floor had been there "a long time". -The facility staff had scrubbed the floor but the stains would not come up. -She could not recall when they tried to scrub the stains on the floor. Interview with the resident who resided in Room #107 on 07/12/17 at 12:00 p.m. revealed: -He had just moved to this room a couple of weeks ago. -The floor was already stained and the wall was already damaged when he moved in. Interview on 07/12/17 at 11:25 a.m. with the	{D 074}		

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resident who resided in Room #110 revealed that she was not aware of anything on the floor and did not know what the black substance was.

Interview on 07/12/17 at 11: 44 a.m. with the resident who resided in Room #102 revealed:
-Her room had been "like that" since she moved in and she did not know how any of the problems noted had occurred.
-The resident could not recall how long she had lived at the facility.
-She had not reported the problems to anyone.

Interview on 07/12/17 at 11:51 a.m. with the resident who resided in room #98 on the West Hall revealed:
-She did not know the outlet was broken.
-She did not know how the wall had been "scraped up."
-She had not reported the problems to anyone.

Interview with the Administrator on 07/12/17 at 4:50 p.m. revealed:
-Housekeeping staff were responsible for cleaning the ceiling vents.
-Ceiling vents were not cleaned daily but should be cleaned as needed.

Interview with a housekeeper on 07/12/17 at 11:39 a.m. revealed:
-She had tried to clean the stains on the floor in Room #113 in the past but they stains would not come up.
-The floors throughout the facility needed buffing.
-The facility did not currently have a maintenance staff person.

Observation of the women's common bathroom beside Resident Room #112 on the West Hall on 07/14/17 at 3:26 p.m. revealed the ceiling

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exhaust fan vent cover had been cleaned.

Observation of Resident Room #107 on the West Hall on 07/14/17 at 3:34 p.m. revealed the wall had been repaired and painted, and the baseboard had been repaired.

Observation of the bathroom beside of Resident Room #110 on the West Hall on 07/14/17 revealed the overhead vent had been cleaned.

Observation of of the two common hallway bathrooms between Resident Rooms #99 and #101 on the West Hall on 07/14/17 revealed the overhead vents had been cleaned.

Observation of Resident Room #98 on the West Hall on 07/15/17 revealed that the outlet cover had been replaced.

Observation of Resident Room #306 on 07/13/17 at 10:12 a.m. revealed:
-There were two approximately 8-inch wide brown ceiling stains over the wall air-conditioner unit.
-There were two scrapes in the left wall 16 inches in length approximately 1-foot from the floor.

Observation of Resident Room #308 on 07/13/17 at 10:18 a.m. revealed there were 3 dark stains in the corner seams of the far right ceiling corner extending approximately 3-feet from the corner.

Observation of Resident Room #310 on the East Hall on 07/13/17 at 10:22 a.m. revealed:
-The base of the right closet door had a 20-inch by 4-inch area of peeling splintered wood laminate.
-The left closet door had a 24-inch horizontal scrape 6-inches below the door handle.
-The linoleum floor tile 2-feet to the right of the

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{D 074}	Continued From page 5 red chair at the wall was torn with black stains. Observation of Resident Room #309 on 07/13/17 at 10:26 a.m. revealed a 3-foot by 3-foot section of 9 linoleum tiles on the right corner had brown stains. Observation of the East Hall living room on 07/13/17 at 10:29 a.m. revealed the thermostat, air handler switch and light switch on the left entry wall were covered in a sticky gray grime. Observation of Resident Room #314 on 07/13/17 at 10:32 a.m. revealed: -The white thermostat cover plate and the wall switch on the left entry wall were dirty and covered with a sticky brown grime. -There was a 5-inch section of peeling paint at the floor approximately 3-feet to the left of the wall outlet on the left wall. Observation of Resident Room #316 on 07/13/17 at 10:35 a.m. revealed the white thermostat cover plate and the wall switch on the right entry wall were dirty and covered with a sticky brown grime. Observation of Resident Room #313 on 07/13/17 at 10:37 a.m. revealed wall by the entrance had light gray stains extending 3-feet from the ceiling across the length of the wall. Observation of Resident Room #318 on 07/13/17 at 10:55 a.m. revealed there was a 3-inch hole in the wall at the baseboard to the left of the headboard. Observation of Resident Room #331 on 07/13/17 at 11:02 a.m. revealed the carpet at the base of the entry door was frayed where it touched the hallway linoleum and had a missing rubber cover	{D 074}		

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{D 074}	Continued From page 6 strip which was rolled up behind the door. Interview with the Administrator on 07/12/17 at 4:50 p.m. revealed: -The brownish black stains on the floor tile in Room #110 was tar seeping through the grout of the tile. -They had tried to remove the tar in Room #110 but it would not come up. -The facility did not currently have a maintenance person. -The previous maintenance person had not worked at the facility in about 1 and ½ months. -The previous maintenance person tried buffing the floors including Room #110 but that did not help. -She thought the only way to remove the tar in Room #110 would be to replace the flooring. -The facility had not moved forward at this point with replacing the flooring in any of the rooms. Observation of the East Hallway on 7/14/17 at 2:43 p.m. revealed: -There were two individuals in conversation with each other identifying needed room repairs. -The two individuals, identified as the maintenance contractors, were going between rooms on the East Hall. Interview with two maintenance contractors on 7/14//17 at 2:45 p.m. revealed: -They were sent by the corporate office to check the building for repairs. -They were instructed to go room to room and write down specific repairs for each room. -They had never visited the facility before 7/14/17. -The facility did not have a maintenance person on staff. -They could not give an estimated time of repairs as they were just beginning to survey the	{D 074}		

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{D 074}	Continued From page 7 property. Interview with the Administrator on 7/14/17 at 3:05 p.m. revealed: -There was no current log book for items in need of repair. -She did a walk-through of the facility each day but had not identified items in need of repair nor kept a log of things to repair or replace. -If staff identified anything in need of repair or replacement, those staff had told the RCC who would then inform her. -She had not been notified of anything in need of repair. -The communication between the Resident Care Coordinator (RCC) and the Administrator was mostly verbal. -She was unaware there were floors, walls and ceilings in need of repair. -She would do a complete walk through each room and identify needed repairs. -She would contact the corporate office to ensure any repairs identified at the facility would be performed.	{D 074}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.	{D 079}		

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{D 079}	Continued From page 8 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure the residents' rooms and common areas were free of hazards as evidenced by the presence of roaches, flies, ants and fruit flies in residents' rooms, dining room and common hallways; and failed to follow the established protocol when bed bug activity was confirmed in residents' rooms to include not treating the linens or clothing and not cleaning the residents' rooms or common areas with known bed bug activity. The findings are: Observation of Resident Room #117 on the West Hall on 07/12/17 at 11:15 a.m. revealed: -There were two roaches crawling on the floor under a chair and under the trash can. -There were multiple small roaches crawling on the floor and on the side of the mini-refrigerator in the room. Interview with the resident who resided in Room #117 on 07/12/17 at 11:15 a.m. revealed: -She had roaches in her room and saw them crawling occasionally. -She had seen a roach on the floor near her bed that morning on 07/12/17. -Someone sprayed for the roaches in her room about every 2 weeks but she did not know who sprayed. -She saw a bug crawling in her bed a couple of days ago but she was not sure what kind of bug. -She did not report it to staff. -She thought something bit her while she was in the bed a few weeks ago on her left hand and	{D 079}		

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{D 079}	Continued From page 9 arm but she did not see it. -The doctor told her it was dry skin. Observation of Resident Room #117 on the West Hall on 07/14/17 at 3:28 p.m. revealed: -There were several small dead roaches laying on the floor near the mini-refrigerator. -There were dead roaches laying in a clear liquid on the floor around the refrigerator. -There were two roaches crawling on the mini-refrigerator. Confidential interview with a staff person revealed: -The staff person found a "big" roach in Resident Room #113 on 07/12/17. -The staff person killed the roach. Observation of the medication room on the East Hall on 07/12/17 at 12:30 p.m. revealed there were multiple ants crawling on the countertop at the sink and up the wall above the sink. Interview with a medication aide (MA) on 07/12/17 at 12:30 p.m. revealed: -She had not noticed the ants crawling in the medication room. -This was the first time she had seen ants in the medication room. -She had seen roaches "here and there". -The exterminator came to the facility and sprayed about 2 to 3 weeks ago. Observation of the medication room on 07/14/17 at 3:37 p.m. revealed: -There were a few dead ants on the wall above the sink. -No live ants were seen. Confidential resident interview revealed:	{D 079}		

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{D 079}	Continued From page 10 -The resident had seen roaches in the facility and once or twice the resident had killed some roaches in the facility. -Someone sprayed the facility about once a month but it did not help because the roach problem stayed the same. Confidential staff interview revealed: -Every room in the facility had roaches and some rooms had a lot of roaches. -Roaches had been observed in the facility during the past year. -The exterminating company came to the facility to spray but there were more roaches now than when it first started. -All halls (East, West, and South) had bedbugs and bedbugs could be seen crawling on the residents. -The bedbugs were worse on the East Hall. -The staff person saw a bed bug last Monday (07/03/17) crawling on the wall near the janitor's room on the East Hall. Observations on the East Hall on 07/13/17 between 10:20 a.m. and 2:45 p.m. revealed: -There were 2 flies on the waste basket in room #306. -There were 2 live roaches in front of the closet doors in Room #310. -There were 3 dead roaches to the right of the red chair in Room #310. -There was a live roach beneath the window in Room #316. -There was a live roach to the right of a pink plastic bin on the floor in the closet in Room #316. -There was a dead roach at the foot of the bed in Room #316. -There was a live roach crawling on the floor by the window in Room #318.	{D 079}		

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{D 079}	Continued From page 11 -There was a fly on the bedspread in Room #318. -There was a dead roach on the nightstand in Room #320. -There was a fly on the wall above the head of the bed in Room #320. -There was a dead roach on the floor in the center of the room in Room #323. -There were 10 live roaches inside the bathroom sink cabinet and 1 roach crawling on the exterior door of the cabinet in Room #323. -There was a crushed roach on the door frame of Room #323. -There were several dead roaches, flies and bed bugs under the dresser and along the far wall baseboard in Room #323. -There was a roach approximately 5 feet from the floor crawling on the hallway wall to the right of the door of Room #306. Observations on the West Hall on 07/13/17 between 10:20 a.m. and 2:45 p.m. revealed: -There was a live bed bug crawling on the floor by the left post of the bed's headboard in Room #112. -There were 8 live bed bugs in the vinyl half-inch white seam of the mattress in Room #112. -There were 3 live bed bugs in Room #114 on the floor in the corner to the left of the bed where the resident was sleeping. -There were approximately 20 drain flies on the left wall over the sink in the women's shared bathroom to the left of Room #99. Observation of Resident Room #97 on the West Hall on 07/14/17 at 11:00 a.m. revealed there was a line of approximately one hundred ants extending from the window sill to the upper far right corner ceiling, to the headboard, to the refrigerator, to the wall and to the right of the bed.	{D 079}		

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{D 079}	Continued From page 12 Interview with the resident of Room #97 on the West Hall on 07/14/17 at 11:00 a.m. was unsuccessful. Interview with the Administrator on 07/14/17 at 11:05 a.m. revealed: -She was unaware of the ants in Room #97. -She would call the pest control company about the ants right away. Interview with the Administrator on 07/14/17 at 11:30 a.m. revealed: -The pest control company "told me to kill the ants with window cleaner." -She had already sprayed the room and the problem was taken care of. -She was not allowed to call the pest control company for "spot treatments" between regularly scheduled visits. Observation of the kitchen on 07/13/17 at 4:45 p.m. revealed: -There was a dead roach on the handle of a white coffee cup on a metal shelf where the clean dishes were stored. -There was a fly on the clean dishes on the upper metal. Observation of the dining room on 07/13/17 between 5:00 p.m. and 5:30 p.m. revealed: -There were two flies on a full plate of food on the first table on the left of the entrance -There were fruit flies hovering over a white bowl filled with strawberries at the table across from the piano where the resident was eating. Observation of Resident Room #97 on the West Hall on 07/14/17 at 3:00 p.m. revealed: -There were dried light blue stains on the entire	{D 079}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 079}	Continued From page 13 window sill, refrigerator and far right corner wall at the floor. -There were approximately one hundred ants extending from the window sill to the upper far right corner ceiling. -The Administrator was trying to determine where the ants were entering the room. Review of the facility's pest control service tickets for the last 3 months revealed: -On 06/20/17, the company treated rooms #99, #115, #329, #310, #308 and #305 for bed bugs by steaming the rooms to 315 degrees and advising the facility to follow the "14-day cleaning protocol." -On 06/20/17, all rooms, kitchen, offices, storage and common areas were treated for household pests. -On 05/17/17, the company treated rooms #99, #115, #329, #310, #308, #201 and #305 for bed bugs by steaming the rooms to 315 degrees and advising the facility to follow the "14-day cleaning protocol." -On 05/17/17, all rooms, kitchen, offices, storage and common areas were treated for household pests. -On 04/18/17, the company treated rooms #97, #109, #201, #202, #305, and #308 for bed bugs by steaming the rooms to 300 plus degrees. -On 04/18/17, all rooms, kitchen, offices, storage and common areas were treated for household pests. Observation of the facility's pest control service tickets for the last 3 months revealed that all rooms noted as having bed bug treatments had residents residing in those rooms except room #308. Telephone interview with the facility's pest control	{D 079}		

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{D 079}	Continued From page 14 company on 07/14/17 at 3:30 p.m. revealed: -They were not allowed to answer any questions to non-clients related to pest control. -They would email the 14-day protocol noted on the pest control tickets to the facility. Review of the 14-Day Cleaning Process for Bed Bug Treatments provided by the facility's pest control company revealed: -After treatment is complete, all cracks, holes, and seams must be sealed with caulking or putty by maintenance. -All areas treated should be vacuumed including furniture, beds, closets and flooring with a crack and crevice attachment for a minimum of 2 weeks. -All cardboard should be disposed of as it creates a harborage for pests including bed bugs and roaches. -Clean rooms daily with a solution of one-half ounce of dish liquid per quart of water for a minimum of 2 weeks. -Clothing items must be dried on high heat for at least 30 minutes after pest control treatment. -The pest control company is not responsible for re-treatment if the facility failed to follow the 14-day process. Interview with the Administrator on 07/14/17 at 3:00 p.m. revealed: -She had sprayed with window cleaner which caused the blue stains. -The window cleaner had killed the ants but new ones kept coming back in the room. -She could not locate where the ants were entering the room. -The corporate office did not allow her call the pest control company for spot treatments between regularly scheduled pest control treatments.	{D 079}		

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{D 079}	Continued From page 15 -She did not feel that the ants were a problem. -She did not notice any live roaches in the resident rooms. -There were flies in the facility but they were not a problem. -She was unaware that any flies landed on residents' food. -No residents had complained to her about roaches, flies, fruit flies, bed bugs or ants. -She was unaware of any current bed bug activity in the facility. -The pest control company was doing an effective job but it was the residents' fault that the same rooms in the facility kept needing treatment for bed bugs as they brought them into the facility. -The staff knew the protocols for cleaning bed bug rooms after the pest control company treated the rooms. She was responsible for monitoring for bed bugs and overseeing the procedures related to the facility's bed bug protocol. -No residents had complained of being bitten or had been observed with bites. -The facility did not have an infestation of bed bugs or other pests. -The facility does not have a Maintenance Director. -Any maintenance needs were emailed to corporate. -She did much of the maintenance required at the facility. -She did not keep a maintenance log. Confidential interviews with six residents revealed: -The resident had seen roaches and bed bugs in the facility. -The facility was full of tiny roaches. -There was always "something flying around" in the bathrooms.	{D 079}		

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{D 079}	Continued From page 16 -It was common to see fruit flies in the bathroom and house flies hovering over your dessert during meals. -One resident had seen roaches in his room and would "stomp them." -A second resident saw roaches in the hallways often but didn't see many in his room. -A third resident had seen roaches in the facility since becoming moving to the facility. -"It was difficult to eat when you had to keep swatting flies off your food." -"There was always at least one fly on the table while you ate." Interview with the Regional Director on 07/14/17 at 3:15 p.m. revealed: -The Administrator was not authorized to call the pest control company for treatments between regularly scheduled monthly treatments. -She was not authorized to call the pest control company for treatments between regularly scheduled monthly treatments. -The corporate office had to approve any and all pest control treatments. -The next pest control treatment was scheduled for 07/18/17 at 9:00 a.m. -There was no need to call them for spot treatments when they were scheduled to arrive on the regularly scheduled visit in 4 days. -She was unaware that the facility had any "major issues" with roaches or ants. -She was aware that "one or two rooms" had a history with bed bugs but the pest control company took care of it. -The fruit fly problem was addressed as of 3/31/17. -The flies at the facility, especially in the dining room, were caused by the residents opening the front door which allowed them into the building. -There was nothing in place to address the flies at	{D 079}		

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{D 079}	Continued From page 17 the facility. -If pests were discovered at the facility, staff were instructed to call the pest control company. -She was unaware that there were bed bugs in Room #112 and #114. Interview with the Vice President of Resident Services on 07/14/17 at 3:22 p.m. revealed: -Staff were instructed to follow the 14-day protocol post-bed bug treatments. -The protocol required using a spray solution made up of "1 teaspoon of dishwashing liquid to 1 quart of water." -The protocol used to be vinegar and water but changed as of the beginning of the year. -All staff should know about and be using the new protocol. -The rooms' mattress, floors, dressers and walls would be wiped down using the spray each day for 14 days after the pest control company treated the rooms for bed bugs. -The clothing in the rooms' drawers, closets and bed linens would bagged up and placed in the dryer and dried on high heat. Confidential interview with a staff revealed: -The staff member did not know about a 14-day protocol. -The staff member was told to use vinegar and water 50-50 mix only on the bed mattress and wash the bed linens the day after pest control treated for bed bugs. -The staff member could not recall any protocols in place or facility training after bed bug treatment was performed. -The staff member had seen bed bugs but would not say which rooms were affected. Confidential interview with a second staff revealed:	{D 079}		

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{D 079}	Continued From page 18 -The 14-day protocol consisted of using a "super strong commercial spray provided by the company with a professional label that killed anything it touches" for 14-days on the mattress and walls, as well as heat drying the comforter. -The staff member could not identify any rooms treated. - The staff member could not recall any protocols in place or facility training's after bed bug treatment was performed. -The pest control company sprayed the entire facility every month. -The staff member could not say which rooms were treated. -The staff member had seen bed bugs but would not say which rooms were affected. Confidential interview with a third staff revealed: -The staff member did not know about a 14-day protocol. -There was a vinegar and water solution they were told to clean walls and mattress with after they stripped the beds. -The staff member did not know how frequently they were supposed to use it. -The facility's pest control company was ineffective because the facility had a lot of roaches and bed bugs. -The facility was unable to control the flies in the building. Confidential interview with a fourth staff revealed: -"I think we use dishwashing liquid to spray directly on a bed bug when we see one." -After the rooms were treated by the pest control company, the room was wiped down with vinegar and water, and all clothing was heated in the dryer. -The same rooms kept getting repopulated with bed bugs.	{D 079}		

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{D 079}	Continued From page 19 -All staff knew to check their shoes and pant cuffs before leaving the facility to ensure no bed bugs were brought home. Confidential interview with a fifth staff revealed: -The staff member did not know about a 14-day protocol. -The Administrator and Resident Care Coordinator (RCC) knew about the roaches and bed bugs but could not do anything about them. -The pest control company sprayed the entire facility every month. --- The facility failed to ensure the residents environment was free from roaches, flies, fruit flies, ants and bed bugs, and the continued bed bug infestations and staff's lack of knowledge of bed bug protocols was detrimental to the health and safety of the residents. This constitutes a Type B violation. --- Review of the facility's Plan of Protection dated 6/28/17 revealed: -Rooms identified as having live bed bug activity will be thoroughly cleaned. -The pest control company had been notified. -Dietary staff will receive training on dining room cleanliness and use of cleaning supplies. -Cleaning solution supplier will provide chemicals to help rid flies and fruit flies. -Continue current contract with pest control provider. -Remind residents of storing food in air-tight containers if they have food in their rooms. -Housekeeping staff and direct care staff will be retrained by 7/14/17 on reporting seeing any live activity with pests to immediate supervisor. -Supervisor will contact regional and/or corporate for spot treatments. -Administrator/designee will perform daily walk	{D 079}		

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{D 079}	Continued From page 20 through within the community to ensure facility is free of clutter, clean and orderly, free of hazards. -Administrator designee will randomly monitor housekeeping task sheets. -Any staff not found following cleaning and preventative procedures will receive additional training. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 28, 2017.	{D 079}		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure personal care assistance was provided in accordance with the assessed needs for 1 of 5 sampled residents (#1) by not providing nail care. The findings are: Review of Resident #1's current FL-2 dated 05/08/17 revealed: -Diagnoses included Urinary Tract Infection (UTI), Dementia without behaviors, history of falling, Dysphagia, Major Depressive Disorder,	{D 269}		

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{D 269}	Continued From page 21 Postherpetic Nervous System Disease, Hypertension (HTN) and history of Transient Ischemic Attack (TIA). -The resident was constantly disoriented. -The resident was non-ambulatory and incontinent of bowel and bladder. Review of the resident's assessment and care plan dated 09/04/16 revealed: -The resident required total care with bathing, dressing, grooming and transferring. -The resident required limited assistance with eating. -The resident required extensive assistance with toileting and ambulation. Observation of Resident #1 on 07/12/17 at 11:38 a.m. revealed: -The resident was sitting in her geri-chair (geriatric recliner chair). -The resident was confused. Observation of Resident #1 on 07/13/17 at 11:50 a.m. revealed: -Resident #1 was in the dining room sitting in her geri-chair waiting for lunch. -The resident's fingernails on both hands had dried brown matter underneath the nails. -The resident's fingernails were 1/4th to ½ inches long and were jagged and uneven. Observation of Resident #1 on 07/13/17 at 4:55 p.m. revealed: -The resident was sitting in her room in her geri-chair. -The resident's fingernails on both hands had dried brown matter underneath the fingernails. -The resident's fingernails were long and jagged. Interview with a personal care aide (PCA) on	{D 269}		

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{D 269}	Continued From page 22 07/13/17 at 5:20 p.m. revealed: -Resident #1 was total care and required assistance with all activities of daily living. -The PCAs documented personal care tasks for each resident on the personal care logs including nail care. -The PCAs did not do nail care daily but they should provide nail care when a resident got their shower. -Residents were usually bathed 3 times a week. -They could clean residents' nails with a wash cloth or they could use orange nail care sticks to clean under the nails. -He did not know when Resident #1's nails had last been cleaned or trimmed. -He was looking for her personal care log sheet now. Review of Resident #1's personal care log sheet for July 2017 revealed: -There was a section to document personal hygiene which included shower/bath, shampoo, nail care, grooming, and shave. -The personal hygiene section was last documented as completed on 07/13/17 on second shift. A second interview with the same PCA on 07/13/17 at 5:25 p.m. revealed: -He had documented personal hygiene was completed for Resident #1 on second shift today on 07/13/17. -He did not provide nail care to the resident because it was usually done when a resident received a shower/bath. -The resident's next shower day was tomorrow on Friday, 07/14/17. Observation of Resident #1 on 07/14/17 at 8:00 a.m. revealed:	{D 269}		

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{D 269}	Continued From page 23 -The resident was sitting in her geri-chair in the hallway. -The resident's fingernails had dried brown matter underneath the nails. -The resident's fingernails were long and jagged. Based on observations, interviews, and record reviews, Resident #1 was not interviewable due to diagnosis of dementia. Interview with a second PCA on 07/14/17 at 8:23 a.m. for Resident #1 revealed: -The bath days for Resident #1 were Monday, Wednesday and Friday. -The resident required total care. -The resident did not put any weight on her legs and was a total transfer. -The resident had not had a bath today and would get one after breakfast. Interview with a third PCA on 07/14/17 at 8:34 a.m. revealed nail care for Resident #1 was done on Mondays. Interview with Resident #1's family member on 07/14/17 at 9:10 a.m. revealed: -The resident had been at the facility for five years. -The resident got "pretty good care." -A family member did the residents nails when they noticed that they needed to be done. -He had seen times when the resident's nails were done at the facility but he did not know who did them. Observation of Resident #1 on 07/14/17 at 10:25 a.m. revealed: -The resident had on the same clothing that she was wearing at 8:00 a.m. on 07/14/17. -The resident's fingernails had dried brown matter	{D 269}		

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{D 269}	Continued From page 24 underneath the nails. -The resident's fingernails were long and jagged. Observation of Resident #1 on 07/14/17 at 2:50 p.m. revealed: -The resident was sitting in a geri-chair in her room. -The resident had on clean clothes and her hair was damp and combed back. -The resident's fingernails on both hands had dried brown matter underneath. -The resident's fingernails were long and jagged. Interview with a fourth PCA on 07/14/17 at 2:53 p.m. revealed: -She had just given Resident #1 a shower a few minutes ago. -She had not noticed the resident's fingernails were long and jagged and had brown matter underneath. -There was a man who came to the facility twice a week to do nails for the residents. Observation of the fourth PCA on 07/14/17 at 2:53 p.m. revealed: -The PCA did not offer to clean or trim the resident's fingernails. -The PCA left Resident #1's room. Interview with the Resident Care Coordinator (RCC) on 07/14/17 at 3:05 p.m. revealed: -The PCAs should provide nail care to residents who require assistance weekly, including cleaning, and trimming or clipping the nails. -The PCAs should clean the hands, including fingernails, of residents who require feeding assistance after each meal. -The facility had orange nail care sticks for staff to use to clean underneath the residents' fingernails. -They ran out of nail care sticks but she could not	{D 269}		

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{D 269}	Continued From page 25 recall how long they had been out of the nail care sticks. -She was not aware Resident #1's fingernails were long, jagged, and had brown matter underneath the nails. -She would have the PCA clean Resident #1's fingernails with a warm soapy wash cloth now. -She would also have the PCA to clip the resident's fingernails. Interview with the Regional Director on 07/14/17 at 3:15 p.m. revealed: -She was not aware Resident #1's fingernails were long, jagged, and had brown matter underneath the nails. -The facility had some orange nail care sticks. -Staff would provide care to Resident #1's fingernails. Observation of Resident #1 on 07/14/17 at 3:21 p.m. revealed: -The resident was sitting in her geri-chair in the dining room. -The brown matter had been cleaned from all of her fingernails. -The resident's fingernails were long and jagged.	{D 269}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION	{D 273}		

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{D 273}	Continued From page 26 The Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION. Based on observations, interviews, and record reviews, the facility failed to assure the primary care provider (PCP) was contacted for 1 of 5 sampled residents (#3), who had a history of urinary tract infections and had not received ordered Tamsulosin for two weeks, and did not have a catheter removed as ordered prior to the resident's urology appointment. The findings are: Review of Resident #3's current FL-2 dated 06/10/17 revealed: - Diagnoses included Sepsis, Proteus Bacteremia, Acute Kidney Insufficiency (AKI), Hypertension, Chronic Heart Failure and Chronic Atrial Fibrillation. - The resident was intermittently disoriented. - The resident had an indwelling catheter and was continent with bowel. - The resident required assistance with bathing and dressing. - Under the "Additional Information" section, documentation revealed "Indwelling indwelling Catheter and had been referred to urology as outpatient for management." Review of Resident #3's Care Plan dated 12/02/16 revealed: - The resident required limited, hands on assistance with bathing, dressing, feeding, and toileting. - The resident required verbal cueing or supervision with ambulation.	{D 273}		

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{D 273}	Continued From page 27 Review of Resident #3's Physician's Consultation Report form dated 06/29/17 revealed: - On 06/29/17 at 3:00 p.m., the resident was seen by the urologist. - There were orders for Tamsulosin 0.4mg at bed time and to remove the currently placed indwelling catheter at 12:00am on 07/13/17, the night prior to the morning urology appointment at 10:30 a.m. on 7/13/17. - "Next follow up appointment in 2-3 weeks." Interview with the Resident Care Coordinator (RCC) on 07/13/17 at 10:38 a.m. revealed: - Resident #3 had gone to a urology appointment this morning (07/13/17). - The appointment was scheduled for the removal of Resident #3's indwelling catheter. - She was aware of the resident's order to remove the indwelling catheter. - Resident #3's indwelling catheter was not removed the night before his urology appointment at midnight per provider order because catheter removals had to be handled by the registered nurse (RN) which the facility did not have on duty to perform the task. -The facility had not scheduled a nurse to remove the indwelling catheter on 07/13/17 at 12:00am since the 06/29/17 provider order because the facility did not have access to a nurse at that time. - The personal care aides (PCA) empty the resident's catheter as needed. - The PCAs changed the urine bag nightly. - The PCAs will notified the medication aides if the areas around the catheter were irritated or had an odor when emptying the catheter drainage bag. - The staff emptied Resident #3's leg bag regularly.	{D 273}		

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{D 273}	Continued From page 28 - Resident #3 used a motorized wheelchair to get around but he could transfer and walk short distance. - Resident #3 had right-sided paralysis so the staff assisted with shower and dressing. Review of Resident #3's "Care Notes" between 06/29/17 and 07/13/17 revealed there were no notes which indicated that the area around Resident #3's indwelling catheter had been irritated or had an odor. Observation of Resident #3 on 07/13/17 at 3:30 p.m. revealed: -Resident #3 was in a wheelchair sitting on the front porch. -The resident was agitated. -The resident was holding a business card from the urologist's office with the words "Flomax/Tamsulosin" written on the back of the card. Interview with Resident #3 on 07/13/17 at 3:30 p.m. revealed: -The resident had just returned from a scheduled urology appointment. -The resident was upset because a indwelling catheter currently in place was not removed at the urology appointment. -The indwelling catheter was not removed "because the doctor discovered Resident #3 was not taking Tamsulosin for the last two weeks as prescribed." -The resident was angry because the facility "never gave me my pills." Telephone interview with the Registered Nurse (RN) from the Urologist's Office on 07/13/17 at 1:05pm revealed: -Resident #3 was supposed to have his catheter	{D 273}		

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{D 273}	Continued From page 29 removed at midnight prior to his appointment after having been on Tamsulosin for two weeks. -Resident #3 was expected to inform the doctor during the morning appointment if the resident was able to urinate between the midnight catheter removal on 07/13/17 at the facility and the doctor's appointment at 10:30 a.m. on 07/13/17. -The indwelling catheter was never removed by the facility as ordered by the doctor prior to the appointment. -The indwelling catheter was not removed during the appointment because the facility's medication administration records (MARs) showed the resident had not taken the two weeks of prescribed Tamsulosin as the facility never had filled the prescription on 06/29/17. -The reason for having Tamsulosin for two weeks was to build up the muscle tone in the resident's bladder, then remove the catheter at the end of the 2 weeks in the resident's home setting. -Residents could urinate more comfortably in their own homes after catheter removals the night before and successfully urinate prior to the urologist visits the next morning. -Had Resident #3 indwelling catheter been removed at midnight prior to the 07/13/17 office visit, the resident most likely would have had to be re-catheterized due to the inability to urinate without having 2 weeks of Tamsulosin treatment, which the facility had failed to administer. -Upon discovery of the lack of Tamsulosin administration between 06/29/17 and 07/13/17, the provider left the indwelling catheter in Resident #3 and reissued the order for Tamsulosin. -The facility failed to communicate with the Urology Office that the resident had not received Tamsulosin as ordered, nor was the indwelling catheter removed as ordered on 07/13/17 at midnight.	{D 273}		

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{D 273}	Continued From page 30 -The facility did not provide a note to send with the resident to his appointment noting the orders were not implemented. Interview with the Resident Care Coordinator (RCC) at 07/14/17 at 10:30 a.m. revealed: -She could not explain why Resident #3's orders were not in the "medication orders" folder to be addressed. -The facility used two back-up pharmacies. -The facility's process to fill medication orders was for staff to call the primary pharmacy and the primary pharmacy contacted one of the two back up pharmacies when the facility informed them of an immediate need. -The facility picked up all prescriptions from the back up pharmacy which were both located within a mile from the facility. -When residents returned from any provider appointments, the driver/transporter gave any prescriptions or paperwork to the RCC, or Supervisor if the RCC was unavailable. -The recipient of the prescriptions or paperwork, be it the RCC or Supervisor, was responsible for faxing the medication orders to the primary pharmacy. -The RCC could not recall if she had sent Resident #3's urology orders from 06/29/17 to the pharmacy. -The RCC maintained a folder with previous orders for all residents, but Resident #3's orders were not among them. -It was possible that Resident #3's orders were placed directly in the chart and not in her folder containing orders to be addressed. -Normal procedure would be to place all orders from all residents returning from provider appointments into the RCC folder located on the wall of the RCC's office.	{D 273}		

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{D 273}	Continued From page 31 Review of Resident #3's medication administration records (MARs) from June and July 2017 revealed there was no entry for Tamsulosin. Review of Resident #3's urology visit summary dated 07/13/17 revealed: - On 07/13/17 at 10:30 a.m., the resident was seen by urologist. - There was an order for Tamsulosin 0.4 mg, 2 tabs at bed time. Observation of Resident #3's medications on hand on 07/13/17 at 10:45 a.m. revealed Tamsulosin 0.4 mg was not in the medication cart. Interview with the 1st shift medication aide (MA) on 07/13/17 at 10:50 a.m. revealed: - The MA was not aware of Resident #3's Tamsulosin order. - Tamsulosin was not in the medication cart. Interview with the primary pharmacist on 07/13/17 at 12:35 p.m. revealed: - The pharmacy received a copy of the 06/29/17 Tamsulosin order today (07/13/17) at 11:25 a.m. - Tamsulosin 0.4 mg was not dispensed in the past. Review of Resident #3's medication administration record (MAR) of 07/13/17 revealed there was an entry for Tamsulosin 0.4mg, 2 tabs given at bedtime. Observation of Resident #3's medications on hand on 07/14/17 at 9:30 a.m. revealed Tamsulosin 0.4 mg was in the medication cart. Interview with a Medication Aide on 07/14/17 at	{D 273}		

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{D 273}	Continued From page 32 12:55 p.m. revealed Tamsulosin 0.4mg arrived on 07/13/17 on the evening from the back-up pharmacy on-time for Resident #3's bedtime dose. Interview with the RCC at 07/14/17 at 1:00 p.m. revealed: -Had she seen the 06/29/17 order for Tamsulosin, she would have ordered it. -Had she seen the order for the removal of the indwelling catheter on 07/13/17 at midnight, she would have called the doctor for alternate orders because the facility does not have a nurse on staff. -The doctor must have thought that the facility was a skilled nursing facility and wrote the midnight indwelling catheter removal order accordingly. Interview with the Administrator on 07/14/17 at 3:15 p.m. revealed: -The facility's policy was to have the transporter taking a resident to an appointment to return with the paperwork and give it to the medication aide or Supervisor on duty. -The SIC or Medication Aide scanned the prescriptions to the pharmacy, received a confirmation sheet, and gave the paperwork to the RCC. -If the RCC was off duty, the Supervisor or MA placed the paper work on her desk. -When the RCC processed and confirmed all of the paperwork or prescriptions ordered, the RCC told the Administrator. -All communication was verbal. -The Administrator did not have a system in place to check if the RCC performed and completed the processing of any paperwork or prescriptions. -She could not explain how the Tamsulosin prescription and provider orders for the indwelling	{D 273}		

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{D 273}	Continued From page 33 catheter removal at midnight the night prior to the appointment for Resident #3 were not processed. Interview with the Regional Director on 07/14/17 at 4:00 p.m. revealed: -There was a Medication Order/Check Sheet which the facility was supposed to use to track all provider orders to ensure all residents had their provider orders processed. -The form was not being used by the facility staff. -She could not explain why the form was not being utilized. Review of a copy of the Medication Order/Check sheet provided by the Regional Director revealed the sheet had blank areas to be signed when a resident's medication order was faxed to the pharmacy, transcribed, initialed by the Supervisor and initialed by the RCC. _____ The facility's failure to ensure that Resident #3 received Tamsulosin for two weeks as ordered by the provider on 06/29/17 prevented the urologist from removing Resident #3's indwelling catheter on 07/13/17. The facility also failed to remove the catheter per provider order on the night before Resident #3's morning appointment. The urologist issued a second order of Tamsulosin for two weeks and kept the indwelling catheter in the resident which posed a risk for a urinary tract infection. This failure was detrimental to the health and safety of Resident #3, who had a history of urinary tract infection and constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 07/13/17 revealed: -Immediate retraining with the RCC/Supervisor on	{D 273}		

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{D 273}	Continued From page 34 ensuring that hospital discharge orders and/or instructions and/or referrals were reviewed with the physician the day of return. -Immediate retraining with the RCC/Supervisor to ensure that all contacts related to referral and follow-up with the physician are documented. -Residents identified during the survey had a follow-up with the physician as of 07/13/17. -All hospital discharge orders and/or instructions shall be reviewed by the Regional Director and RCC upon receipt to ensure they are carried out . -The Regional Director shall review hospital discharge orders and/or instructions bi-weekly for the next 3 months then weekly thereafter. -The Regional Director shall continue to have daily phone calls with the Administrator and RCC to follow-up on any recent hospitalizations and/or order changes with residents to ensure referral and follow-up has been completed. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 28, 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: Based on observations, interviews and record reviews the facility failed to ensure that 1of 5 residents sampled (#5) was treated with respect,	D 338		

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consideration and dignity, related to having to walk down the South hall to dispose of soiled incontinent briefs in the Women's Bathroom and having to wait outside the bathroom with the soiled incontinent briefs in her hand.

The findings are:

Review of Resident #5's FL-2 dated 12/14/16 revealed:
-Diagnoses included Hypertension, Insulin Dependent Diabetes Mellitus, history of Schizophrenia, Gastroesophageal Reflux Disease, Dry Eye Syndrome, Chronic Sinusitis and Chronic Obstructive Pulmonary Disease.
-The resident was incontinent of bladder.

Review of Resident #5's Care Plan dated 01/07/16 revealed:
-She was independent with transfers and ambulation using rolling walker.
-She pulled up and down garments independently.
-She needed assistance to empty trash and dispose of incontinence supplies.

Observation of the South hall on 07/12/17 at 10:35 a.m. revealed Resident #5 sitting outside the Women's Bathroom holding a soiled incontinent brief in her hand.

Interview with Resident #5 on 07/12/17 at 10:40 a.m. revealed:
-She had to carry her soiled incontinent briefs to the Women's Bathroom to throw them away.
-The Women's Bathroom was currently occupied by another resident so she had to wait.

Observation of the South hall on 07/12/17 at 10:55 a.m. revealed Resident #5 sitting outside

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the Women's Bathroom still holding a soiled incontinent brief in her hand.

Interview with Resident #5 on 07/13/17 at 10:37 a.m. revealed:
-She had lived at the facility for 2-3 years.
-When she came to the facility she had sores and "staff did not want to catch what I had."
-When she changed her soiled incontinent brief she had to carry the soiled diaper to the Women's Bathroom to throw it away.
-She had to carry the soiled incontinent brief to the Women's Bathroom to throw it away since she came to the facility.
-Staff would not allow her to put soiled incontinent briefs in the trash can in her room, because it would make the room smell bad.
- When she took her soiled incontinent brief to the Women's Bathroom to throw it away, she had to wait a ½ hour or more in order to throw diaper away, because the bathroom was occupied.
- Staff used to give her a bag to put the soiled incontinent briefs in when she carried it down the hall to throw it away but they stopped.
-She could not remember why and when they stopped, "they just stopped."
-Now she had to take the soiled incontinent briefs in her hand to throw them away.
-This made her feel "funny" and "embarrassed".
-Other residents snickered and laughed at her when they saw her taking the soiled incontinent brief down the hall.
-Sometimes some of the other residents would call her "stinky".
-Sometimes she got upset with the other residents and yelled at them.
-The other residents said she did not wash her hands after she threw the soiled incontinent briefs away.
-She had not talked to anyone about having to

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take her soiled incontinent briefs to the Women's Bathroom or about other residents calling her names.
-She "just thought that was how it was".
-She noticed that she was the only one that did that.

Interview with a Medication Aide on 07/13/17 at 11:05 a.m. revealed:
-She could not recall anyone having told Resident #5 to take her soiled incontinent briefs to the Women's Bathroom.
-She had never noticed Resident #5 sitting outside the Women's Bathroom with soiled incontinent briefs in her hand.

Interview with the Activity Director (AD) on 07/13/17 at 11:10 a.m. revealed she could not say she had ever noticed Resident #5 sitting outside the Women's Bathroom with soiled incontinent briefs in her hand in the last 1 year and 2 months since she had been at the facility.

Interview with another Medication Aide on 07/13/17 at 11:20 a.m. revealed:
-Resident #5 was independent with her toileting.
-Since she had started working at the facility in February 2017, she had not seen Resident #5 waiting outside the Women's Bathroom.
-Resident #5 had never mentioned to her that she was told to take her soiled incontinent briefs to the Women's Bathroom.

Interview with the Supervisor on 07/13/17 at 12:00 p.m. revealed:
-Resident #5 had never told her that she was instructed to take her soiled incontinent briefs to the Women's Bathroom and not throw them in the trash can in her room.
-She had never seen Resident #5 waiting outside

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D 338	Continued From page 38 the Women's Bathroom. Interview with Resident Care Coordinator (RCC) on 07/13/17 at 12:03 p.m. revealed: -Resident #5 was independent with her toileting. -She had not noticed Resident #5 sitting outside the Women's Bathroom. -The Personal Care Aides made rounds every two hours and if they notice a soiled incontinent briefs in a trash can while they are making rounds, they were supposed to discard of it. -Resident #5 had never told her that she was told to take her soiled incontinent briefs to the Women's Bathroom. -She would speak with Resident #5 about the situation and let her know that it was okay to throw soiled incontinent briefs into the trash can in her room and not take it down the hall to the Women's Bathroom. Interview with the Administrator on 07/13/17 at 12:20 p.m. revealed: -She had seen Resident #5 sitting outside the Women's Bathroom, but did not notice any soiled incontinent brief in her hand. -Resident #5 was facing the den as if she was watching the television, but did not want to go into the den. -Resident #5 had never mentioned to her that she was told to take soiled incontinent briefs to the Women's Bathroom and could not throw them in the trash can in her room. -She would speak with Resident #5 to reassure her that she did not have to take her soiled diapers to the Women's Bathroom and that she could throw it in her trash can in her room. -The Personal Care Aides made the resident care rounds every 2 hours and if they saw garbage in any of the residents' trash cans they were to dispose of it.	D 338		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents sampled (#3, #9) including a resident (#3) with a urinary catheter who had a new order for a medication to improve urination that was not implemented and for a diabetic resident (#9) who did not receive sliding scale insulin at bedtime as ordered for 12 consecutive days in July 2017; and 3 of 8 residents (#6, #7, #8) observed during the medication passes including errors with an inhaler (#6), two eye drops for glaucoma (#8), and Aspirin and an iron supplement (#7). The findings are:	{D 358}		

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{D 358}	Continued From page 40 1. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 07/11/08. Review of Resident #3's current FL-2 (from the hospital) dated 06/10/17 revealed: - Diagnoses included Sepsis, Proteus Bacteremia, Acute Kidney Insufficiency (AKI), Hypertension (HTN), Chronic Heart Failure (CHF) and Chronic Atrial Fibrillation (A-Fib). - The resident was intermittently disoriented. - The resident had indwelling catheter for bladder and continent with bowl. - The resident required assistance with bathing and dressing. - Under the "Additional Information" section, there was a documented "Indwelling Foley Catheter and had been referred to urology as outpatient for management." Review of Resident #3's Care Plan dated 12/02/16 revealed: - The resident required limited, hands on assistance with bathing, dressing, feeding, and toileting. - The resident required verbal cueing or supervision with ambulation. Review of Resident #3's urology visit summary, facility's "Physician's Consultation Report" and "Examination or Contact by Physician" form dated 06/29/17 revealed: - On 06/29/17 at 3:00 p.m., the resident was seen by the urologist. - There was an order for Tamsulosin 0.4mg by mouth at bed time. - "Next follow up appointment in 2-3 weeks." Interview with the Resident Care Coordinator	{D 358}		

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{D 358}	Continued From page 41 (RCC) on 07/13/17 at 10:38 a.m. revealed: - Resident #3 had gone to a urology appointment this morning (07/13/17). - The appointment was scheduled for the removal of Resident #3's Foley catheter. Observation of Resident #3 on 07/13/17 at 3:30 p.m. revealed: -Resident was in a wheelchair sitting on the front porch. -Resident was agitated. -The resident was holding a business card from the urologist's office with the words "Flomax/Tamsulosin" written on the back of the card. Interview with Resident #3 on 07/13/17 at 3:30 p.m. revealed: -The resident had just returned from a scheduled urology appointment. -The resident was upset because a Foley catheter currently in place was not removed at the urology appointment. -The Foley catheter was not removed "because the doctor discovered [Resident #3] was not taking Flomax for the last two weeks as prescribed." -The resident was angry because the facility "never gave me my pills." Interview with the Registered Nurse (RN) from the Urologist's Office on 07/13/17 at 1:05 p.m. revealed: -Resident #3 was supposed to have his catheter removed at midnight prior to his appointment after having been on Tamsulosin for two weeks. -Resident #3 was expected to inform the doctor during the morning appointment if the resident was able to urinate between the midnight catheter removal on 07/13/17 at the facility and the	{D 358}		

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{D 358}	Continued From page 42 doctor's appointment at 10:30 a.m. on 07/13/17. -The Foley catheter was never removed as ordered by the doctor prior to the appointment. -The Foley catheter was not removed during the appointment because the facility's medical administration records (MARs) showed the resident had not taken the two weeks of prescribed Tamsulosin as the facility never had filled the prescription on 06/29/17. -The reason for having Tamsulosin on board for two weeks was to build up the muscle tone in the resident's bladder then remove the catheter at the end of the 2 weeks in the resident's home setting. -Had Resident #3 Foley catheter been removed at midnight prior to the 07/13/17 office visit, the resident would most likely would have had to be re-catheterized due to the inability to urinate without having 2 weeks of Tamsulosin treatment which the facility had forgotten to administer. -The urologist determined that Resident #3 had not received Tamsulosin prior to the appointment based on the resident's MARs provided by the facility. -Upon discovery of the lack of Tamsulosin administration between 06/29/17 and 07/13/17, the provider left the Foley catheter in Resident #3 and reissued the order for Tamsulosin. -The facility failed to communicate with the Urology Office that the resident had not received Tamsulosin as ordered, nor was the Foley catheter removed as ordered on 07/13/17 at midnight. -The facility did not provide a note to send with the resident to his appointment noting the orders not implemented. -The facility did not call the urology office prior to Resident #3's urology visit informing them that the Foley catheter was not removed per order, nor the Tamsulosin not being given for the past two weeks.	{D 358}		

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{D 358}	Continued From page 43 -The facility had a history of poor communication with the Urology office. Interview with the Resident Care Coordinator (RCC) at 07/14/17 at 10:30 a.m. revealed: -She could not explain why Resident #3's orders were not in the "medication orders" folder to be addressed. -The facility uses two back-up pharmacies. -The facility's process to fill medication orders was for staff to call the primary pharmacy and that primary pharmacy contacted one of the two back up pharmacies when the facility informs them of an immediate need. -The facility picked up all prescriptions from the back up pharmacy which are both located within a mile from the facility. -When residents returned from any provider appointments, the driver/transporter gave any prescriptions or paperwork to the RCC, or SIC if the RCC is unavailable. -The recipient of the prescriptions or paperwork, be it the RCC or SIC, was responsible for faxing the medication orders to the primary pharmacy. -The RCC could not recall if she had send Resident #3's urology orders of 06/29/17 to the pharmacy. -The RCC maintained a folder with previous orders for all residents but Resident #3's orders were not among them. -It was possible that Resident #3's orders were placed directly in the chart and not in her folder containing orders to be addressed. -Normal procedure would be to place all orders from all residents returning from provider appointments into the RCC folder located on the wall of the RCC's office. Review of Resident #3's medication administration records (MARs) from June and	{D 358}		

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{D 358}	Continued From page 44 July 2017 revealed there was no entry for Tamsulosin. Review of Resident #3's urology visit summary dated 07/13/17 revealed: - On 07/13/17 at 10:30 a.m., the resident was seen by urologist. - There was an another order for Tamsulosin 0.4 mg, 2 tabs by mouth at bed time. Observation of Resident #3's medications on hand on 07/13/17 at 10:45 a.m. revealed Tamsulosin 0.4 mg was not in the medication cart. Interview with the 1st shift medication aide on 07/13/17 at 10:50 a.m. revealed: - The staff was not aware of Resident #3's Tamsulosin order. - Tamsulosin was not in the medication cart. Interview with the facility provider's pharmacist on 07/13/17 at 12:35 p.m. revealed: - The pharmacy received a copy of 06/29/17 Tamsulosin order today (07/13/17) at 11:25 a.m. - Tamsulosin 0.4 mg was not dispensed in the past. Review of Resident #3's medication administration record (MAR) of July 13, 17 revealed there was an entry for Tamsulosin 0.4mg, 2 tabs given at bedtime. Observation of Resident #3's medications on hand on 07/14/17 at 9:30 a.m. revealed Tamsulosin 0.4 mg was in the medication cart. Interview with a Medication Aide on 07/14/17 at 12:55 p.m. revealed Tamsulosin 0.4mg arrived on 07/13/17 on the cart in the evening from the	{D 358}		

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{D 358}	Continued From page 45 back-up pharmacy on-time for Resident #3's bedtime dose. Interview with the RCC at 07/14/17 at 1:00 p.m. revealed that had she seen the 06/29/17 order for Tamsulosin she would have ordered it. Interview with Administrator on 07/14/17 at 3:15 p.m. revealed: -The facility's policy was to have the transporter taking a resident to an appointment to return with the paperwork and give it to the medication aide or SIC on duty. -The SIC or Medication Aide scanned the prescriptions to the pharmacy, received a confirmation sheet, then gave the paperwork to the RCC. -If the RCC was off duty, the SIC or medication Aide placed the paper work on her desk. -When the RCC processed and confirmed all of the paperwork or prescriptions ordered, the RCC told the Administrator. -All communication was verbal. -The Administrator did not have a system in place to check if the RCC performed and completed the processing of any paperwork or prescriptions. -Communication was good between the RCC and Administrator. -She could not explain how the Tamsulosin prescription and provider orders for the Foley catheter removal at midnight the night prior to the appointment for Resident #3 were not processed. Interview with the Regional Director on 07/14/17 at 4:00 p.m. revealed: -There was a Medication Order/Check Sheet which the facility was supposed to use to track all provider orders to ensure all residents had their provider orders processed. -The form was not being used by the facility staff.	{D 358}		

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{D 358}	Continued From page 46 -She could not explain why the form was not being utilized. Review of a copy of Medication Order/Check sheet provided by the Regional Director revealed the sheet had blank areas to be signed when a resident's medication order was faxed to the pharmacy, transcribed, approved by the SIC and approved by the RCC. 2. Review of Resident #9's current FL-2 dated 05/23/17 revealed: -Diagnoses included type 2 diabetes with hyperglycemia, history of cerebrovascular accident (2012), carotid artery stenosis, bilateral osteoarthritis of the knees, generalized anxiety disorder, and Moyamoya disease. -There was an order for blood sugars to be checked before meals and at bedtime. -There was an order for Humulin R sliding scale insulin: 0 - 149 = no insulin; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; if blood sugar is less than (<) 70 or greater than (>) 400 = call the physician. (Humulin R is short-acting insulin used to lower blood sugar in diabetics.) Review of Resident #9's June 2017 medication administration record (MAR) revealed: -There was an entry for blood sugars to be checked before meals and at bedtime. -The blood sugars were scheduled to be checked at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. -There was an entry for Humulin R sliding scale insulin before meals and at bedtime if blood sugar 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; if blood sugar is < 70 or > 400 = call the physician.	{D 358}		

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{D 358}	Continued From page 47 -Humulin R sliding scale insulin was scheduled to be administered at 7:00 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. -There was handwritten documentation beside the entry for blood sugar checks and Humulin R sliding scale insulin to "see flow sheet". Review of Resident #9's June 2017 diabetic flow sheet revealed: -There was computer printed instructions at the top of the page for blood sugar monitoring 4 times a day. -There was a computer printed entry to check blood sugar before meals and at bedtime and give Humulin R sliding scale insulin 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; if blood sugar is < 70 or > 400 = call the physician. -There was a column labeled 8:00 a.m., 12:00 noon, 5:30 p.m. and 9:00 p.m. -Staff documented the resident's blood sugar and administration of sliding scale insulin 4 times a day including 9:00 p.m. from 06/01/17 - 06/30/17. -The resident's blood sugar ranged from 84 - 306 at 8:00 a.m. from 06/01/17 - 06/30/17. -The resident's blood sugar ranged from 71 - 303 at 12:00 noon from 06/01/17 - 06/30/17. -The resident's blood sugar ranged from 113 - 256 at 5:30 p.m. from 06/01/17 - 06/30/17. -The resident's blood sugar ranged from 142 - 291 at 9:00 p.m. from 06/01/17 - 06/30/17. Review of Resident #9's July 2017 MAR revealed: -There was an entry for blood sugars to be checked before meals and at bedtime. -The blood sugars were scheduled to be checked at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. -There was an entry for Humulin R sliding scale insulin before meals and at bedtime if blood	{D 358}		

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{D 358}	Continued From page 48 sugar 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; if blood sugar is < 70 or > 400 = call the physician. -Humulin R sliding scale insulin was scheduled to be administered at 7:00 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. -There was handwritten documentation beside the entry for blood sugar checks and Humulin R sliding scale insulin to "see flow sheet". Review of Resident #9's July 2017 diabetic flow sheet revealed: -There was computer printed instructions at the top of the page for blood sugar monitoring 3 times daily before meals and sliding scale. -There was a handwritten entry for Humulin R insulin 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; if blood sugar is < 70 or > 400 = call the physician. -There was a column labeled 7:00 a.m., 11:00 a.m., and 4:00 p.m. -Staff documented the resident's blood sugar and administration of sliding scale insulin at 7:00 a.m., 11:00 a.m., and 4:00 p.m. from 07/01/17 - 07/13/17. -There was no column designated for a bedtime blood sugar or sliding scale insulin. -There was no documentation the resident's blood sugar had been checked or sliding scale insulin administered as ordered at bedtime from 07/01/17 - 07/12/17. -The resident's blood sugar ranged from 110 - 302 at 7:00 a.m. from 07/01/17 - 07/13/17. -The resident's blood sugar ranged from 96 - 261 at 11:00 a.m. from 07/01/17 - 07/13/17. -The resident's blood sugar ranged from 182 - 293 at 4:00 p.m. from 07/01/17 - 07/12/17.	{D 358}		

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{D 358}	Continued From page 49 Review of Resident #9's physicians' orders revealed there was no order to discontinue blood sugar checks with sliding scale insulin at bedtime. Interview with a medication aide (MA) on 07/13/17 at 1:15 p.m. revealed: -She usually worked first shift and she did not know if Resident #9's order for sliding scale had changed. -She used the diabetic flow sheet to document blood sugars and sliding scale insulin administration. -She had not noticed the instructions for blood sugars and sliding scale insulin listed on the MAR did not match the diabetic flow sheet for Resident #9. Interview with a second MA on 07/13/17 at 2:20 p.m. revealed: -She usually worked second shift from 2:00 p.m. - 10:00 p.m. -At one time, she checked Resident #9's blood sugar and administered sliding scale insulin at bedtime. -She could not recall when she stopped doing the bedtime fingerstick and administering sliding scale insulin to Resident #9 at bedtime. -She used the MAR and the diabetic flow sheet when she administered medications, but they documented blood sugars and sliding scale insulin on the flow sheet, not the MAR. -She had noticed the instructions on the MAR and the diabetic flow sheet for Resident #9 did not match, but she had not reported it to anyone. -She could not recall when she noticed it did not match. -She continued to use the instructions on the diabetic flow sheet because they used that form to document it.	{D 358}		

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{D 358}	Continued From page 50 Interviews with Resident #9 on 07/12/17 at 11:05 a.m. and 07/13/17 at 2:08 p.m. revealed: -She was diabetic and her blood sugar was checked 3 times a day before meals. -She received scheduled insulin 3 times a day and sliding scale insulin 3 times a day before meals. -She used to get a blood sugar check and sliding scale insulin at bedtime but it stopped and she was not sure why it stopped. -She could not recall when the bedtime dose stopped. -She thought the physician might have changed it but she was not sure. -Her blood sugar "runs pretty good". -She felt dizzy if her blood sugar got too low and she felt "funny" if her blood sugar was too high. -She thought her blood sugars were running about the same as before she stopped receiving the sliding scale insulin at bedtime. Interview with the Resident Care Coordinator (RCC) on 07/13/17 at 1:27 p.m. revealed: -She was not aware the MAR and diabetic flow sheet for Resident #9 did not match for the blood sugar checks and the sliding scale insulin. -She did not recall any recent order changes for Resident #9's blood sugars or insulin. -She or the supervisor were responsible for maintaining and printing the diabetic flow sheets each month. -She did not know why the bedtime column was blank on the July 2017 flow sheet for Resident #9. -They must have overlooked it. -She would contact the physician about the bedtime dose. Interview with the Regional Director on 07/13/17 at 1:30 p.m. revealed:	{D 358}		

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{D 358}	Continued From page 51 -The facility used their own diabetic flow sheets to document blood sugars and sliding scale insulin administration. -The RCC and supervisor were responsible for maintaining and printing the diabetic flow sheets each month. -They may have printed an old version of the flow sheet in error. -They would contact the physician about the bedtime blood sugars and sliding scale insulin. Review of a physician's order dated 07/13/17 for Resident #9 revealed there was an order indicating the resident's blood sugar and sliding scale insulin should be checked and administered 4 times a day. Telephone interview with Resident #9's primary care provider (PCP) on 07/14/17 at 12:42 p.m. revealed: -The facility contacted the PCP yesterday (07/13/17) and made her aware they had only checked Resident #9's blood sugar and administered the sliding scale insulin 3 times a day in July 2017. -The resident's blood sugar and sliding scale insulin should be 4 times a day. -She was concerned but would have been more concerned if the resident's blood sugar had been in the 400 or 500 range during that time. -She sent a verification order to the facility yesterday (07/13/17) for the blood sugar and sliding scale insulin to be administered 4 times a day. 3. The medication error rate was 17% as evidenced by the observation of 5 errors out of 28 opportunities during the 12:00 noon medication pass on 07/12/17 and the 8:00 a.m./9:00 a.m. and 11:00 a.m./12:00 noon medication passes on	{D 358}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 52 07/13/17. A. Review of Resident #7's current FL-2 dated 07/05/17 revealed diagnoses included gastrointestinal bleed and acute blood loss anemia. a. Review of Resident #7's current FL-2 dated 07/05/17 revealed there was an order to hold Aspirin for 5 days and then follow up with primary care provider (PCP) or gastroenterologist for recheck of hematocrit and hemoglobin (H/H) to determine if restart okay. (Aspirin is used to treat pain, fever, and inflammation and may be used to help prevent heart disease. Aspirin is acidic and may promote ulcers and it may increase the risk of bleeding. Hematocrit and Hemoglobin are blood tests used to help determine if someone has anemia.) Review of a hospital discharge summary dated 07/05/17 revealed: -The resident was admitted to the hospital on 07/03/17 with diagnoses of gastrointestinal (GI) bleed secondary to large antral (lower stomach) ulcer, superficial ulcer at the gastroesophageal junction, and acute blood loss anemia secondary to GI bleed. -The resident presented with a hemoglobin of 6.1 (reference range 12.5 - 17.2) and a hematocrit of 19 (reference range of 37 - 47) -The resident was positive for blood in stools and iron studies showed iron deficiency anemia. -The resident received a blood transfusion and the hemoglobin trended up and remained stable around 9.7. -The resident's Aspirin needed to be held for 5 days and the PCP could restart Aspirin if hemoglobin was stable in 5 days.	{D 358}		

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{D 358}	Continued From page 53 Review of a telephone order dated 07/06/17 for Resident #7 revealed: -There was an order to discontinue follow up with PCP. -The PCP would see the resident at the next facility visit. -There was no documentation or orders regarding the Aspirin and H/H. Observation of the morning medication pass on 07/13/17 revealed the medication aide (MA) administered Aspirin 81mg to Resident #7 at 8:23 a.m. Review of Resident #7's July 2017 medication administration record (MAR) revealed: -There was an entry for Aspirin 81mg 1 tablet daily for cardiac management and it was scheduled to be administered at 9:00 a.m. -Aspirin 81mg was documented as administered on 07/01/17 and 07/02/17. -Aspirin was not administered from 07/03/17 - 07/05/17 due to the resident being in the hospital. -Aspirin was not documented as administered on 07/06/17 with no reason documented. -Aspirin was documented as held on 07/07/17 - 07/10/17. -Aspirin was documented as administered on 07/11/17 - 07/13/17. Review of Resident #7's physician's orders revealed no order to restart the Aspirin after discharge from the hospital on 07/05/17. Interview with Resident #7 on 07/13/17 at 12:57 p.m. revealed: -His medication did not hurt his stomach. -He was recently in the hospital for some stomach trouble. -He had an appointment next week with his	{D 358}		

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{D 358}	Continued From page 54	{D 358}		

stomach doctor.
-He had some blood drawn yesterday on 07/12/17.
-He was not sure what kind of medication he was taking.

Interview with the Resident Care Coordinator (RCC) on 07/13/17 at 1:27 p.m. revealed:
-She was not aware staff was administering the Aspirin to Resident #7.
-She discussed the hospital discharge paperwork with the PCP (physician) when the resident returned to the facility on 07/05/17.
-She could not recall all of the details of the conversation and she did not document it.
-The PCP wanted to see the resident at his next scheduled visit to the facility.
-The PCP was at the facility yesterday (07/12/17) and the resident had blood drawn for labwork.
-She would contact the PCP about the Aspirin.

Review of an order from Resident #7's primary Nurse Practitioner (NP) dated 07/13/17 revealed an order to hold Aspirin until provider reviews labs.

Telephone interview with Resident #7's PCP (physician) on 07/14/17 at 1:02 p.m. revealed:
-He was aware of the resident's hospitalization and discharge paperwork from 07/05/17.
-The facility usually discussed hospital discharge paperwork with him to get approval of the orders verbally.
-He recalled speaking with the facility staff about the orders on the paperwork to follow up with the PCP and getting labwork.
-He told the facility staff it was okay for the resident to be seen on his next visit to the facility (07/12/17) and the labwork could be done then as well.

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{D 358}	Continued From page 55 -He did not tell the facility to administer the Aspirin. -The facility contacted his NP yesterday and let her know the facility had failed to hold the Aspirin. -The labwork just came back last night or this morning and once he reviewed it, he would let the facility know about restarting the Aspirin. -He would also send a copy of the labwork to the facility. Review of labwork dated 07/13/17 for Resident #7 revealed: -The resident's hemoglobin was 8.6 (reference range 12.6 - 17.7). -The resident's hematocrit was 27.9 (reference range 37.5 - 51.0). Review of an order from Resident #7's primary physician dated 07/14/17 revealed an order to resume Aspirin 81mg once daily. b. Review of Resident #7's current FL-2 dated 07/05/17 revealed there was an order for Ferrous Sulfate 325mg twice a day before meals. (Ferrous Sulfate is an iron supplement used to treat anemia. Ferrous Sulfate may be taken with food to prevent stomach upset.) Review of a hospital discharge summary dated 07/05/17 revealed: -The resident was admitted to the hospital on 07/03/17 with diagnoses of gastrointestinal (GI) bleed secondary to large antral (lower stomach) ulcer, superficial ulcer at the gastroesophageal junction, and acute blood loss anemia secondary to GI bleed. -The list of discharge medications included an order for Ferrous Sulfate 325mg twice a day with meals.	{D 358}		

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{D 358}	Continued From page 56 Review of physician's orders for Resident #7 revealed there was no order to clarify if the Ferrous Sulfate should be given before meals or with meals. Review of Resident #7's July 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Ferrous Sulfate 325mg twice daily with meals. -Ferrous Sulfate was scheduled to be administered at 7:30 a.m. and 4:30 p.m. Observation of the morning medication pass on 07/13/17 revealed: -Resident #7 was lying in bed in his room. -The resident stated he was not going to eat breakfast. -The medication aide (MA) administered Ferrous Sulfate 325mg to Resident #7 at 8:23 a.m. on an empty stomach. Interview with the MA on 07/13/17 at 8:25 a.m. revealed: -Resident #7 did not usually eat breakfast. -He administered Ferrous Sulfate to the resident each morning when the resident received his other morning medications. Interview with Resident #7 on 05/12/17 at 12:57 p.m. revealed: -The resident did not eat breakfast but he usually ate lunch every day. -His medication did not hurt his stomach. -He was recently in the hospital for some stomach trouble. -He was not currently having any stomach trouble. Interview with the Resident Care Coordinator (RCC) on 07/13/17 at 1:27 p.m. revealed:	{D 358}		

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{D 358}	Continued From page 57 -She was not aware Resident #7 did not eat breakfast. -The MAs should have notified the physician or the RCC so they could get the order clarified and changed. -Medications ordered with meals should be given while the resident was eating or they could have given the resident a snack like crackers and juice. -She would contact the physician about the Ferrous Sulfate. Telephone interview with Resident #7's primary Nurse Practitioner (NP) on 07/14/17 at 12:42 p.m. revealed: -The Ferrous Sulfate should be given with meals to avoid stomach upset since he has ulcers. -She was not aware the resident was taking Ferrous Sulfate on an empty stomach. -She changed the order on 07/13/17 for the Ferrous Sulfate to be given at lunch since the resident did not eat breakfast. Review of an order from Resident #7's Nurse Practitioner (NP) dated 07/13/17 revealed an order to start Ferrous Sulfate 325mg daily at lunch. B. Review of Resident #8's current FL-2 dated 08/21/16 revealed: -Diagnoses included history of glaucoma, dementia, altered mental status, renal failure, ambulatory dysfunction, history of hypertension, and history of urinary tract infection with sepsis. -There was an order for Systane Balance instill 1 drop in each eye 3 times a day. (Systane Balance is a lubricant eye drop used to treat symptoms of dry eyes.) -There was an order for Dorzolamide/Timolol solution, instill 1 drop in each eye twice daily. (Dorzolamide/Timolol is a combination eye drop	{D 358}		

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{D 358}	Continued From page 58 used to treat glaucoma.) Review of a report from an optometrist visit for Resident #8 on 06/12/17 revealed: -The resident was seen for glaucoma follow up. -The glaucoma in both of the resident's eyes was stable. -There was an order to continue drops as directed. -The order did not specify the names of the eye drops or specific instructions. Review an order written by Resident #8's primary care provider (PCP) on 06/20/17 revealed there was an order for Dorzolamide 2% instill 1 drop in each eye twice a day. (Dorzolamide is used to treat glaucoma. Dorzolamide is one of the medications in the combination eye drop, Dorzolamide/Timolol.) Review of Resident #8's physician's orders revealed there was no documentation the PCP was contacted to clarify the duplicate therapy. Review of Resident #8's July 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Dorzolamide 2% instill 1 drop in each eye twice a day and it was documented as administered at 8:00 a.m. and 8:00 p.m. -There was a computer printed entry for Dorzolamide/Timolol instill 1 drop in both eyes twice a day and it was documented as administered at 9:00 a.m. and 9:00 p.m. -There was a computer printed entry for Systane Balance instill 1 drop in both eyes 3 times a day and it was documented as administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. Observation of the 8:00 a.m./9:00 a.m.	{D 358}		

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{D 358}	Continued From page 59 medication pass on 07/13/17 revealed: -The medication aide (MA) administered Systane Balance, 1 drop in each eye to Resident #8 at 8:51 a.m. -The MA then administered Dorzolamide 2%, 1 drop in each eye to the resident 15 seconds after she administered the Systane Balance. -The Dorzolamide eye drops are white and the white solution ran out of the resident's eye and down her cheeks. -The MA did not wait 3 to 5 minutes between the eye drops. (Waiting 3 to 5 minutes between the different eye drops allows the first drop time to absorb so there will be enough space for the eye to hold the second drop. The eyelid only holds about 1 drop at a time.) -The MA did not administer Dorzolamide/Timolol eye drops because there was none available in the facility to administer for the resident. Interview with the MA on 07/13/17 at 8:55 a.m. revealed: -The Dorzolamide/Timolol eye drops ran out last night (07/12/17) and they were ordered yesterday on 07/12/17. -The Dorzolamide/Timolol should have come in the pharmacy tote last night but she did not see it. -They usually tried to order eye drops before they ran out but sometimes it was hard to tell when the eye drops were getting low. -They had a back-up pharmacy they could call to get the eye drops and she would check on getting the eye drops. Interview with the MA on 07/13/17 at 1:20 p.m. revealed: -She told the supervisor they were out of Resident #8's Dorzolamide/Timolol eye drops so the supervisor was going to contact the back-up pharmacy to get them in.	{D 358}		

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{D 358}	Continued From page 60 -She usually waited about 2 minutes between the different eye drops. -She usually gave one drop before she administered the resident's oral medications then she gave a second eye drop after the resident took the oral pills. -She was not sure why she did not wait between the drops today (7/13/17). Interview with Resident #8 on 07/14/17 at 3:00 p.m. revealed: -She got eye drops every day. -The eye drops usually ran down her face. -She thought the eye drops helped her eyes. Interview with the Resident Care Coordinator (RCC) on 07/13/17 at 1:27 p.m. revealed: -The MAs had been trained on the proper technique for administering eye drops including waiting 3 to 5 minutes between different eye drops. -The MAs were supposed to order medications when there was a 7 day supply remaining. -For eye drops, the MAs could use the dispensing date to help determine when they should reorder the eye drops, before they run out. -She had not noticed the Dorzolamide 2% and Dorzolamide/Timolol eye drops had the same medication in them. -She would contact the resident's PCP to clarify the order she wrote on 06/20/17. Telephone interview with Resident #8's PCP on 07/14/17 at 12:42 p.m. revealed: -She did not usually write orders for eye drops. -She could not recall why she wrote the orders for the Dorzolamide 2% on 06/20/17. -She wrote an order to discontinue the Dorzolamide 2% yesterday (07/13/17).	{D 358}		

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{D 358}	Continued From page 61 Review of an order for Resident #8 dated 07/13/17 revealed the PCP wrote an order to discontinue the Dorzolamide 2% but to continue Dorzolamide/Timolol 1 drop in each eye twice a day. Attempt to contact Resident #8's optometrist by phone on 07/14/17 was unsuccessful. C. Review of Resident #6's current FL-2 dated 03/26/17 revealed: -Diagnoses included chronic obstructive pulmonary disease, diabetes type II, seizures, history of myocardial infarction, wide complex tachycardia, near syncope, cardiac murmur, prolonged QT interval, and schizophrenia. -There was an order for Atrovent inhale 1 puff 4 times a day. (Atrovent is used in the treatment of chronic obstructive pulmonary disease.) Review of Resident #6's July 2017 medication administration record (MAR) revealed: -There was an entry for Atrovent inhale 1 puff 4 times a day (shake well). -Atrovent was scheduled to be administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Observation of the 12:00 noon medication pass on 07/12/17 revealed: -The medication aide (MA) shook the Atrovent inhaler and handed it to Resident #6. -The MA instructed the resident to take 2 puffs. -The resident pressed the inhaler 2 quick puffs in a row at 12:23 p.m. without inhaling the medication. -The medication vapors came back out of the resident's mouth. Observation of Resident #6's medications on hand on 07/12/17 revealed:	{D 358}		

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{D 358}	Continued From page 62 -The Atrovent inhaler was dispensed on 07/10/17. -The instructions on the label were to inhale 1 puff 4 times a day. Interview with the MA on 07/12/17 at 2:13 p.m. revealed: -Resident #6 preferred to hold the inhaler himself. -Sometimes the resident would take 3 or 4 puffs even if she instructed him to take less. -She must have looked at the wrong label when she told the resident to take 2 puffs of Atrovent today (07/12/17). -The resident also had a different inhaler for prn (as needed) use and the instructions for it was 2 puffs. -The resident usually got 1 puff of Atrovent. -She just looked at the wrong information today (07/12/17). -Resident #6 was sometimes short of breath when he was agitated or when he walked a lot. Interview with the Resident Care Coordinator (RCC) on 07/12/17 at 2:19 p.m. revealed: -The MAs had been trained to read the MARs and the medication labels and administer the medications as ordered. -If the MA handed the inhaler to the resident, the MA should instruct the resident on the correct number of puffs to take. -The MA should also instruct the resident on the proper technique for inhaling the medication. Interview with Resident #6 on 07/14/17 at 12:15 p.m. revealed: -The MAs always handed the Atrovent inhaler to Resident #6 to administer. -He used two different inhalers. -The "green one" (referring to Atrovent) was not strong enough and it did not help much. -He usually got 2 puffs of the green inhaler	{D 358}		

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{D 358}	Continued From page 63 (Atrovent). -He either got 1 or 2 puffs of the other inhaler when he needed it. -He got short of breath sometimes when he was walking and when lying in bed. Telephone interview with Resident #6's primary care provider (PCP) on 07/14/17 at 12:42 p.m. revealed: -The facility contacted her on 07/12/17 and told her Resident #6 was given the wrong amount of puffs with the Atrovent inhaler. -She told the facility to make sure it was given correctly at the next dosage time. -She did recall Resident #6 having any acute breathing issues when she last saw him (could not recall date of last visit). _____ The facility failed to assure that Resident #3, who had a history of urinary tract infections, received Tamsulosin (a medication to improve urination) for two weeks as ordered by the provider on 06/29/17; failed to administer Humulin R sliding scale insulin to a diabetic resident at bedtime for twelve days from 07/01/17 - 07/12/17; and failed to administer medications as ordered to 3 of 8 residents observed during medication passes with a 17% error rate including Resident #7 whose Aspirin was restarted without an order after a hospitalization for gastrointestinal bleed with ulcers. The failure of the facility to administer medications as ordered resulted in substantial risk for harm to the residents and constitutes a Type A2 Violation. _____ Review of the facility's Plan of Protection dated 07/13/17 revealed: -Residents' physicians were notified of medication	{D 358}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 64 errors. -Eye drops that were not available for administration were ordered. -Review of all residents' MARs, orders and medications on hand to ensure medications are being given as ordered 07/13/17 - 07/15/17. -Retraining with staff on administering medications and/or treatments per physician orders 07/13/17 - 07/14/17. -Director, RCC and/or Designee to audit medication administration records to assure that medications are being given per physicians' orders daily for 30 days and then weekly thereafter. -Director, RCC and/or Designee to perform monthly audit medication passes to assure staff are giving medications per physicians' orders. -Any staff not following physicians' orders will receive re-training and/or disciplinary action up to termination. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 13, 2017.	{D 358}		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure Resident #5 was treated with respect, dignity, and consideration as related to having to dispose of	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 07/14/2017

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D911	Continued From page 65 her soiled incontinence briefs. The findings are: Based on observations, interviews and record reviews the facility failed to ensure that 1of 5 residents sampled (#5) was treated with respect, consideration and dignity, related to having to walk down the South hall to dispose of soiled incontinent briefs in the Women's Bathroom and having to wait outside the bathroom with the soiled incontinent briefs in her hand. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights.]	D911		
{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 to housekeeping and furnishings, health care, and medication administration. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to assure the residents' rooms and common areas were free of	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 66 hazards as evidenced by the presence of roaches, flies, ants and fruit flies in residents' rooms, dining room and common hallways; and failed to follow the established protocol when bed bug activity was confirmed in residents' rooms to include not treating the linens or clothing and not cleaning the residents' rooms or common areas with known bed bug activity. [Refer to Tag D079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to assure health care needs were met for 1 of 5 sampled residents (#3), who had a history of urinary tract infections and had not received ordered Tamsulosin for two weeks, and did not have a catheter removed as ordered prior to the resident's urology appointment. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents sampled (#3, #9) including a resident (#3) with a urinary catheter who had a new order for a medication to improve urination that was not implemented and for a diabetic resident (#9) who did not receive sliding scale insulin at bedtime as ordered for 12 consecutive days in July 2017; and 3 of 8 residents (#6, #7, #8) observed during the medication passes including errors with an inhaler (#6), two eye drops for glaucoma (#8), and Aspirin and an iron supplement (#7). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]	{D912}		