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ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a follow-up survey and complaint investigation on July 19-21, 2017, and July 24, 2017. The Alexander County Department of Social Services initiated the complaint investigation on June 27, 2017.	D 000		
D 128	10A NCAC 13f .0404(1) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director There shall be a designated adult care home activity director who meets the following qualifications: (1) The activity director (employed on or after August 1, 1991) shall meet a minimum educational requirement by being at least a high school graduate or certified under the GED Program or by passing an alternative examination established by the Department of Health & Human Services. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the facility had a current Activity Director (Staff A) that met all qualifications for the position of Activity Director. The findings are: Review of Staff A's personnel record on 7/24/17 revealed: -Staff A had a hire date of 6/31/17. -An employment application which listed completion of the GED.	D 128		

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D 128	Continued From page 1 -Staff A had been hired as an Activity Coordinator / Housekeeper. -No documentation / copy of a high school diploma, GED, or alternate exam available for review. -She did not have a job description in her personnel record for Activity Coordinator. Interview on 7/20/17 at 11:40am with the Activity Coordinator revealed: -She had worked at the facility for about 3 to 4 weeks. -She had been hired to do activities with the residents. -She does housekeeping two days per week and when needed, but will do activities when she gets her housekeeping assignment completed. -She had not had any activity training. -She knew how to do activities because she has 4 children. -She had put the activities on the calendar for July 2017. -She had not conducted any of the activities on the July 2017 activity calendar. -She had not been told that she had to do the activities listed on the calendar. -She had done "a few" activities for the residents like putting out pictures for them to color, and putting out games for them to play. -She had taken some of the residents to the store to shop. -She had not been told about the activity requirements. -She had done activity assessments on the residents, but they were at her house. -She had not been told that she would eventually need certification related to activity coordination for adult care homes. -She had received her GED, but she could not remember the date, nor did she have any	D 128		

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documentation to validate her statement.

Review of the job description for Activity Coordinator provided by the Administrator revealed:
-Responsibilities: development and coordination of activities program designed to promote the resident's active involvement with each other, their families and the community, and involve staff in implementing program goals.
-Demonstrate involvement with all residents, staff, residents' families, volunteers, and community resources.
-Maintain a written updated residents' interest list and capabilities.
-Using the "Activities Supervisor's Guide," plan a minimum of 10 [SIC] hours of group activities and individual activities per week taking into consideration residents' interests.
-Prepare a monthly calendar for planned activities in large print, and post in prominent location on first day of month and update as needed, before the activities take place.
-Include the following types of activities on the posted calendar: social and recreational activities, diversional and intellectual activities, and work-type and volunteer activities.
-Participate in evaluating the overall effectiveness of activities program at least once every six months.

Observations made throughout the survey on 7/19/17, 7/20/17, 7/21/17 and 7/24/17 revealed the Activity Director did not hold any activities with the residents at the facility.

Interview on 7/21/17 at 10:45am with the Administrator revealed:
-Staff A was hired to assist with activities, but also helped with housekeeping when the regular

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D 128	Continued From page 3 housekeeper was off. -She was instructed to do an activity assessment on all residents. -The facility did not have a full time Activity Coordinator. -There was not anyone in his corporation who was a Certified Activity Director. -The Administrator stated he was not aware that the activities scheduled for 7/19/17 and 7/21/17 had not taken place.	D 128		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 5 staff (Staff A) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Staff A's personnel file revealed: -She was hired as the Activity Coordinator on 6/31/17.	D 131		

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D 131	Continued From page 4 -There was no documentation of a TB skin test in Staff A's record. Interview with Staff A on 7/24/17 at 10:45am revealed: -She was hired to do activities with the residents. -She also does housekeeping duties. -She "thought" the Resident Care Coordinator (RCC) had given her a TB test. -She could not recall if she had ever had a positive reading from a TB test. Interview with the Administrator on 7/24/17 at 3:30pm revealed: -The RCC is responsible for assuring that all new staff have a TB test done before employment. -The TB test should have been done at the health department before employment. -If needed the Licensed Health Professional Support (LHPS) nurse will give a TB test to an employee. -He will make sure that the nurse does a TB test on Staff A. -He did not know why a TB test had not been done.	D 131		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following:	D 164		

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D 164	Continued From page 5 (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure that training on the care of diabetic residents was provided for 3 of 3 sampled Medication Aides (MA), (Staff C, D, and E) who administer insulin in the facility. The findings are: A. Review of Staff C's personnel file revealed: -Staff C was hired as a Medication Aide on 7/21/16. -She had passed the medication aide test on 10/16/03. -She had the medication clinical skills validation completed on 8/18/16. -There was no documentation of diabetic care training for Staff C. Interview with Staff C on 7/24/17 at 3:30pm revealed: -She had received diabetic training at the facility where she had previously worked.	D 164		

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-She had received diabetic training on the various types of insulin, how they work, storage of insulin, and the importance on administration times of insulin.
-She could explain the difference between fast acting and slow acting insulin.
-She had not received diabetic training at this facility.
-She did administer insulin at the facility.

Refer to interview with the Administrator on 7/24/17 at 3:30pm.

Refer to attempted telephone interview with the LHPS nurse on 7/24/17 at :2:45pm.

B. Review of Staff D's personnel file revealed:
-Staff D was hired on 1/5/17 as a Personal Care Aide.
-She started passing medications on 3/1/17.
-She had the medication clinical skills validation completed on 3/1/17.
-She had passed the medication aide test on 4/18/17.
-There was no documentation of diabetic care training for Staff D.

Interview with Staff D on 7/24/17 at 3:00pm revealed:
-The nurse who did her medication clinical skills validation did talk with her about diabetic care.
-The nurse showed her how to do finger sticks and give injections.
-She did not go over the insulin types with her.
-She had not had any "formal" diabetic training since working at the facility.
-She felt comfortable administering insulin to the residents.

Refer to interview with the Administrator on

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D 164	Continued From page 7 7/24/17 at 3:30pm. Refer to attempted telephone interview with the LPHS nurse on 7/24/17 at :2:45pm. C. Review of Staff E's personnel file revealed: -Staff E was hired on 12/15/16 as a Personal Care Aide. -She started passing medications on 3/1/17. -She had a medication clinical skills validation completed on 3/1/17. -She had passed the medication aide test on 10/28/14. -There was no documentation of diabetic care training for Staff E. Attempted telephone interview with Staff E on 7/24/17 at 3:15pm was unsuccessful. Refer to interview with the Administrator on 7/24/17 at 3:30pm. Refer to attempted telephone interview with the LHPS nurse on 7/24/17 at :2:45pm. _____ Interview with the Administrator on 7/24/17 at 3:30pm revealed: -The Resident Care Coordinator (RCC) is responsible for assuring that all new staff have required training. -He thought the nurse did diabetic training when she did the medication competency validation for the med aides. -He will schedule the nurse to do diabetic training for the medication aides. -All the medication aides are required to administer insulin to the diabetic residents. Attempted telephone interview on 7/24/17 at	D 164		

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D 164	Continued From page 8 2:45pm with the Licensed Health Professional Support (LHPS) nurse was unsuccessful.	D 164		
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 B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled residents (#2) had an injectable medication, Invega Sustenna, available for home health to administer and failed to try to obtain the medication resulting in the resident not receiving the medication for almost 2 months and failed to ensure the resident's physician was aware the medication was not administered as ordered. The findings are: Review of Resident #2's current FL2 dated 2/9/17 revealed: -Diagnoses included paranoid schizophrenia, and diabetes. -A medication order for Invega Sustenna 156 mg Inject Intramuscular (IM) every four weeks for psychosis (Invega is an injectable medication used to treat schizophrenia.)	D 273		

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D 273	Continued From page 9 Interview with the Medication Aide (MA) on 7/20/17 at 9:40am revealed: -Resident #2 did not get her Invega Sustenna last month because the medication did not come in from the pharmacy. -When the home health nurse came in to give the Invega injection to Resident #2, it was not available. -The MA did not call the pharmacy to get the medication or to find out why the facility did not have the medication to give. -The physician was not notified that Resident #2 did not receive her Invega Sustenna 156 mg injection for June. Interview with Resident #2 on 7/20/17 at 12:00pm revealed: -She would have taken her Invega Sustenna if it had been offered in June. -The MA had told her her medication was not available. -The medication "helped" with her paranoia. Observation of Resident #2's medications on hand revealed an unopened box containing Invega Sustenna 156mg with a dispense date of 7/2/17 was available to be administered. Review of Resident #2's electronic Medication Administration Records (eMARs) for May, June and July 2017 revealed: -The Invega Sustenna 156 mg was documented as administered on 5/5/17. -An entry for Invega Sustenna 156 mg Inject Intramuscular (IM) every four weeks for psychosis with a scheduled administration time of June 3, 2017 at 8am. -The Invega Sustenna 156 mg IM every four weeks was documented as not available for	D 273		

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administration on 6/3/17 of the June 2017 eMAR.
-The next four week dose was due on 6/30/17 and had been administered on 7/2/17.

Review of Resident #2's record revealed there was no documentation noting any changes in the resident's behavior.

Phone interview with the pharmacy provider on 7/21/17 at 8:45am revealed:
-The pharmacy computer system was down and they could not provide information on Resident #2's medications.
-They would return the call as soon as their system was back up.

The pharmacy never returned the call.

Phone interview with the staff at the physicians office on 7/21/17 at 12:03pm revealed:
-The physician was out of the country at this time.
-She would have another physician in the practice review and call when they were available.
-The physician's office was unaware Resident #2 had missed her medication for June.

The Physician did not return the call by the end of the survey.

The facility failed to ensure 1 of 1 sampled residents (#2) had an injectable medication, Invega Sustenna, available for home health to administer, and failed to try to obtain the medication. As a result, Resident #2 did not receive the medication for almost 2 months and failed to ensure the resident's physician was aware the Invega Sustenna was not administered as ordered. This failure exposed Resident #2 to an increased risk of breakthrough psychosis due to a diagnosis of paranoid schizophrenia.

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D 273	Continued From page 11 Therefore, this failure was detrimental to the health and safety of Resident #2 and constitutes a Type B Violation. _____ A Plan of Protection was requested from Provider on 8/4/17.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to protect all food being stored, prepared and served by the facility from contamination. The findings are: Observation on 7/19/17 at 10:07am of the facility kitchen, freezer and pantry storage area revealed: -The floor of the pantry was dark, discolored and dirty. -A 5 lb. bag of buttermilk pancake mix was opened and rolled over at the top and was not dated after it was opened. -A clear plastic 1 gallon container of barbecue sauce was half full and had an expiration date of 5/24/17. -A large clear bag with approximately 2 cups of uncooked elbow macaroni was tied closed at the top of the bag but not dated after it was opened.	D 282		

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D 282	Continued From page 12 -A closed freezer bag contained another small bag tied off at the top with approximately 2 cups of a white powder in it that was not labeled or dated after it was opened. -A 16 oz. bag of potato chips had been open, ½ left, not dated after it was opened. -A bag of vanilla wafers approximately ¼ full was open and partially rolled closed but was not dated after it was opened. -There was one pack of graham crackers open with 3 crackers remaining in the pack and not dated after it was opened. -There was one opened bag of multi colored cereal that had been loosely twisted closed sitting beside another opened bag of brown flaked cereal that the top of the bag was just folded over and neither bag was dated after it was opened. -There was a bag of 4 hamburger buns sitting on the third shelf from the bottom in the right side of the pantry after it was opened. -There was an open loaf of bread and the top of the bag tied in a knot, not dated, with 4 pieces of bread after it was opened. -There was another open loaf of bread with the top of the bag folded around four pieces of bread that was not dated after it was opened. Observation on 7/20/17 at 8:42am of the freezer in the pantry revealed: -An opened bag of onion rings was tied in a knot that was not dated after it was opened. -A clear plastic bag with 6 frozen hamburger patties was not labeled or dated after it was opened. -A bag with approximately 24 fish fillets was opened and not dated after it was opened. Observation on 7/20/17 at 8:47am of the freezer in the kitchen revealed: -A form titled "KITCHEN STAFF" on the outside of	D 282		

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the freezer had "Label and date everything that is left over so it is getting discarded at the right times including ALL beverages."
-A large freezer bag closed with sliced frozen carrots was on the top shelf of the freezer and was not dated after it was opened.
-A large clear bag with broccoli, cauliflower and carrots had been tied in a knot at the top of the bag and was not dated after it was opened.
-Two large clear bags of lima beans had been opened and tied closed and not labeled or dated after it was opened.
-A large blue see through bag with green beans had been opened tied shut and not dated after it was opened.
- A large clear bag with biscuit dough was ¼ full sitting on an open box of 218 count biscuit dough that was not dated after it was opened.

Observation on 7/20/19 at 8:48am of the refrigerator in the kitchen revealed:
-A 2 liter bottle of a soft drink ½ full not dated after it was opened.
-A bowl covered with tin foil not labeled or dated after it was opened.
-A gallon tea pitcher ½ full with tea not dated or labeled.
-A large container with a lid ¼ full of applesauce not dated or labeled after it was opened.
-A large container with a lid ¼ full of potato salad opened, was not dated on the second shelf.
-Another open large container of potato salad on the third shelf ¾ full was not dated after being opened.

Interview on 7/20/17 at 8:30am with the Cook revealed:
-She had worked for the facility for about 5 months.
-When the delivery truck comes in she dates and

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D 282	Continued From page 14 groups the stock together as much as possible. -She had been trained to put the date on items, label and initial after the containers or packages were opened but she did not always do it as she gets has been very busy. -She had not put the date on the open items because she was the only one working in the kitchen and had been very busy. Interview on 7/24/17 at 3:30pm with the Administrator revealed: -He expected staff to get out what they needed and then label and date it. -He expected food and drink items to be dated after they were opened. -He could not say why the staff had not dated items in the kitchen after opening them.	D 282		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure all therapeutic diets for 4 of 4 sampled residents (Resident #1, #2, #7 and #9) were served as ordered related to puree and no concentrated sweets diet orders. The findings are:	D 310		

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D 310	Continued From page 15 Review of the facility's therapeutic menus for No Concentrated Sweets (NCS) and Pureed revealed: -There was a column for daily food items and portion sizes to be served to residents on therapeutic diets. -Residents on a NCS diet should also have received sugar free fruit cocktail. -Residents on a puree diet should also have received one serving of breakfast meat. -Residents on a NCS diet should have recieved sugar free syrup. -The menu had at the bottom of each page for "low concentrated sweets, consistent carbohydrates, no concentrated sweets and calorie controlled diets -all beverages, gelatin, syrup, jelly and sweeteners except milk should be sugar free". A. Review of Resident #7's FL2 dated 7/29/16 revealed: -Diagnoses that included mental retardation, cardiopulmonary disease and diabetes mellitus. -A physician order for a diabetic puree diet with thickened liquids (with no clarification for type of thickness). -A physician order for finger stick blood sugar checks on Monday, Wednesday and Friday. Observation of the breakfast meal on 7/21/17 between 7:30 am and 8:00 am revealed: -Resident #7 was feeding herself independently. -Resident #7's plate contained pureed scrambled eggs, pureed fruit cocktail, and a finely chopped biscuit with no liquid in it (dried bread crumbs). -Resident #7 mixed all of the food together on her plate and put spoonfuls of thickened coffee (consistency of oatmeal) and thickened orange juice in her food and mixed it up together.	D 310		

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D 310	Continued From page 16 -Resident #7 ate 100% of her breakfast meal. -Resident #7 had no difficulties with swallowing and no coughing during the meal. Review of the Resident Therapeutic "Diet" List with no date posted in the kitchen on 7/19/17 revealed Resident #7 was to be served a" pureed diet and thickened liquids only". -Review of the label on the fruit cocktail can revealed it contained 20 grams of sugar per ½ cup serving. Review of Resident #7's July 2017 electronic Medication Administration Records revealed: -Entries for FSBS for Monday, Wednesday and Friday at 6am with the initials of the staff who administered the blood sugar readings as ordered. -There were no recordings of what Resident #7's blood sugar actually was. Interview with the Cook on 7/20/17 at 1:05pm revealed: -She had been with the facility for about 4 months. -She had never worked in a facility kitchen prior to this but "I have cooked for my family". -No one had taught her how to make a pureed meal other than to chop it up in the food processor. -The bread did not make it to the pureed resident's plates for lunch on 7/20/17. -She had poured the bread crumbs for lunch in the trash as she had forgotten to put them on the plate. -She put the roll/bread in the food processor and chopped it up but doesn't add any liquid to it, as that was how she was taught to do the pureed bread.	D 310		

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D 310	Continued From page 17 -She goes by the sheet on the wall in the kitchen labeled "Diets" for all therapeutic diets. -If the correct diet is not on there she had no way of knowing what diet a resident needed. -She had been taught to put two scoops of thickener in Resident #7's drinks except for the small 4 ounce juice glass and to put 1 ½ scoops in it and stir it up. -She was not aware of any differences between honey or nectar thicken liquids. -She was not aware of the sugar content in the fruit cocktail. -"I don't know if it would hurt a diabetic or not (referring to the fruit cocktail)." -She was not aware of the recipe book for the therapeutic diets and regular meals. -If she did not know what something on the menu was she would cook something she knew how to cook. Interview with the Dietary Manager on 7/21/17 at 11:15pm revealed: -He had worked at the facility for around 2 years. -Resident #7 had been on a pureed diet since he had started working at the facility. -His personal preference that he liked to make Resident #7's drinks so they had a consistency "a little thicker than motor oil". -He had never been taught the consistency of Resident #7's thickened liquids but had always put two scoops of thickener in her drinks. -He was aware Resident #7 was a diabetic. -He cooks the same for everyone, he did not follow the therapeutic diet list, he followed what was on the weekly menu. -There were a couple of things he does different for the diabetics like unsweetened tea, and sugar free puddings but that was "about it". -He does not add anything to the puree bread, he just puts the bread that he cooks in the chopper	D 310		

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and then puts it on the pureed plates.
-"They don't like anything added to it."
-He had never checked the fruit cocktail to see if it was sugar free or had added sugar.
-He usually just gives Resident #2 applesauce for dessert.
-He had not had any training at this facility but he had at other facilities he had worked for.
-He did not use the recipes book for the menus as he had been cooking for 45 years and knew how to cook most of the items on the menu.

Refer to interview on 7/21/17 at 5:05pm with the Administrator

Refer to interview on 7/24/17 at 10:08am with the Dietary Manager.

Refer to interview on 7/24/17 at 10:16am and 12:35pm with the Resident Care Coordinator (RCC) and the Administrator.

Based on review of Resident #7's record and attempted interview with Resident #7, it was determined the resident was not interviewable.

B. Review of Resident #9's current FL2 dated 7/29/16 revealed:
-Diagnoses included mild MR (mental retardation), hypertension, psychosis, and diabetes.
-A physician diet order for a no concentrated sweets diet.

Review of the facility's therapeutic menus for a mechanical soft diet revealed all meats were to be mechanical soft (chopped meats and other foods that make it easier to chew).

Review of the Resident Therapeutic "Diet" List

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with no date posted in the kitchen on 7/19/17 revealed:
-Resident #9 was to be served a "chopped diet and no fresh apples or hard food due to teeth".
-Resident #9 should have been served a mechanical soft breakfast meat.
-Resident #9 should have been served sugar free fruit cocktail.

Observation on 7/21/17 at 7:30am of the breakfast meal revealed Resident #9 received pureed scrambled eggs, a finely chopped biscuit with no liquid, and pureed fruit cocktail in regular syrup.

Review of the record for Resident #9 revealed there was no order for a pureed diet.

Review of the label on the fruit cocktail can revealed it contained 20 grams of sugar per ½ cup serving.

Interview with the Cook on 7/20/17 at 1:05pm revealed:
-She had been with the facility for about 4 months.
-She had never worked in a facility kitchen prior to this but "I have cooked for my family".
-She was not aware of the sugar content in the fruit cocktail.
-"I don't know if it would hurt a diabetic or not (referring to the fruit cocktail)."
-She was not aware of the recipe book.
-If she did not know what something on the menu was she would cook something she knew how to cook.
-The residents either received a regular diet or a pureed diet.
-She was aware Resident #9 was on the diet list for chopped meats but stated, Resident #9 was

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D 310	Continued From page 20 given a puree diet because she didn't have any teeth. Interview on 7/21/17 at 7:39am with Resident #9 revealed: -The facility gave her puree because she didn't have any teeth. -She would have liked to have had "some sausage" if she couldn't have the bacon. -She "don't eat bread crumbs"! -"It's all the same color who knows what we are eating, it's good when you're hungry." Interview with Dietary Manager on 7/21/17 at 11:15pm revealed: -He had worked at the facility for around 2 years. -He was aware Resident #9 was a diabetic because she received an artificial sweetener. -He cooks the same for everyone except there a couple of things he does different for the diabetics like unsweetened tea, and sugar free puddings. -He had never checked the fruit cocktail to see if it was sugar free or had added sugar. -He had not had any training at this facility but he had at other facilities he had worked for. -He did not use the recipes book for the menus as he had been cooking for 45 years and knew how to cook most of the items on the menu. -He does not add anything to the puree bread, he just puts the bread that he cooks in the chopper and then puts it on the pureed plates. -Resident #9 did not like anything added to her bread. -The bacon does not puree well so he did not give Resident #9 or the other 2 residents who received puree any breakfast meat. Refer to interview on 5/21/17 at 5:05pm with the Administrator.	D 310		

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D 310	Continued From page 21 Refer to interview on 7/24/17 at 10:08am with the Dietary Manager. Refer to interview on 7/24/17 at 10:16am and 12:35pm with the Resident Care Coordinator (RCC) and the Administrator. C. Review of Resident #2's FL2 dated 1/11/17 revealed: -Diagnosis included schizophrenia, paranoid type, mild renal insufficiency, insulin dependent diabetic and gastroesophageal reflux disease. -There was no physician's order for a diet on the FL2. -A physician's order to check finger stick blood sugars (FSBS) three times a day and as needed daily. -A physician's order for Levemir 55 units at 8am and 8pm (a long acting insulin used to lower blood sugar). -Novolog 100 units with flex pen with sliding scale insulin three times daily (a rapid-acting insulin pen). Review of Resident #2's record revealed a physician order dated 1/9/17 on a discharge summary from a local hospital revealed a No Concentrated Sweets (NCS) diet. Observation of the noon meal on 7/20/17 at 12:40pm revealed: -Resident #2 was served Salisbury steak, a baked potato, succotash, a roll, fruit cocktail and sweet tea. Review of Resident #2's care plan dated and signed by the physician on 1/11/17 revealed a diagnosis of insulin dependent diabetes and a NCS diet.	D 310		

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Review of the Resident Therapeutic "Diet" List with no date posted in the kitchen on 7/20/17 revealed Resident #2 was not on the list for a therapeutic diet.

Review of the label on the fruit cocktail can revealed it contained 20 grams of sugar per ½ cup serving.

Review of Resident #2's June 2017 electronic Medication Administration Records revealed:
-Entries for FSBS at 6:00am, 11:00am. 4:00pm and 9:00pm.
-FSBS at 6:00am ranged from 114 to 400.
-FSBS at 11:00pm ranged from 74 to 362
-FSBS at 4:00pm ranged from 142 to 434.
-FSBS at 9:00pm ranged from 118 to 370.

Review of Resident #2's July 2017 electronic Medication Administration Records revealed:
-Entries for FSBS at 6:00am, 11:00am. 4:00pm and 9:00pm.
-FSBS at 6:00am ranged from 116 to 344.
-FSBS at 11:00pm ranged from 146 to 417.
-FSBS at 4:00pm ranged from 173 to 368.
-FSBS at 9:00pm ranged from 132 to 356.

Interview on 7/19/17 at 10:00am with Resident #2 revealed:
-She was diabetic and on sliding scale insulin but the facility gave her "what everyone else gets".
-She was aware she was supposed to be on a diabetic diet.
-She did not always follow her diet because she would eat what was on her plate as she was hungry.
-Her blood sugars usually always run high as she is served a regular diet.

Interview with the Cook on 7/20/17 at 1:05pm

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revealed:
-She was aware that Resident #2 was diabetic but she received a regular diet.
-She goes by the sheet on the wall in the kitchen labeled "Diets" for all therapeutic diets.
-If the correct diet is not on there she had no way of knowing what diet a resident needed.
-She was not aware of the sugar content in the fruit cocktail.
-"I don't know if it would hurt a diabetic or not (referring to the fruit cocktail)."

On 7/24/17 at 10:16am and 12:35pm with the Resident Care Coordinator (RCC) and the Administrator revealed:
-The RCC was aware that Resident #2 had a diagnosis of diabetes and was on sliding scale insulin.
-The RCC stated "they should be doing it (in reference to the NCS diet)."
-The RCC was unaware that Resident #2 was not on the therapeutic diet list in the kitchen.
-The Administrator stated "that's probably why she is not getting the diabetic diet."

Refer to interview on 7/21/17 at 5:05pm with the Administrator.

Refer to interview on 7/24/17 at 10:08am with the Dietary Manager.

Refer to interview on 7/24/17 at 10:16am and 12:35pm with the Resident Care Coordinator (RCC) and the Administrator.

D. Review of Resident #1's FL2 dated 7/2/17 revealed:
-Diagnoses of hepatitis C, coronary artery disease, hypertension, history of traumatic brain injury, mixed dementia, insulin dependent

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diabetes, and chronic pain.
-There was an order for an ADA (American Diabetes Association) diet.

Interview with Resident #1 on 7/19/17 at 10:33am revealed:
-He had been served pancakes with regular syrup for breakfast.
-"I can't eat that, I'm an insulin dependent diabetic. I ate it because that's all I had."

Interview with the first shift medication aide on 7/19/17 at 10:47am revealed:
-Resident #1's CBG (capillary blood glucose) was 352 after breakfast.
-Resident #1 received 12 units of Novolog insulin (medication to treat high blood glucose) after his CBG was obtained.
-"It's the syrup."
-"That must be why everyone's blood sugar is so high."

Review of the facility kitchen on 7/20/17 at 8:25am revealed there was no sugar free syrup in the kitchen or pantry area.

Observation of the noon meal on 7/20/17 at 12:40pm revealed:
-Resident #1 was served Salisbury steak, a baked potato, succotash, a roll, fruit cocktail and sweet tea.

Review of the Resident Therapeutic "Diet" List with no date posted in the kitchen on 7/20/17 revealed Resident #1 was not on the list for a therapeutic diet.

Review of the label on the fruit cocktail can revealed it contained 20 grams of sugar per ½ cup serving.

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D 310	Continued From page 25 Refer to interview on 7/21/17 at 5:05pm with the Administrator. Refer to interview on 7/24/17 at 10:08am with the Dietary Manager. Refer to interview on 7/24/17 at 10:16am and 12:35pm with the Resident Care Coordinator (RCC) and the Administrator. _____ Interview on 7/21/17 at 5:05pm with the Administrator revealed: -He was unaware the dietary staff did not have the correct diet orders for each resident. -He was unaware the staff were not following the menu for therapeutic diets. -He expected the residents to receive the diet the provider ordered. On 7/24/17 at 10:08am with the Dietary Manager revealed: -He had not received any new diet orders or clarifications, since 7/21/17as stated in the Plan of Protection, and the residents continued to receive the same diets they had last week. -No one had spoken with him about the puree, NCS diets nor had he received any clarification on Resident # 7's thickened liquids since 7/21/17. -He was unfamiliar with a mechanical soft diet. -He had not been trained how to do the consistency for the pureed meals he just put it in the blender and chopped it up until it was like "cake batter". On 7/24/17 at 10:16am and 12:35pm with the Resident Care Coordinator (RCC) and the Administrator revealed: -The Administrator stated he had spoken with the	D 310		

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D 310	Continued From page 26 Cooks about the therapeutic menus. -The Administrator stated a Dietician would be coming in to teach the dietary staff about therapeutic diets. -The RCC stated she had not done an audit of the residents diet orders as stated in the Plan of Protection on 7/21/17 because she was waiting until the physician came in on 7/27/17 to update everyone's diet orders. -The dietary staff had not been given an updated list of all residents' diets since 7/21/17 as stated in the Plan of Protection. _____ The facility failed to assure proper training of dietary staff on the use and knowledge of using therapeutic menus resulting in therapeutic diets and thickened liquids not being served for 4 of 4 sampled residents (Resident #1, #2, #7 and #9) related to puree and NCS diet orders. The facility's failure to serve theraputic diets as ordered was detrimental to the health of the residents resulting in a Type B Violation. _____ The facility provided a Plan of Protection on 7/21/17 that included: -The Administrator will ensure that each cook is following proper orders for the residents and to follow the menu that is listed. -The Administrator will go over the menu to make sure they understand the how to read and understand the menu. -The Administrator will make sure the cooks are properly serving the correct portion sizes. -The Administrator continue to monitor closely the menu and all cooks will meet with a Dietician to ensure the importance and understanding of following the menu and proper serving sizes. -All residents will get served the proper diets the	D 310		

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D 310	Continued From page 27 provider calls for. -The Administrator or designee will audit all resident records to obtain the correct diet and date order posted and update the diet list in the kitchen for all cooks. -The RCC will ensure all thickened liquid orders are correct. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2017	D 310		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop a program of activities designed to promote the residents' active involvement with each other, their families and the community. The findings are: Observations on 7/19/17 at 10:45am of a large wooden activity calendar hanging on the wall in the facility's main hallway revealed: -The top of the calendar had an area for the	D 315		

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month and year and was labeled July 2017.
-Below the month and year, the board had been divided into seven sections, each containing a different day of the week.
-Below each day of the week there were 6 additional boxes for a total of 42 sections.
-Eleven of the sections were empty. The remaining 31 sections each contained a numbered piece of colored paper approximately 3 inches by 5 inches had been arranged to represent the activity calendar for July 2017.
-Activities listed on the calendar included: make someone laugh day 7/1, color time 7/2, card game day 7/3, happy 4th of July 7/4, fun in the sun 7/5, story time 7/6, bingo 7/14, silly hat day 7/8, wacky sock day 7/9, do a good deed day 7/10, take a walk outside 7/11, board games 7/12, snack time outside 7/13, movie day 7/14, exercise outside today 7/15, necklace making 7/16, who wants to play musical chairs 7/17, music day 7/18, exercise inside or outside 7/19, scavenger hunt 7/20, let's throw Frisbee outside 7/21, write in your journal today 7/22, picnic outside 7/23, bingo 7/24, take a walk outside 7/25, cupcake / ice cream party 7/26, wacky sock day 7/27, silly hat day 7/28, opposite day (do everything backwards) 7/29, necklace making 7/30 and lazy day 7/31.
-The activities listed did not have a beginning or ending time.

Continued observations in the facility on 7/19/17, 7/20/17 and 7/21/17 revealed:
-The activity listed on the activity calendar for 7/19/17, exercise inside or out, did not take place.
-The activity listed for 7/20/17, scavenger hunt, did not take place.
-The activity listed for 7/21/17, let's throw Frisbee outside, did not take place.
-On 7/19/17 and 7/21/17 there were no alternative

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activities provided in the place of the scheduled activities.

Observation in the facility on 7/20/17 between 10:00 am and 11:30 pm revealed approximately 15 to 20 youth from a church group singing with the residents.

Interview with a resident on the initial tour on 7/19/17 between 10:30am and 12:15pm revealed:
-There were no activities provided for the residents, "You watch TV, smoke or walk the halls.
-They would like to have something to do.
-They sometimes go to the store to shop.
-"There is a bunch of kids come in on Tuesday and Thursday and talk with the residents and sometimes will play games."
-"Sometimes the staff will throw out kids pictures to color, but I don't color-I am not a child."
-The activity calendar is never followed "we have never done anything on the calendar."

Interview with a second resident on the initial tour on 7/19/17 between 10:30am and 12:15pm revealed:
-There used to be a corn hole game, but they had not seen it in a while.
-They did not like to color pictures like a child.
-They had never been asked what type of activities they like to do.
-They do less now than they used to.
-It was pretty boring in the facility.
-They go out to the store a couple of times per month.

Interview with a third resident on the initial tour on 7/19/17 between 10:30am and 12:15pm revealed:
-There were no activities but did enjoy sitting on the screened porch when there were no smokers

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on the porch.
-During the summer some kids came from church and would do some activities like coloring or playing games.
-They would like to have things to do, so they would not be so bored.

Interviews with fourth and fifth residents during a tour of the facility between 10:20am and 12:15pm on 7/19/17 revealed the facility doesn't do any activities for the residents.

Interview with a sixth resident during a tour of the facility between 10:20am and 12:15pm on 7/19/17 revealed:
-The facility doesn't have any activities for the residents.
-We used to play bingo occasionally, but "it's been a long time since we played bingo."

Interview with a seventh resident on 7/21/17 at 10:15am revealed:
-The facility doesn't have many activities.
-They play bingo sometimes, but "I don't like to play bingo."
-She mostly watches her soap operas.

Interview with an eighth resident on 7/24/17 at 9:00am revealed:
-The facility doesn't do any activities.
-"We (residents) try to find something to do."
-We have church groups come in "about twice a week."
-The church groups have preaching and singing and each program lasts "about an hour and a half."

Interview on 7/20/17 at 11:40am with the Activity Coordinator revealed:
-She had worked at the facility for about 3 to 4

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weeks.
-She had been hired to do activities.
-She had done activity assessments on the residents, but they were at her house.
-She would call her family member to bring them to the facility.
-She did housekeeping 2 days per week and when needed, but would do activities when she gets her housekeeping assignment completed.
-She had not had any activity training.
-She had helped the residents make bead necklaces.
-There was one resident who she would play "go fish" with.
-She knew how to do activities because she had 4 children.
-She had put the activities on the calendar for July 2017.
-She had not done any activity on the July activity calendar.
-She had not been told that she had to do the activities on the calendar.
-She had done "a few" activities for the residents like putting out pictures for them to color, and putting out games for them to play.
-She had taken some of the residents to the store to shop.
-There is a church that comes into the facility on Tuesday and Thursday to do activities.
-She had not been told about the activity requirements.
-She did keep a log of who participated in activities, but could not get it because it was at her house.
-She divides the housekeeping and activity times about 50 / 50.

Confidential interview on 7/20/17 with a staff member revealed:
-The new activity person also does

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housekeeping.
-A couple times a week church groups come and sings with the residents.
-They had never been told they needed to do activities with residents.
-The new activity person did not do much with the residents.
-Some of the activities on the activity calendar were not appropriate for the residents.
-Most of the residents did not want to color pictures.
-The activity calendar was not used for activities.
-The residents went in the van to shop only, but not on fun outings such as bowling or to the park.
-"I am sure it is pretty boring for the residents."

Interview on 7/21/17 at 10:45am with the Administrator revealed:
-Staff A was hired to assist with activities.
-The activity coordinator was instructed to do an activity assessment on all residents.
-The facility did not have a full time Activity Director.
-He felt the calendar provided at least 14 hours of activities each week.
-His expectation was for all staff to help with activities when they were not busy.
-He was not aware the activities scheduled for 7/19/17 and 7/21/17 had not taken place.

Interview on 7/21/17 at 11:00am with the Resident Care Coordinator revealed:
-Most of the residents will not participate in the activities.
-There was no documentation of residents who either refused or participated in activities.
-Most of the residents just want to smoke and sit around.
-The corn hole game is kept in the storage shed and got out when needed.

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D 315	Continued From page 33 -It has been too hot for the residents to do activities outside. -Opposite day on the calendar is where the residents can do things the opposite as they normally do. -It has been too hot to do the "Fun in the Sun" activity. -The activity "wacky sock day" is where the residents can wear mismatched socks, or only wear one sock. -The activity "lazy day" is just do nothing and relax for that day. -The activity "scavenger hunt" is where the residents sit in the dayroom and the staff say "I spy something green", and the residents guess what we are looking at. Observation on 7/21/17 at 11:15am of the activities supply closet revealed board games to include checkers, trouble, sorry, and cards along with some craft supplies. Observation on 7/24/17 between 8:00am and 4:30pm revealed: -The scheduled activity listed on the activity calendar was bingo. -No activities being done in the facility. -The Activity Coordinator was on the smoking porch at 9:45am, 10:30am, and 11:45pm. -The Activity Coordinator's work day ended at 2:00pm. No activity assessment or participation documentation had been provided by time of exit on 7/24/17.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 34 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 all residents were treated with respect related to extra servings of coffee and treatment of a vegetarian resident (#10) after receiving regular diet plate containing pulled pork. The findings are: A. Observation of a notice posted on the kitchen door on 7/21/17 at 8:15am revealed: -Coffee at meals only. -Only one cup of coffee per meal per resident. Interviews with 3 out of 4 residents on 7/21/17 revealed: -Residents could only request one cup of coffee during meals. -"We have to beg for a second cup. It's rare that you get another." -"You are only allowed one cup." -"Order is from the boss (the Administrator)." -"They say we can get one cup for breakfast and one cup for dinner." -"We get one cup of coffee only in the dining room." Interview with a facility cook on 7/21/17 at 8:45am revealed: -"Generally the residents can have a single cup (8 ounces)."	D 338		

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-"I make two pots and fill up the pitcher (1 gallon), and that's it."
-"If residents ask for a second cup and the pitcher is empty, I tell them that's it."
-"I think that comes from the Administrator."
-"That's the policy."

Interview with the Administrator on 7/21/17 at 8:55am revealed:
-"I don't have a set policy (regarding coffee)."
-"They (the residents) can have what they want".

B. Review of Resident #10's FL2 dated 12/30/16 revealed:
-Diagnosis that included anxiety disorder, paranoid schizophrenia, gastro esophageal reflux disease.
-A physician's order for a vegetarian diet.

Observation on 7/21/17 at 12:45pm in the main dining room revealed:
-There were 21 residents eating lunch in the main dining room.
-The Medication Aide (MA) came out of the kitchen with a plate containing pulled pork, baked beans, Brussel sprouts, corn bread and chocolate pudding.
-The MA told Resident #10 that "You didn't say you wanted the alternate this morning so I brought you the pulled pork."
-Resident #10 responded "You know I don't eat meat."
-MA returned plate to the kitchen.
-The Cook came out with the plate and spoke to Resident #10 loudly saying "you did not tell him you wanted the alternate this am".
-Resident #10 again stated "You know I don't eat meat."
-The Cook stated, "Sometimes you eat fish and sometimes you don't, sometimes you eat chicken

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and sometimes you don't, how are we supposed to know what you want if you don't tell us what you want in the am."
-The Cook asked Resident #10 "so you want the plate with just the vegetables"?
-Resident #10 looked down towards the floor and stated "You know I don't eat meat."
-The Cook took the plate back to the kitchen.
-Resident #10 was brought a plate with baked beans, Brussel sprouts, corn bread and chocolate pudding.
-Resident #10 ate her chocolate pudding and 2 bites of her beans, got up from the table and left the dining room.

Interview on 7/21/17 at 12:53pm with the cook revealed:
-Resident was supposed to let dietary know if she wanted the alternate in the am.
-He stated he knew Resident #10 was a vegetarian and she was on the dietary list as vegetarian but sometimes she would eat fish or chicken and sometimes she doesn't.

Interview on 7/21/17 at 1:05pm with Resident #10 revealed:
-She did not understand why the staff did that as they know she does not eat meat.
-The staff had never done that before.
-They usually just give her a plate with everything but the meat on it.
-She did not usually eat breakfast.
-"That's the way it is here."
-The Cook "usually smiles and is nice to me, they never put meat on my plate."
-I just don't understand why he did that, they know I don't eat meat."

Interview with the Administrator on 7/24/17 at 5:30pm revealed he was unaware of the issue

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D 338	Continued From page 37 with the Resident who had a vegetarian diet and was served pulled pork.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record review, the facility failed to clarify readmission orders for Novolog insulin that were incomplete with a prescribing practitioner for 1 of 4 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 7/2/17 revealed: -Diagnoses included insulin dependent diabetes. - A physician order for Novolog sliding scale insulin (regulates blood glucose levels) subcutaneous injections three times daily.	D 344		

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D 344	Continued From page 38 -There was no further documentation or instructions regarding the dosage of Novolog to administer for blood sugar ranges. Review of Resident #1's hospital discharge summary dated 7/3/17 revealed recent acute renal failure. Review of Resident #1's July 2017 electronic Medication Administration Record (eMAR) on 7/19/17 and 7/24/17 revealed: -An entry for Novolog sliding scale insulin, give before meals and at bedtime for CBG (capillary blood glucose level): 150-200 give 2u (units), 201-250 give 4u, 251-300 give 6u, 301-350 give 8u, 351-400 give 10u, 401-450 give 12u, greater than 450 give 12u and recheck in one hour, with scheduled administration times of 6:00am, 11:30am, 4:30pm, and 8:00pm. -There was documentation that Novolog sliding scale insulin had been given 44 times out of 62 opportunities from 7/4/17 at 6:00am - 7/19/17 at 11:30am for blood sugar range of 158-417. -The last documented entry on the July 2017 eMAR was on 7/19/17 at 11:30am with no documentation of Novolog sliding scale insulin given from 7/20/17-7/23/17. Review of Resident #1's previous physician order sheet dated 5/31/17 revealed: -Novolog sliding scale insulin before meals and at bedtime for CBG 150-200 give 2u, 201-250 give 4u, 251-300 give 6u, 301-350 give 8u, 351-400 give 10u, 401-450 give 12u and recheck in one hour. Interview with a pharmacy technician at the provider pharmacy on 7/20/17 at 11:00am revealed:	D 344		

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D 344	Continued From page 39 -The last FL2 for Resident #1 they had received from the facility was dated 2/19/17. -"We just received a faxed FL2 dated 7/3/17 yesterday (7/19/17)." Interview with the Resident Care Coordinator (RCC) on 7/20/17 at 10:50am revealed: -"I just called the doctor to get the sliding scale insulin orders (dated 7/3/17) clarified." -"We fax all new orders and FL2s to the pharmacy." Review of a clarification physician's order for Resident #1 dated 7/20/17 revealed an order for Novolog sliding scale insulin for CBG below 200, give no insulin, 200-250 give 1u, 251-300 give 2u, 301-350 give 3u, 351-400 give 4u, 401-450 give 5u, 451-500 give 6u, greater than 500 inject 8u and recheck blood sugar in one hour, if not below 400 call MD. Review of Resident #1's July 2017 electronic Medication Administration Record (eMAR) on 7/19/17 revealed: -An entry of 2units of Novolog insulin were administered on 7/4/17 at 6:00am for blood sugar of 159, at 11:30am for blood sugar of 179, and 4:30pm for blood sugars of 197, with no insulin required. -An entry of 2units of Novolog insulin was administered on 7/5/17 at 4:30pm for blood sugar of 166, with no insulin required. -An entry of 2units of Novolog insulin was administered on 7/10/17 at 4:30pm for blood sugar of 195, with no insulin required. -An entry of 2units of Novolog insulin was administered on 7/12/17 at 8:00pm for blood sugar of 198, with no insulin required. -An entry of 2units of Novolog insulin was administered on 7/14/17 at 11:30am for blood	D 344		

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ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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sugar of 197 and at 4:30pm for blood sugar of 188, with no insulin required
-An entry of 2units of Novolog insulin was administered on 7/15/17 at 11:30am for blood sugar of 181, with no insulin required.
-An entry of 2units of Novolog insulin was administered on 7/17/17 at 6:00am for blood sugar of 158, with no insulin required.
-An entry of 2units of Novolog insulin was administered on 7/18/17 at 6:00am for blood sugar of 170, with no insulin required.

Interview with the Administrator on 7/20/17 at 10:55am revealed:
-The Administrator and RCC check all new orders and FL2s, and fax them to the pharmacy.
-"We get a monthly report from the pharmacy about what has been faxed. Then we just throw it out."
-Changes in medication orders are noted by flags on the eMAR.
-"We can review and accept (medication orders on the eMAR)."
-"We don't enter orders. The pharmacy does. We only review for accuracy."
-"We don't have an actual policy and procedure."

Interview with the Executive Assistant for Clinical Services at the prescribing physician's office on 7/21/17 at 11:20am and 7/24/17 at 9:15am revealed that the Novolog sliding scale insulin doses given were not detrimental to the resident.

Interview with Resident #1 on 7/24/17 at 10:32am revealed:
-"No they are not checking my blood sugar since Wednesday or Thursday of last week."
-"It's not even written on my chart. They just stopped cold turkey with no explanation. That's kind of dangerous I think."

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D 344	Continued From page 41 -"They checked one time this morning." Interview with the Medication Aide on 7/24/17 at 10:35am revealed: -"I have been checking blood sugars and giving him (Resident #1) sliding scale insulin. He has new orders. Checking blood sugars before meals." -"The sliding scale has dropped off the eMAR." -The RCC had the new Novolog sliding scale insulin order written on a physician order sheet. -"I've been writing it down on a piece of paper. When I find it, I will bring it to you." Interview with the RCC on 7/24/17 at 10:40am revealed: -"The pharmacy (computer) is down." -"We sent the order (clarified Novolog sliding scale insulin order dated 7/20/17) last week." -"The med aides have been checking his (Resident #1) blood sugars and writing it down on a piece of paper." -The facility did not provide documentation of Resident #1's blood sugars for 7/20/17 - 7/23/17. Review of Resident #1's glucometer provided by the facility on 7/24/17 at 11:00am revealed: -A date and time of 7/24/17 at 10:00am. -A reading of 235 on 7/6/17 at 11:12am. -A reading of 318 on 7/6/17 at 4:20am. -A reading of 250 on 7/5/17 at 6:51pm. -There were no other readings for July 2017. -There was another resident's name in faded print on the back of the meter. -The facility did not provide another meter with the resident's name on it. Review of Resident #1's July 2017 eMAR on 7/24/17 at 3:15pm revealed: -A CBG of 235 on 7/6/17 at 11:30am.	D 344		

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D 344	Continued From page 42 -A CBG of 318 on 7/6/17 at 6:00am. -A CBG of 145 on 7/5/17 at 8:00pm. _____ The facility failed to clarify readmission orders for Novolog insulin that were incomplete with a prescribing practitioner for 1 of 4 sampled residents (#1). This failure resulting in Resident #1 receiving Novolog sliding scale insulin 11 times from 7/3/17 through 7/20/17 when no insulin should have been administered and exposed the resident to an increased risk of a hypoglycemic reaction. Therefore this failure was detrimental to the health and well being of Resident #1 and constitutes a Type B Violation. _____ Review of the Plan of Protection provided by the facility on 7/21/17 revealed: -All admission or readmission FL2s for residents will be faxed to the pharmacy and to the onsite care doctor for review and clarification. -These will be monitored by the Administrator when the FL2 is received and on a weekly basis. -All orders will be monitored and approved or discontinued and kept up to date. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2017	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358		

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D 358	Continued From page 43 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered to 4 of 6 sampled residents as evidenced by the failure to administer a pain medication, Percocet, to Resident # 5 when requested due to the facility's electronic medication administration system was not operating; failed to administer readmission medications (furosemide, lisinopril, Novolog, hydroxyzine and lactulose) from a hospitalization to Resident #1 as ordered due to the orders not being sent to the pharmacy until almost 3 weeks later; and failed to administer medications as ordered to 2 other sampled residents (Residents #3 and #9.) (Sertraline, fluticasone nasal spray, cyclobenzaprine.) The findings are: A. Review of Resident #5's current FL-2 dated 6/9/17 revealed: -Diagnoses included altered mental status, hyperplasia of prostate, hypertension and atrial fibrillation. -Medications included Hydromorphone 2mg tablet (a narcotic medication used to treat severe pain), take 1 tablet three times per day. -Hydromorphone 2mg 1 tablet every 6 hours as needed for pain.	D 358		

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D 358	Continued From page 44 Review of a physician's order for Resident #5 dated 7/21/17 at 2:52pm revealed: -Dilaudid (brand name) discontinued. -Norco discontinued. -Start Percocet 10/325mg (a pain medication) every 6 hours as needed. Interview with a Medication aide on 7/24/17 at 9:30am revealed: -"She felt bad that Resident #5 was in so much pain, but could not have anything for pain." -The Hydromorphone pain medication had been discontinued on 7/21/17. -She turned in 3 Hydromorphone tablets to the Resident Care Coordinator on Friday. -She was told by the Resident Care Coordinator that since the new order for the Percocet was not on the eMAR it could not be given. -The Percocet was delivered on 7/22/17. -She did have the Percocet 10/325mg pain medication on the cart. -She "guessed" the Administrator or RCC had discontinued the medications on the eMAR. Observation on 7/24/17 at 9:35am of the medication cart revealed 30 tablets of Percocet 10/325mg available for administration was dispensed on 7/22/17. Review of the July 2017 eMAR for Resident #5 on 7/24/17 at 10:45am revealed: -The Hydromorphone 2mg, 1 tablet three times daily was on the eMAR as being discontinued. -The Hydromorphone 2mg tablet 1 tablet every 6 hours PRN for pain was on the eMAR as being discontinued. -The Norco 10-325mg 1 tabled every 12 hours PRN for pain was on the eMAR as being discontinued. -The Percocet 10/325mg 2 tablets every 6 hours	D 358		

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D 358	Continued From page 45 PRN was not listed on the eMAR. Interview on 7/24/17 at 10:30am with Resident #5 revealed: -He had not received any pain medication over the weekend. -He did tell the medication aide over the weekend that he was hurting, but could not remember which medication aide he had told. -He was told by staff, unsure of which staff member, that he could not have anything for pain. Interview on 7/24/17 at 10:35am with the Hospice Nurse revealed: -The physician had discontinued the Hydromorphone since it did not seem to be working. -The resident should have received the Percocet when it was available at the facility. -She was available over the weekend if the facility had needed clarification about administering the Percocet. Interview with the facility pharmacy on 7/21/17 at 9:00am revealed: -The pharmacy's computer system was down. -They could fill orders from the facility. -They could not put the order on the electronic medication administration record (eMAR). Interview with the Resident Care Coordinator (RCC) on 7/24/17 at 11:15pm revealed: -She received the order on Friday to discontinue the Hydromorphone and to start the Percocet. -She sent the remaining Hydromorphone back to the pharmacy on Friday. -The Percocet arrived in the facility on Saturday. -She did not think the medication could be administered if it was not on the eMAR. -She had discontinued the pain medication on the	D 358		

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eMAR.
-She could not add medications to the eMAR, the pharmacy had to do that.

Interview with the Administrator on 7/24/17 at 11:30am revealed:
-The Medication Aide could have administered the Percocet and signed it out on the controlled substance sheet.
-The Medication Aides should have written the new medications on a blank MAR sheet until the eMARs came back up.
-He did not know why the RCC told the Medication Aides the medication could not be administered.

Review of Resident #1's current FL2 dated 7/2/17 revealed:
-Diagnoses included hepatitis C, coronary artery disease, hypertension, history of traumatic brain injury, mixed dementia, insulin dependent diabetes, and chronic pain.
-Physician orders for furosemide (diuretic used to treat elevated blood pressure) 40mg by mouth daily as needed (prn), hydroxyzine 50mg three times daily prn itching, lactulose (laxative given to reduce ammonia levels) 30ml by mouth every six hours, Novolog sliding scale insulin (regulates blood glucose levels) subcutaneous injections three times daily.
-There was no further documentation or instructions regarding the dosage of Novolog to administer for blood sugar ranges 150-500.
-There was no order for lisinopril (used to treat elevated blood pressure) 10mg daily.

Review of Resident #1's hospital discharge summary dated 7/3/17 revealed the following:
-Change furosemide from 40mg daily to 40mg daily as needed for swelling because of recent

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acute renal failure.
-Change hydroxyzine from 50mg by mouth three times daily to 50mg by mouth three times daily as needed for itching.
- Discontinue the lisinopril because of recent renal failure and control blood pressure without the medication.
-There were lab values dated 6/27/17 of a potassium level (an electrolyte) of 4.4 (3.5-5.1 reference range), creatinine level of 1.6 (0.9-1.5 reference range), and BUN level of 9.1 (7.0-25.0 reference range).

Review of Resident #1's record revealed there were no lab values for July 2017.

Review of the National Institute of Health revealed that creatinine and BUN blood levels are used to assess kidney function.

Review of Resident #1's July 2017 electronic Medication Administration Record (eMAR) on 7/19/17 and 7/24/17 revealed:
-Furosemide 40mg tablet, give one tablet daily with a scheduled administration time of 8:00am.
-There was documentation that the furosemide had been given daily from 7/4/17-7/19/17.
-Hydroxyzine 50mg capsule, give one capsule three times daily with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.
-There was documentation that the hydroxyzine had been given one time on 7/3/17, three times daily on 7/4/17-7/18/17, and given one time on 7/19/17.
-Lisinopril 10mg tablet, give one tablet two times daily with scheduled administration times of 8:00am and 8:00pm.
-There was documentation that the lisinopril had been given one time on 7/3/17, given twice daily 7/4/17-7/18/17, and given one time on 7/19/17.

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D 358	Continued From page 48 -Lactulose 67.5ml by mouth four times daily with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation that the lactulose had been given once daily on 7/3/17 and 7/19/17, given three times daily 7/5/17 and 7/16/17, and given four times daily 7/6/17 - 7/15/17 and 7/17/17 - 7/18/17. -Novolog sliding scale insulin, give before meals and at bedtime for CBG (capillary blood glucose level): 150-200 give 2u (units), 201-250 give 4u, 251-300 give 6u, 301-350 give 8u, 351-400 give 10u, 401-450 give 12u, greater than 450 give 12u and recheck in one hour, with scheduled administration times of 6:00am, 11:30am, 4:30pm, and 8:00pm. -There was documentation that Novolog sliding scale insulin had been given 44 times out of 62 opportunities from 7/4/17 at 6:00am - 7/19/17 at 11:30am for blood sugar ranges 158 - 417. -There was no documentation of Novolog sliding scale insulin given from 7/20/17 - 7/23/17. Review of Resident #1's physician order sheet dated 5/31/17 revealed the following previous physician orders: -Lisinopril 10mg by mouth twice daily. -Hydroxyzine 30mg capsule by mouth three times daily. -Furosemide 40mg tablet by mouth daily. -Lactulose 10gm/15ml give 45gm by mouth four times daily. -Novolog sliding scale insulin before meals and at bedtime for CBG 150-200 give 2u, 201-250 give 4u, 251-300 give 6u, 301-350 give 8u, 351-400 give 10u, 401-450 give 12u and recheck in one hour. Interview with a pharmacy technician at the	D 358		

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provider pharmacy on 7/20/17 at 11:00am revealed:
-The last FL2 for Resident #1 they had received from the facility was dated 2/19/17.
-"We just received a faxed FL2 dated 7/3/17 yesterday (7/19/17)."

Interview with the Resident Care Coordinator (RCC) on 7/20/17 at 10:50am revealed:
-"I just called the doctor to get the sliding scale insulin orders (dated 7/3/17) clarified."
-"We fax all new orders and FL2s to the pharmacy."

Review of a clarification physician order for Resident #1 dated 7/20/17 revealed:
-There was an order for Novolog sliding scale insulin for blood sugar below 200 give no insulin, 200-250 give 1u, 251-300 give 2u, 301-350 give 3u, 351-400 give 4u, 401-450 give 5u, 451-500 give 6u, greater than 500 inject 8u and recheck blood sugar in one hour, if not below 400 call MD.

Review of Resident #1's July 2017 electronic Medication Administration Record (eMAR) on 7/19/17 and 7/24/17 revealed:
-An entry of 2units of Novolog insulin were administered on 7/4/17 at 6:00am for blood sugar of 159, at 11:30am for blood sugar of 179, and 4:30pm for blood sugars of 197, with no insulin required.
-An entry of 2units of Novolog insulin was administered on 7/5/17 at 4:30pm for blood sugar of 166, with no insulin required.
-An entry of 2units of Novolog insulin was administered on 7/10/17 at 4:30pm for blood sugar of 195, with no insulin required.
-An entry of 2units of Novolog insulin was administered on 7/12/17 at 8:00pm for blood sugar of 198, with no insulin required.

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D 358	Continued From page 50 -An entry of 2units of Novolog insulin was administered on 7/14/17 at 11:30am for blood sugar of 197 and at 4:30pm for blood sugar of 188, with no insulin required -An entry of 2units of Novolog insulin was administered on 7/15/17 at 11:30am for blood sugar of 181, with no insulin required. -An entry of 2units of Novolog insulin was administered on 7/17/17 at 6:00am for blood sugar of 158, with no insulin required. -An entry of 2units of Novolog insulin was administered on 7/18/17 at 6:00am for blood sugar of 170, with no insulin required. Interview with the Administrator on 7/20/17 at 10:55am revealed: -The Administrator and RCC check all new orders and FL2s, and fax them to the pharmacy. -"We get a monthly report from the pharmacy about what has been faxed. Then we just throw it out." -Changes in medication orders are noted by flags on the eMAR. -"We can review and accept (medication orders on the eMAR)." -"We don't enter orders. The pharmacy does. We only review for accuracy." -"We don't have an actual policy and procedure." Interview with the Executive Assistant for Clinical Services at the prescribing physician's office on 7/21/17 at 11:20am and 7/24/17 at 9:15am revealed: -The hydroxyzine and lactulose medication given scheduled was not detrimental to the resident. -The Novolog sliding scale insulin doses given were not detrimental to the resident. -The lisinopril and furosemide medication given was not detrimental but "it could have been".	D 358		

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D 358	Continued From page 51 Interview with Resident #1 on 7/24/17 at 10:32am revealed: -"No they are not checking my blood sugar since Wednesday or Thursday of last week." -"It's not even written on my chart. They just stopped cold turkey with no explanation. That's kind of dangerous I think." -"They checked one time this morning." Interview with the Medication Aide on 7/24/17 at 10:35am revealed: -"I have been checking blood sugars and giving him (Resident #1) sliding scale insulin. He has new orders. Checking blood sugars before meals." -"The sliding scale has dropped off the eMAR." -The RCC had the new Novolog sliding scale insulin order written on a physcian's order sheet. -"I've been writing it down on a piece of paper. When I find it, I will bring it to you." -The facility did not provide documentation of Resident #1's blood sugars or insulin administered for 7/20/17 - 7/23/17. Interview with the RCC on 7/24/17 at 10:40am revealed: -"The pharmacy (computer) is down." -"We sent the order (clarified Novolog sliding scale insulin order dated 7/20/17) last week." -"The med aides have been checking his blood sugars and writing it down on a piece of paper." Review of Resident #1's personal glucometer provided for review from the facility on 7/24/17 at 11:00am revealed: -A current date and time of 7/24/17 at 10:00am. -A reading of 235 on 7/6/17 at 11:12am. -A reading of 318 on 7/6/17 at 4:20am. -A reading of 250 on 7/5/17 at 6:51pm. -There were no other readings for July 2017.	D 358		

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D 358	Continued From page 52 -There was another resident's name in faded print on the back of the meter. -The facility did not provide another meter with the resident's name on it. Review of Resident #1's July 2017 eMAR on 7/24/17 at 3:15pm revealed: -A CBG of 235 on 7/6/17 at 11:30am. -A CBG of 318 on 7/6/17 at 6:00am. -A CBG of 145 on 7/5/17 at 8:00pm. C. The medication pass error rate was 6% as evidenced by 2 medication errors out of 32 opportunities during a medication pass observed on 7/20/17 at 8:09am. Review of Resident #9's current FL2 dated 7/29/16 revealed: -Diagnoses included mild MR (mental retardation), hypertension, psychosis, and diabetes. -A medication order for fluticasone nasal spray, 1 spray into each nostril once daily. (Fluticasone nasal spray is an inhaled aerosol medication used to treat seasonal allergies.) -A medication order for sertraline 100mg, 1 and 1/2 tablets daily. (Sertraline is a medication used to treat depression and anxiety.) Continued review of Resident #9's medication orders revealed a subsequent order dated 3/13/17 increased the dose of sertraline to 175mg daily. Review of a Resident #9's prescriber progress note dated 4/10/17 referenced a dosage increase in sertraline to 250mg per day. Observation of a medication pass on 7/20/17 at 8:09am revealed:	D 358		

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D 358	Continued From page 53 -Resident #9 received 13 oral medications and 1 injection. -Resident #9 did not receive any nasal spray. -The medication cassette slot containing Resident #9's sertraline 100mg for Thursday morning contained 2 100mg tablets and 2 1/2 tablets of a 100mg tablet. -A count of the number of medications in the medication cup revealed there was an extra 1/2 tablet of sertraline for a total dose of 300mg. -The medication aide (MA) then pulled the extra 1/2 tablet of sertraline 100mg from the medication cup and gave Resident #9 her medications. Interview with the MA on 7/20/17 at 8:15am revealed: -She normally would not have counted the medications in the cup prior to administering Resident #9's medications. -She would have given the extra 1/2 tablet of sertraline 100mg to Resident #9 had a count of medications in the cup not been requested by the surveyor. -Occasionally the pharmacy packs the medications incorrectly and we usually catch those. Interview with the MA on 7/20/17 at 11:55am revealed: -Resident #9 usually refused her fluticasone nasal spray. -She did not ask the resident this morning if she wanted her nose spray. Interview with Resident #9 at 12:00pm on 7/20/17 revealed she would have taken her fluticasone nasal spray this morning if it had been offered. Observation of Resident #9's medications available for administration revealed:	D 358		

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D 358	Continued From page 54 -A box containing a bottle of fluticasone nasal spray 120 sprays, labeled 1 spray in each nostril, with a dispense date of 3/10/17. -The bottle of fluticasone nasal spray was 90% full. -The fluticasone nasal spray, if administered as ordered, would have lasted 2 months, or 60 doses. Review of Resident #9's electronic Medication Administration Records (eMARs) for June and July 2017 revealed: -An entry for fluticasone nasal spray, 1 spray into each nostril once daily, with a scheduled administration time of 8am. -The fluticasone nasal spray had been initialed as administered daily from 6/1/17 through 7/20/17 except for one refusal on 6/9/17 for a total of 49 doses. Interview with the pharmacy provider on 7/21/17 at 8:45am revealed: -The pharmacy computer system was down and they could not provide information on Resident #9's medications. -They would return the call later today. The pharmacy never returned the call. Interview with the pharmacy provider on 7/24/17 at 10:00am revealed the pharmacy computer system was still down. D. Review of Resident #3's current FL2 dated 1/07/17 revealed diagnoses included convulsions, and chronic pain. Review of Resident #3's Resident Register revealed an admission date to the facility of 10/8/2016.	D 358		

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D 358	Continued From page 55 Review of Resident #3's medication orders revealed an order dated 3/14/17 for cyclobenzaprine 10mg, 1 three times a day as needed for muscle spasms. (Cyclobenzaprine is a medication used to treat muscle spasms.) Review of Resident #3's electronic Medication Administration Record (eMAR) for May, June, and July 2017 revealed: -An entry on the eMAR for all three months for cyclobenzaprine 10mg, 1 tablet by mouth three times a day as needed for muscle spasms. - In May 2017, Resident #3's cyclobenzaprine was documented as administered 75 times. -In June 2017, Resident #3's cyclobenzaprine was documented as administered 72 times. -In July 2017, from 7/1/17 through 7/19/17, Resident #3's cyclobenzaprine was documented as administered 18 times. Review of the pharmacy statement summaries revealed: -For the month of May 2017, 120 tablets of cyclobenzaprine 10mg were dispensed and sent to the facility for Resident #3, with 30 tablets sent on 5/4/17, 5/12/17, 5/19/17, and 5/27/17. -For the month of June 2017, 90 tablets of cyclobenzaprine 10mg were dispensed and sent to the facility for Resident #3, with 30 tablets sent on 6/5/17, 6/15/17, and 6/19/17. -For the month of July 2017, 60 tablets of cyclobenzaprine 10mg were dispensed and sent to the facility for Resident #3, with 30 tablets sent on 7/3/19 and 7/19/17. Interview with the pharmacy provider on 7/19/17 at 10:15am confirmed the dispensing records for Resident #3's cyclobenzaprine.	D 358		

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D 358	Continued From page 56 Observation of Resident #3's medications on hand at 2pm on 7/19/17 revealed: -A cassette labeled cyclobenzaprine 10mg, 1 tablet by mouth three times a day as needed for muscle spasms, with a dispense date of 7/19/17. -Twenty-eight tablets remained in the cassette from an original dispense quantity of 30. Interview with Resident #3 on 7/19/17 at 2:11pm revealed: -He had been without his cyclobenzaprine since the 9th or the 10th of July 2017. -His medication "goes missing all the time, he did not know why his medication kept going missing." Interview with Resident Care Coordinator (RCC) on 7/21/17 at 3:00pm revealed: -Medication Aides (MA) should report to the RCC when medication is getting low. -She did not know that Resident #3 was out of his cyclobenzaprine because he did not ask for it. -The RCC reported that there was a "documentation error" and that was why the cyclobenzaprine appeared to be missing. Interview with the MA on 7/24/17 at 10:35am revealed: -The MA reported Resident #3 "goes through his cyclobenzaprine quickly, but is not sure if it is him or if someone is taking them." -The MA reported that "it seemed that Resident #3 was running out of cyclobenzaprine every 5 days." -The MA reported Resident #3 usually takes the cyclobenzaprine 3 times a day. -The MA reported "when the medication is low they are to tell the RCC and she is to order the medication." -The MA reported that within the last three months Resident #3 had been without his	D 358		

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D 358	Continued From page 57 cyclobenzaprine at least 4 times. -The MA reported when Resident #3's cyclobenzaprine "gets down to the last 5 or 6 tablets she told the RCC" it needed to be reordered. -The MA reported that she did not know how often Resident #3 was supposed to get his cyclobenzaprine on the original order. Review of the eMARs, medications on hand, and pharmacy dispensing records for Resident #3's cyclobenzaprine revealed: -During the months of May, June, and July 2017, Resident #3 was administered 165 tablets and 242 tablets were used from his supply. -If Resident #3 took the maximum number of tablets allowed per day per the physician's order, he would been administered 233 tablets and would never run out. _____ The facility failed to ensure medications were administered to 4 of 6 sampled residents. Resident # 5, a hospice resident, had Percocet, a pain medication, ordered as needed on 07/21/17 when the resident's other pain medications were discontinued. The resident did not receive the Percocet when requested from 07/22/17 to 07/24/17 due to the facility's electronic medication administration system (eMAR) was not working and the order could not be entered into the eMAR. Resident # 5 went without pain medication, although the Percocet was in the facility, due to the facility not implementing another method for documenting the administration of new medication orders. Readmission orders dated 07/02/2017 from a hospitalization for Resident # 1, with a diagnoses of insulin dependent diabetes and documentation of recent acute renal failure, were not	D 358		

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D 358	Continued From page 58 implemented until identified during the survey on 07/19/17. Medications administered incorrectly included lisinopril , furosemide, Novolog, lactulose and hydroxyzine. The medication errors placed Resident # 1 at risk of renal failure again and electrolyte imbalance that could affect the resident's heart and other organs and experiencing hypoglycemia. In addition, the facility failed to administer medications as ordered to 1 of 3 residents (#9) observed during the medication pass and 1 of 6 other sampled residents (#3). Resident #3 failed to receive cyclobenzaprine as ordered exposing him to an increased risk unrelieved pain secondary to muscle spasms. Resident #9 failed to receive sertraline and fluticasone nasal spray as ordered exposing her to risk of overdose of sertraline and unrelieved allergy symptoms. The facility's failure to have a safe and effective system for the administration of medications, as well as, Resident # 5 experiencing pain and not receiving a pain medication that was available for administration and Resident # 1 not receiving medications as ordered after a recent hospitalization placed the residents at substantial risk of serious physical harm and serious neglect. This constitutes a Type A2 Violation. _____ Review of the Plan of Protection provided by the facility on 7/20/17 revealed: -The Administrator will have a staff meeting with all MA to ensure they are following proper procedure in looking at the MARs, making sure all medications are given correctly, and all documentation is written correctly. -The Administrator will ensure all narcotic sheets are documented correctly and turned in to the director when completed. -The Personal Care Aide or Nursing Assistant will	D 358		

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D 358	Continued From page 59 witness any narcotics given until the medication pass is completed. -The Licensed Health Professional Support nurse will conduct an inservice on 7/26/17 with all MA to ensure they are correctly doing their jobs and all documentation is correct. -All MA will turn in the narcotic sheets to the director when completed. -The Administrator and director will ensure all medications that are discontinued will be pulled from the med cart by the MA, and and everything on the MAR will be available to the resident at correct times. -The Administrator/director will ensure MA understand the importance of all medications. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 23, 2017.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the	D 367		

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D 367	Continued From page 60	D 367		

omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

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

The Type B Violation was abated.
Non-compliance continues.

Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 2 of 6 (#1 and #5) sampled residents related to the medications Percocet and Flonase for Resident #5 and Novolog insulin for Resident #1 not being administered because they were not on the MARs due to the pharmacy computer system being down for 5 or more days.

The findings are:

A. Review of Resident #5's current FL-2 dated 6/9/17 revealed:
-Diagnoses included altered mental status, hyperplasia of prostate, hypertension and atrial fibrillation.
-Medications included Hydromorphone 2mg, 1 tablet three times daily and Hydromorphone 2mg tablet 1 tablet every 6 hours PRN.
-Medications included Flonase 0.05% nasal spray, use 2 sprays into each nostril once daily.

1. Review of a physician's order for Resident #5 dated 7/21/17 at 2:52pm revealed:
-Dilaudid (brand name) discontinued.
-Norco discontinued.

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D 367	Continued From page 61 -Start Percocet 10/325mg (a pain medication) every 6 hours as needed. Review of the July 2017 eMAR for Resident #5 on 7/24/17 at 10:45am revealed: -The Hydromorphone 2mg, 1 tablet three times daily was on the eMAR as being discontinued. -The Hydromorphone 2mg tablet 1 tablet every 6 hours PRN for pain was on the eMAR as being discontinued. -The Norco 10-325mg 1 tabled every 12 hours PRN for pain was on the eMAR as being discontinued. -The Percocet 10/325mg 2 tablets every 6 hours PRN was not listed on the eMAR. Interview with a Medication aide on 7/24/17 at 9:30am revealed: -"She felt bad that Resident #5 was in so much pain, but could not have anything for pain." -The Hydromorphone pain medication had been discontinued on 7/21/17. -She turned in 3 Hydromorphone tablets to the Resident Care Coordinator on Friday. -She was told by the Resident Care Coordinator that since the new order for the Percocet was not on the eMAR it could not be given. -The Percocet was delivered on 7/22/17. -She did have the Percocet 10/325mg pain medication on the cart. -She "guessed" the Administrator or RCC had discontinued the medications on the eMAR. Observation on 7/24/17 at 9:35am of the medication cart revealed 30 tablets of Percocet 10/325mg available for administration was dispensed on 7/22/17. Interview on 7/24/17 at 10:30am with Resident #5 revealed:	D 367		

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D 367	Continued From page 62 -He had not received any pain medication over the weekend. -He did tell the medication aide over the weekend that he was hurting, but could not remember which medication aide he had told. -He was told by staff, unsure of which staff member, that he could not have anything for pain. Interview on 7/24/17 at 10:35am with the Hospice Nurse revealed: -The physician had discontinued the Hydromorphone since it did not seem to be working. -The resident should have received the Percocet when it was available at the facility. -She was available over the weekend if the facility had needed clarification about administering the Percocet. Interview with the Resident Care Coordinator (RCC) on 7/24/17 at 11:15pm revealed: -She received the order on Friday to discontinue the Hydromorphone and to start the Percocet. -She sent the remaining Hydromorphone back to the pharmacy on Friday. -The Percocet arrived in the facility on Saturday. -She did not think the medication could be administered if it was not on the eMAR. -She had discontinued the pain medication on the eMAR. -She could not add medications to the eMar, the pharmacy had to do that. Interview with the Administrator on 7/24/17 at 11:30am revealed: -The Medication Aide could have administered the Percocet and signed it out on the controlled substance sheet. -The Medication Aides should have written the new medications on a blank MAR sheet until the	D 367		

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D 367	Continued From page 63 eMARs came back up. -He did not know why the RCC told the Medication Aides the medication could not be administered. Refer to interview on 7/21/17 at 9:00am with the facility pharmacy. Refer to interview on 7/24/17 at 11:30am with the Administrator. 2. Review of the June 2017 eMAR for Resident #5 on 7/20/17 at 9:25am revealed: -A medication entry for Flonase 0.05% nasal spray. -Use 2 sprays into each nostril once daily at 8:00am. -The medication had been documented as administered the entire month of June 2017. Review of the July 2017 eMAR for Resident #5 on 7/20/17 at 9:25am revealed: -A medication entry for Flonase 0.05% nasal spray. -Use 2 sprays into each nostril once daily at 8:00am. -The medication had been documented as administered from July 16, 2017 at 8:00am through July 20, 2017 at 8:00am. -The Flonase nasal spray was still on the eMAR as an active order to be administered. Review of a Physician's Medication order dated 7/13/17 at 1:57pm revealed "Discontinue Flonase." Interview with a Medication aide on 7/20/17 at 9:30pm revealed: -She could not recall Resident #5's Flonase ever being on the medication cart.	D 367		

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D 367	Continued From page 64 -She had never given him any Flonase. -She had signed off as administered the Flonase on the eMAR. -She had been told to never leave an entry time blank, but could not remember who had told her this. Observation on 7/20/17 at 9:40am of the medication cart revealed no Flonase available for administration. Interview on 7/20/17 at 9:45am with Resident #5 revealed he had not been given a nasal spray that he could remember. Interview with the Resident Care Coordinator (RCC) on 7/24/17 at 11:15pm revealed: -She did not know why there was no Flonase on the medication cart for Resident #5. -She thought the last time she passed medications there was Flonase. -There was an order written on 7/13/17 for the Flonase to be discontinued. -Since the Flonase had been discontinued it was probably pulled off the medication cart. -She had faxed the order to the pharmacy. Attempted telephone interview with a second Medication Aide on 7/24/17 at 3:15pm was unsuccessful. Interview with the Administrator on 7/24/17 at 11:30am revealed: -The Medication Aides could have used a blank paper MAR to administer the new medications. -He did not know why the staff would have been signing for medications that were not administered. -The RCC was responsible to assure all medications were available on the medication	D 367		

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D 367	Continued From page 65 cart for administration. Refer to interview on 7/21/17 at 9:00am with the facility pharmacy. Refer to interview on 7/24/17 at 11:30am with the Administrator. B. Review of Resident #1's current FL2 dated 7/2/17 revealed: -A diagnosis of insulin dependent diabetes. -A physician order for Novolog sliding scale insulin (regulates blood glucose levels) subcutaneous injections three times daily. -There was no order for Novolog sliding scale insulin doses. Review of Resident #1's July 2017 electronic Medication Administration Record (eMAR) on 7/19/17 and 7/24/17 revealed: -Novolog 100units/ml sliding scale insulin, give before meals and at bedtime for CBG (capillary blood glucose level): 150-200 give 2u (units), 201-250 give 4u, 251-300 give 6u, 301-350 give 8u, 351-400 give 10u, 401-450 give 12u, greater than 450 give 12u and recheck in one hour, with scheduled administration times of 6:00am, 11:30am, 4:30pm, and 8:00pm. -There was documentation that Novolog sliding scale insulin had been given 44 times out of 62 opportunities from 7/4/17 at 6:00am - 7/19/17 at 11:30am for blood sugar ranges 158 - 417. -There was no documentation of Novolog sliding scale insulin given from 7/20/17 - 7/23/17. Review of a clarification physician order for Resident #1 dated 7/20/17 revealed: -There was an order for Novolog sliding scale insulin for CBG below 200 give no insulin,	D 367		

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D 367	Continued From page 66 200-250 give 1u, 251-300 give 2u, 301-350 give 3u, 351-400 give 4u, 401-450 give 5u, 451-500 give 6u, greater than 500 inject 8u and recheck blood sugar in one hour, if not below 400 call MD. Interview with a pharmacy technician at the provider pharmacy on 7/20/17 at 11:00am revealed: -The last FL2 for Resident #1 they had received from the facility was dated 2/19/17. -"We just received a faxed FL2 dated 7/3/17 yesterday (7/19/17)." Interview with the Resident Care Coordinator (RCC) on 7/20/17 at 10:50am revealed: -"I just called the doctor to get the sliding scale insulin orders (dated 7/3/17) clarified." -"We fax all new orders and FL2s to the pharmacy." Interview with the Administrator on 7/20/17 at 10:55am revealed: -The Administrator and RCC check all new orders and FL2s, and fax them to the pharmacy. -"We get a monthly report from the pharmacy about what has been faxed. Then we just throw it out." -Changes in medication orders are noted by flags on the eMAR. -"We can review and accept (medication orders on the eMAR)." -"We don't enter orders. The pharmacy does. We only review for accuracy." -"We don't have an actual policy and procedure." Interview with the Executive Assistant for Clinical Services at the prescribing physcian's office on 7/21/17 at 11:20am and 7/24/17 at 9:15am revealed that the Novolog sliding scale insulin doses given were not detrimental to the resident.	D 367		

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D 367	Continued From page 67 Interview with Resident #1 on 7/24/17 at 10:32am revealed: -"No they are not checking my blood sugar since Wednesday or Thursday of last week." -"It's not even written on my chart. They just stopped cold turkey with no explanation. That's kind of dangerous I think." -"They checked one time this morning." Interview with the Medication Aide on 7/24/17 at 10:35am revealed: -"I have been checking blood sugars and giving him (resident #1) sliding scale insulin. He has new orders. Checking blood sugars before meals." -"The sliding scale has dropped off the eMAR." -The RCC had the new Novolog sliding scale insulin order. -"I've been writing it down on a piece of paper. When I find it, I will bring it to you." Interview with the RCC on 7/24/17 at 10:40am revealed: -"The pharmacy (computer) is down." -"We sent the order (clarified Novolog sliding scale insulin order dated 7/20/17) last week." -"The med aides have been checking his blood sugars and writing it down on a piece of paper." -The facility did not provide documentation of Resident #1's blood sugar results for 7/20/17 - 7/23/17. Interview with the Administrator on 7/24/17 at 10:45am revealed the medication aides had been writing down the blood sugar results for 7/22/17 and 7/23/17 on a piece of paper. Review of a paper provided by the Administrator on 7/24/17 at 10:50am revealed:	D 367		

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D 367	Continued From page 68 -The paper was approximately 4 inches x 4 inches and wrinkled. -There was no date or times on the paper. -Resident #1 was not listed on the paper. Review of Resident #1's glucometer provided by the facility on 7/24/17 at 11:00am revealed: -A date and time of 7/24/17 at 10:00am. -A reading of 235 on 7/6/17 at 11:12am. -A reading of 318 on 7/6/17 at 4:20am. -A reading of 250 on 7/5/17 at 6:51pm. -There were no other readings for July 2017. -There was another resident's name in faded print on the back of the meter. -The facility could not provide a meter with the resident's name on it. Review of Resident #1's July 2017 eMAR on 7/24/17 at 3:15pm revealed: -A CBG of 235 on 7/6/17 at 11:30am. -A CBG of 318 on 7/6/17 at 6:00am. -A CBG of 145 on 7/5/17 at 8:00pm. Refer to interview on 7/21/17 at 9:00am with the facility pharmacy. Refer to interview on 7/24/17 at 11:30am with the Administrator. _____ Interview with the facility pharmacy on 7/21/17 at 9:00am revealed: -The pharmacy's computer system was down. -They could fill orders from the facility. -They could not put the order on the electronic medication administration record (eMAR). Interview with the Administrator on 7/24/17 at 11:30am revealed: -The Medication Aides could have used a blank	D 367		

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D 367	Continued From page 69 paper MAR to administer the new medications. -He did not know why the staff would have been signing for medications that were not administered. -The RCC was responsible to assure all medications were available on the medication cart for administration.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records were available to account for the disposition of controlled substances (Hydromorphone and Alprazolam) and to ensure an accurate reconciliation of those controlled substances for 1 of 4 sampled residents (Resident #5) who were administered controlled medications. The findings are: Review of Resident #5's current FL-2 dated 6/9/17 revealed:	D 392		

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D 392	Continued From page 70 -Diagnoses included altered mental status, hyperplasia of prostate, hypertension and atrial fibrillation. -Medications included Hydromorphone 2mg tablet (a narcotic medication used to treat severe pain), take 1 tablet three times per day . -Hydromorphone 2mg 1 tablet every 6 hours as needed (PRN) for pain. -Alprazolam 2 mg (a medication used to treat anxiety) 1 tablet every 8 hours. Interview on 7/20/17 at 2:30pm with Resident #5 revealed: -"I have a lot of pain." -He was unaware of what medications he was taking. -He was in pain even after taking his pain medication. -There were times that he was pain free, but not often. -He could not tell if he was getting the medications the way he was supposed to. 1. Telephone interview with the facility pharmacy on 7/20/17 at 2:15pm revealed: -The facility received 105 Hydromorphone 2mg for Resident #5 on 6/9/17. -The facility received 105 Hydromorphone 2mg for Resident #5 on 6/21/17. -The facility received 105 Hydromorphone 2mg for Resident #5 on 7/5/17. Review of the June 2017 electronic generated Medication Administration Record (eMAR) for Resident #5 revealed: -Hydromorphone 2mg tablet one tablet three times daily. -The scheduled administration times were documented as 8:00am, 2:00pm and 8:00pm. -Between 6/9/17 and 6/30/17 documentation	D 392		

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D 392	Continued From page 71	D 392		

showed 66 times administered out of 66 opportunities for the scheduled Hydromorphone.
-Hydromorphone 2mg tablet 1 tablet every 6 hours PRN for pain.
-The Hydromorphone 2mg PRN between 6/9/17 and 6/30/17 documented 52 times as administered.
-The total number of Hydromorphone 2mg tablets documented as administered were 118 tablets.

Review of the July 2017 eMAR for Resident #5 revealed:
-Hydromorphone 2mg, 1 tablet three times daily.
-The scheduled administration times were documented as 8:00am, 2:00pm and 8:00pm.
-Documentation between 7/1/17 and 7/19/17 at 8:00am documented 54 times administered out of 55 opportunities for the scheduled Hydromorphone.
-Hydromorphone 2mg tablet 1 tablet every 6 hours PRN for pain.
-The Hydromorphone 2mg PRN was documented 40 times as administered.
-The total number of Hydromorphone 2mg tablets documented as administered were 94 tablets.

Review of a controlled substance count sheet with a dispense date of 5/23/17 revealed:
-An amount dispensed was 105 tablets.
-Administration documentation of 5/26/17 at 2:00pm through 6/9/17 at 12:00pm.
-A hand written quantity start amount of 45.
-The number documented as administered was 45.
-The amount of tablets unaccounted for was 60 tablets.

Review of a second controlled substance count sheet with a dispense date of 6/21/17 revealed:
-Hydromorphone 2mg tablets 1 tablet at 8am,

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D 392	Continued From page 72 2pm and 8pm. -The amount dispensed to the facility was 105 tablets. -A hand written quantity start amount of 60. -Administration documentation from 6/24/17 at 2:00pm through 6/14/17 at 2:00pm. -The number documented as administered was 60 -The facility received 105 Hydromorphone 2mg for Resident #5 on 6/21/17. -The amount of tablets unaccounted for was 45 tablets. Review of a third controlled substance count sheet with a dispense date of 7/5/17 revealed: -Hydromorphone 2mg tablets 1 tablet at 8am, 2pm and 8pm. -The amount dispensed to the facility was 105 tablets. -The amount dispensed was struck through and rewritten with the number 45. -A hand written quantity start amount of 15. -Administration documentation from 7/14/17 at 8:00pm through 7/19/17 at 2:00pm. -The number documented as administered was 15. -The facility received 105 Hydromorphone 2mg for Resident #5 on 7/5/17. -The amount of tablets unaccounted for was 90 tablets. Interview with a Medication Aide (MA) on 7/21/17 at 3:00pm revealed: -Resident #5's pain would "come and go". -She did not recall an "as needed" PRN Hydromorphone 2mg ever being on the cart. -There were times where her name was signed on the control sheets as administering medications that she did not give.	D 392		

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D 392	Continued From page 73 Observation of the Hydromorphone 2mg for Resident #5 on the medication cart on 7/19/17 revealed no Hydromorphone available for administration. 2. Telephone interview with the facility pharmacy on 7/20/17 at 2:15pm revealed: -The facility received 58 Alprazolam 2mg tablets for Resident #5 on 6/9/17. -The facility received 60 Alprazolam 2mg tablets for Resident #5 on 6/21/17. -The facility received 60 Alprazolam 2mg tablets for Resident #5 on 7/3/17. -The facility received 42 Alprazolam 2mg tablets for Resident #5 on 7/17/17. Review of the June 2017 electronic generated Medication Administration Record (eMAR) for Resident #5 revealed: -Alprazolam 2mg tablet 1 tablet four times daily. -The scheduled administration times were documented as 8:00am, 12:00pm, 5:00pm and 8:00pm. -Between 6/9/17 and 6/30/17 documentation showed 83 times administered out of 84 opportunities for the scheduled Alprazolam. Review of the July 2017 eMAR for Resident #5 revealed: -Alprazolam 2mg tablet 1 tablet four times daily. -The scheduled administration times were documented as 8:00am, 12:00pm, 5:00pm and 8:00pm. -Between 7/1/17 and 7/19/17 at 8:00am documentation showed 72 times administered out of 73 opportunities for the scheduled Alprazolam. Review of controlled substance count sheets between 6/9/17 through 7/19/17 for Alprazolam 2mg revealed:	D 392		

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D 392	Continued From page 74 -A total of 69 doses documented as administered. -There were 133 doses which were unaccounted for. Review of a controlled substance count sheet for Alprazolam 2mg with a dispense date of 6/9/17 revealed: -The amount dispensed was 60 tablets. -The amount dispensed was struck through and rewritten with the number 58. -A hand written quantity start amount of 58. -Administration documentation from 6/10/17 at 8:00am through 6/23/17 at 8:00pm. -The number documented as administered was 57. -The facility had received 58 Alprazolam 2mg tablets for Resident #5 on 6/9/17. -The amount of tablets unaccounted for was 1 tablet. The facility could not provide any control sheets for the 6/21/17 #60 Alprazolam tablets dispensed or the 7/3/17 #60 Alprazolam tablets dispensed. Review of a controlled substance count sheet for Alprazolam 2mg with a dispense date of 7/17/17 revealed: -The amount dispensed was 42 tablets. -The amount dispensed was struck through and rewritten with the number 30. -A hand written quantity start amount of 30. -Administration documentation from 7/17/17 at 5:00am through 7/20/17 at 12:00pm. -The number documented as administered was 12. Observation of the Alprazolam 2mg for Resident #5 on the medication cart on 7/19/17 revealed 18 doses available for administration.	D 392		

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D 392	Continued From page 75 Interview with the Administrator on 7/20/17 at 10:10am revealed: -When the pharmacy sends the controlled medications he assures there is at least a week's supply of medication on the medication cart and the remainder is locked in the safe. -He is the only one that had access to the safe where the controlled medications were kept. -There were currently no medications in the safe for Resident #5. -When a controlled medication is completed the medication aides were supposed to turn in the control sign off sheet to the Resident Care Coordinator (RCC). -He did not know why there were missing control sign off sheets were. -It was the responsibility of the RCC to assure accountability of the control sheets. Interview with the Resident Care Coordinator on 7/24/17 at 11:15am revealed: -She had been looking for the missing control sheets, but she could not find them. -The medication aides were supposed to give her the control sheets when they were completed. -She did not always get the control sign off sheets. -She did not have a method to assure the control sheets were accounted for. -She did not know where the control sheets were. -She did not have access to the safe where the extra controlled medications are stored. -If a resident's controlled medications are low on the medication cart she lets the Administrator know and he comes to the facility and gets them out of the safe. _____ The facility's failure to accurately account for 195	D 392		

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D 392	Continued From page 76 Hydromorphone tablets resulted in pain relieving medication and 133 Alprazolam tablets which resulted in anxiety medication being unavailable for Resident #5. The facility's failure to maintain accurate controlled substance records was detrimental to the well being of Resident #5, which constitutes an unabated Type B Violation. _____ Review of the Plan of Protection provided by the facility on 7/20/17 revealed: -The MA will have the Personal Care Aide/Nursing Assistant (PCA/NA) witness narcotic administration to make sure all narcotics are given properly and documented at the time the narcotic is given. -The Administrator and Director will count down the med cart at any given time unannounced starting today. -The Administrator will address narcotics in a staff meeting immediately. -All narcotic count sheets will be documented correctly with PCA/NA witness. -The LHPS nurse will go over the importance of narcotics and how they are properly handled. -All documentation will be turned in to the director and kept filed from month to month. -The med cart will be counted down by the Administrator and Director together unannounced to ensure all medications are accounted for.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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

Based on observations and interviews, the facility failed to protect and ensure residents received care and services needed as evidenced by the failure to conduct an internal investigation and report allegations to the Health Care Personnel Registry for 1 of 1 staff (C) related to the impairment of Staff C, a supervisor, and questionable if the supervisor was able to perform duties on multiple days.

The findings are:

Observations by a representative from the county Department of Social Services (DSS) on 7/5/17 at 1:00pm revealed:
-Upon entering the facility, Staff C appeared disoriented and unable to follow simple conversation.
-Staff C's speech was slurred and slow.
-Staff C's gait was unsteady.

Observations by a representative from the county DSS on 7/7/17 at 1:05pm revealed:
-Staff C appeared to be under the influence with slurred speech and an impaired ability to communicate.
-Staff C had an unsteady gait and spilled water while walking down the facility hallway to administer medications to a resident.

Interview with the county representative on 7/19/17 at 9:30am revealed:

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D 438	Continued From page 78 -On 7/12/17, the county representative contacted the facility Administrator to express concerns about Staff C's condition during her previous 2 visits. -On 7/12/17, the county DSS representative reported the Administrator also expressed concerns about Staff C himself and" he would be looking into it." -On 7/14/17, the county DSS representative reported the Administrator believed Staff C had allergies, and this contributed to her appearing impaired. Confidential interview with a resident revealed: -"(Named Staff C) is "high most of the time". -Staff C will hold her head down, her eyes are closed and her speech is slurred. Interview with a second resident during a tour of the facility on 7/19/17 between 10:20am and 12:15pm revealed: -She believed Staff C had been taking "some kind of narcotics." -Staff C would come out to the smoking porch and "nod off" with a cigarette in her hand. -She had not told any other staff about the Staff C's behavior. Interview with a third resident during a tour of the facility on 7/19/17 from 10:20am to 12:15pm revealed: -"She (Staff C) was so high. She has looked high." -"Several times she has fallen in the halls." -"I know (name of the Administrator) is involved in it. He covers up for her." Telephone interviews with the Executive Assistant for Clinical Services at the physician's office on 7/21/17 1:34pm and 7/24/17 at 2:15pm revealed:	D 438		

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D 438	Continued From page 79 -A nurse practitioner and medical assistant were in the facility on 7/13/17 assessing a resident. -A facility staff member (Staff C) was assisting. -The facility staff member appeared to be "under the influence". -"She was stumbling and even fell at one point." -"Ethically that needs to be reported." -It was not reported to administration. -"We felt it was not necessary to bring it to his (the Administrator) attention since he witnessed it." Interview with the facility Administrator on 7/21/17 at 4:50pm revealed: -He had not reported Staff C to the HCPR because he had not observed any behaviors that would lead him to believe she was impaired while on duty. -Nothing in the Staff C's behavior "caused alarm." -The Administrator recalled staff from the county Department of Social Services had expressed concern about the Staff C's impaired behavior they observed while in the facility. -The Administrator believed the impaired behavior noted by the county representative was related to the RCC having a cold or allergies and taking medication for the symptoms. -No health provider had mentioned any concern about the behavior Staff C to him. The facility failed to conduct an internal investigation and report allegations to the Health Care Personnel Registry for 1 of 1 staff (C) related to the impairment of Staff C, a supervisor, and questionable if the supervisor was able to perform duties on multiple days. This failure exposed residents to the risk of being unprotected and failure to receive the care and services.. Therefore, failure to report the Staff C to the HCPR was detrimental to the health and	D 438		

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D 438	Continued From page 80 safety of all residents in the facility and constitutes a Type B Violation. Review of the Plan of Protection provided by the facility on 7/21/17 revealed: -The Administrator will complete a 24 hour report on stated staff member. -The Administrator will do a full investigation, talk with staff and residents and any providers. -The Administrator will follow-up with a 5 day report with all findings. -The Administrator will do random drug test on staff to ensure she has a clean drug screen, checking for narcotics, alcohol, or anything that would make this person anything but clean and sober at all times. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2017.	D 438		
D 449	10A NCAC 13F .1211 (b) Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 449		

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D 449	Continued From page 81	D 449		

facility failed to assure 3 of 5 sampled staff completed training in infection control within 30 days of hire. (Staff A, D and E).

The findings are:

1. Review of Staff A's personnel file revealed:
-Staff A was hired on 6/31/17 as a Activity Coordinator / Housekeeper.
-There was no documentation of any infection control training for Staff A.

Interview with Staff A on 7/24/17 at 10:45am revealed she had not had any infection control training since she started working at the facility.

Observation on 7/19/17 and 7/21/17 between 10:00am and 1:30pm revealed Staff A was sweeping and mopping the floors throughout the facility.

Refer to interview with Resdent Care Coordinator on 7/24/17 at 3:10pm.

Refer to interview with Administrator on 7/24/17 at 3:20pm.

2. Review of Staff D's personnel file revealed:
-Staff D was hired on 1/5/17 as a Personal Care Aide.
-She started administering medications on 3/1/17.
-There was no documentation of any infection control training for Staff D.

Interview with Staff D on 7/24/17 at 3:00pm revealed she had not had any infection control training since working at the facility.

Refer to interview with Resdent Care Coordinator on 7/24/17 at 3:10pm.

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D 449	Continued From page 82 Refer to interview with Administrator on 7/24/17 at 3:20pm. 3. Review of Staff E's personnel file revealed: -Staff E was hired on 12/15/16 as a Personal Care Aide. -She started administering medications on 3/1/17. -There was no documentation of infection control training for Staff E. Attempted telephone interview with Staff E on 7/24/17 at 3:15pm was unsuccessful. Refer to interview with Resdent Care Coordinator on 7/24/17 at 3:10pm. Refer to interview with Administrator on 7/24/17 at 3:20pm. _____ Interview with the Resident Care Coordinator on 7/24/17 at 3:10pm revealed: -There was no infection control training completed upon hire. -The state infection control training was done once per year. Interview with the Administrator on 7/24/17 at 3:20pm revealed: -The RCC is responsible for assuring that all new staff have all required training. -There was no other infection control training done. -The infection control is completed annually for all staff.	D 449		

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D911	Continued From page 83	D911		
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 ensure all residents were treated with respect related to extra servings of coffee and treatment of a vegetarian resident after receiving a regular diet plate containing pulled pork. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure all residents were treated with respect related to extra servings of coffee and treatment of a vegetarian resident (#10) after receiving regular diet plate containing pulled pork. [Refer to Tag 0338 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:	D912		

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D912	Continued From page 84 Based on observations, record reviews, and interviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the areas of food and nutrition, health care, medication orders, and infection control. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure all therapeutic diets for 4 of 4 sampled residents (Resident #1, #2, #7 and #9) were served as ordered related to puree and no concentrated sweets diet orders. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation.)] B. Based on interviews and record review, the facility failed to clarify readmission orders with significant changes that were unclear or incomplete with a prescribing practitioner for 1 of 4 sampled residents (#1). (Novolog sliding scale insulin.) [Refer to Tag 344 10A NCAC 13F .1002(a) Medication Orders. (Type B Violation.)] C. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper disinfection for 2 of 3 sampled residents, (#1 and #2) and maintaining a shared or common glucose meter without proper disinfection. [Refer to Tag 932 G.S. 131D- 4.4(A) ACH Infection Prevention Requirements (Type B Violation.)] Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled residents (#2) had an injectable	D912		

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D912	Continued From page 85 medication, Invega Sustenna, available for home health to administer and failed to try to obtain the medication resulting in the resident not receiving the medication for almost 2 months and failed to ensure the resident's physician was aware the medication was not administered as ordered. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Unabated Type B Violation.)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based observations, record reviews, and interviews, the facility failed to assure residents were free from neglect and exploitation in the areas of Health Care Personnel Registry reporting, medication administration, implementation, and controlled substances record keeping. The findings are: A. Based on observations and interviews, the facility failed to protect and ensure residents received care and services needed as evidenced by the failure to conduct an internal investigation and report allegations to the Health Care Personnel Registry for 1 of 1 staff (C) related to the impairment of Staff C, a supervisor, and questionable if the supervisor was able to perform duties on multiple days.[Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation.)]	D914		

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D914	Continued From page 86 B. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records were available to account for the disposition of controlled substances (Hydromorphone and Alprazolam) and to ensure an accurate reconciliation of those controlled substances for 1 of 4 sampled residents (Resident #5) who were administered controlled medications. [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Unabated Type B Violation.)] C. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered to 4 of 6 sampled residents as evidenced by the failure to administer a pain medication, Percocet, to Resident # 5 when requested due to the facility's electronic medication administration system was not operating; failed to administer readmission medications (furosemide, lisinopril, Novolog, hydroxyzine and lactulose) from a hospitalization to Resident #1 as ordered due to the orders not being sent to the pharmacy until almost 3 weeks later; and failed to administer medications as ordered to 2 other sampled residents (Residents #3 and #9.) (Sertraline, fluticasone nasal spray, cyclobenzaprine.) [Refer to Tag D 358 10A NCAC 13F .1004(a) Medication Administration. (Type A2 Violation.) D. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, medication orders, health care, staff	D914		

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D914	Continued From page 87 qualifications, nutrition and food service, activities, infection control, Health Care Personnel Registry reporting, and residents' rights. [Refer to Tag 980 G.S. 131D-25 Implementation (Unabated Type A2 Violation.)]	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident,	D932		

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D932	Continued From page 88 equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper disinfection for 2 of 3 sampled residents, (#1 and #2) and maintaining a shared or common glucose meter without proper disinfection. The findings are: Observation of the medication cart on 7/24/17 at 11:30am revealed: -A glucose meter stored on the top shelf of the medication cart. -The glucose meter was not in a container or case. -The glucose meter did not have a resident's name or any other identifying marks anywhere on the meter. Interview with the Medication Aide (MA) on	D932		

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D932	Continued From page 89 7/24/17 at 11:37am revealed: -The unmarked glucose meter on the top shelf of the medication cart was a "spare" glucose meter, but everyone has their own meter. -They use the spare glucose meter "whenever we need to, " i.e. whenever there was a problem with a resident's own meter. -"We disinfect the spare meter, but not every time we use it." -They disinfected the meters with "some type of wipe in a plastic container with a red top." -"No one ever told me we cannot share glucose meters." -She was trained by the RCC on diabetic testing. Observation of the medication room and the medication cart on 7/24/17 at 11:40am revealed no disinfection wipes available to disinfect the glucose meters. A. Review of Resident #2's FL2 dated 1/11/17 revealed: -Diagnoses included schizophrenia, paranoid type, mild renal insufficiency, insulin dependent diabetic and gastroesophageal reflux disease. -A physician's order to check finger stick blood sugars (FSBS) three times a day and as needed daily. -A physician's order for Levemir 55 units at 8am and 8pm (a long acting insulin used to lower blood sugar). -Novolog flex pen with sliding scale insulin three times daily (a rapid-acting insulin pen). Review of Resident #2's care plan dated and signed by the physician on 1/11/17 revealed a diagnosis of insulin dependent diabetes and a NCS diet. Review of Resident #2's personal glucometer on	D932		

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D932	Continued From page 90 7/24/17 at 11:30am revealed: -A glucose reading of 193 on 2/7/17 at 11:12am. -A glucose reading of 318 on 1/30/17 at 4:51am. -A glucose reading of 250 on 1/27/17 at 5:08am. -No readings for March, April, May, June or July 2017. Review of Resident #2's June and July 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for Novolog sliding scale insulin, give before meals and at bedtime for CBG (capillary blood glucose level): 150-200 give 2u(units), 201-250 give 4u, 251-300 give 6u, 301-350 give 8u, 351-400 give 10u, greater than 400 give 12u., with scheduled administration times of 6:00am, 11:30am, 4:30pm, and 8:00pm. Review of Resident #2's June 2017 eMAR revealed: -FSBS at 6:00am ranged from 114 to 400. -FSBS at 11:00pm ranged from 74 to 362 -FSBS at 4:00pm ranged from 142 to 434. -FSBS at 9:00pm ranged from 118 to 370. -There were 116 entries of CBG results from 6/2/17 through 6/30/17. Review of Resident #2's July 2017 electronic Medication Administration Records revealed: -FSBS at 6:00am ranged from 116 to 344. -FSBS at 11:00pm ranged from 146 to 417. -FSBS at 4:00pm ranged from 173 to 368. -FSBS at 9:00pm ranged from 132 to 356. -There were 96 entries of CBG results from 7/1/17 through 7/24/17. Interview with a first shift MA on 7/24/17 at 12:00am revealed: -The MA had been checking Resident #2's blood	D932		

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D932	Continued From page 91	D932		

sugar levels daily before meals.
-Resident #2 had a personal glucometer.
-There is a glucometer in the medication cart that "gets used by everybody. It gets wiped down when we feel it needs to with a disinfectant wipe."
-"I was not told the same glucometer could not be used on another person."
-The RCC had only told her moments before this interview to "clean all the glucometers with Clorox and water".
-There was a nurse coming on 7/26/17 to "train us on the glucometers".

Refer to interview with the Administrator on 7/24/17 at 11:50am.

B. Review of Resident #1's current FL2 dated 7/2/17 revealed:
-Diagnoses included hepatitis C, coronary artery disease, hypertension, history of traumatic brain injury, mixed dementia, insulin dependent diabetes, and chronic pain.
-An order for Novolog sliding scale insulin three times daily.

Review of Resident #1's personal glucometer on 7/24/17 at 11:00am revealed:
-A glucose reading of 235 on 7/6/17 at 11:12am.
-A glucose reading of 318 on 7/6/17 at 4:20am.
-A glucose reading of 250 on 7/5/17 at 6:51pm.
-No other readings for July 2017.

Review of Resident #1's July 2017 electronic Medication Administration Record (eMAR) on 7/19/17 and 7/24/17 revealed:
-Novolog sliding scale insulin, give before meals and at bedtime for CBG (capillary blood glucose level):
150-200 give 2u(units), 201-250 give 4u, 251-300 give 6u, 301-350 give 8u, 351-400 give 10u,

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D932	Continued From page 92 401-450 give 12u, greater than 450 give 12u and recheck in one hour, with scheduled administration times of 6:00am, 11:30am, 4:30pm, and 8:00pm. -Entries of blood sugar results with ranges 158 -417 sixty-two times from 7/3/17 at 8:00pm to 7/19/17 at 11:30am. Observation of Resident #1's glucometer on 7/24/17 at 11:05am revealed it had another resident's name printed in faded ink on the back of the glucometer. Interview with a first shift MA on 7/24/17 at 10:35am and 11:35am revealed: -The MA had been checking Resident #1's blood sugar levels daily before meals. -Resident #1 had a personal glucometer. -There is a glucometer in the medication cart that "gets used by everybody. It gets wiped down when we feel it needs to with a disinfectant wipe." -"I thought we could use it (glucometer), I wasn't told we couldn't share." -There were no disinfectant wipes in the facility. -There was no glucometer in the facility with Resident #1's name on it. Refer to interview with the Administrator on 7/24/17 at 11:50am Interview with the Administrator on 7/24/17 at 11:50am revealed: -He did not know what happened with the glucose meters. -"Everyone has their own meter, and they (MA) know they are not supposed to share." -"It's the facility policy not to share meters."	D932		

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D932	Continued From page 93 The facility failed to implement proper infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control for 2 of 3 sampled residents (#1 and #2) with orders for FSBS monitoring. By allowing the sharing of glucose meters between residents, including Resident #1 with a diagnosis of hepatitis C, without proper disinfection, the facility exposed residents to the risk of contracting serious blood borne illnesses including hepatitis and human immunodeficiency virus and constitutes a Type B violation. Review of the Plan of Protection provided by the facility on 7/24/17 revealed: -The Administrator will schedule an infection control class within the next 30 days or as soon as possible. -We will have an immediate staff meeting to inform staff that each resident has they own glucose meter and at no time should meters be shared between residents. -We will keep a (new) backup meter in the med room in case there is a malfunction with a meter. -The Administrator and or Director will make sure each new hire understands blood glucose meters and the importance of not sharing. -Infection control and diabetic training will be strongly enforced. -Upon hire, we will continue to enforce infection control and make sure each staff member understands the importance. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2017.	D932		

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D935	Continued From page 94	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 95 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 5 medication aides (Staff E) sampled completed the 15 hour medication training. The findings are: Review of Staff E's personnel file revealed: -Staff E was hired on 12/15/16 as a Personal Care Aide. -Staff E had a position change to Medication Aide on 3/1/17. -She had a medication clinical skills validation completed on 3/1/17. -She had passed the medication aide test on 10/28/14. -There was a completed 15 hour medication test worksheet with no score. -There was no documentation for either the 5 hour or 15 hour medication training signed by an instructor. Attempted telephone interview with Staff E on 7/24/17 at 3:15pm was unsuccessful. Review of the June 2017 and July 2017 Medication Administration Records revealed Staff E had administered medications to the residents in the facility. Interview with the Resident Care Coordinator on 7/24/17 at 3:10pm revealed:	D935		

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D935	Continued From page 96 -The nurse who did the medication competency validation did the medication training. -She did not know if any medication training was completed on Staff E. Interview with the Administrator on 7/24/17 at 3:30pm revealed: -The Resident Care Coordinator (RCC) is responsible for assuring that all new staff have required training. -The pharmacy consultant had done the medication training in the past, but did not know if they done it any longer. -He will schedule the nurse to do the 15 hour medication training for Staff E. -There was not an employment verification for Staff E. Attempted telephone interview on 7/24/17 at 2:45pm with the Licensed Health Professional Support (LHPS) nurse was unsuccessful.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated.	D980		

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Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, medication orders, health care, staff qualifications, nutrition and food service, activities, infection control, Health Care Personnel Registry reporting, and residents' rights.

The findings are:

Interview with a resident during a tour of the facility on 7/19/17 between 10:20am and 12:15am revealed:
-The Administrator comes around "occasionally."
-When he's at the facility, "he's always in the office."

Interview with a second resident during a tour of the facility on 7/19/17 between 10:20am and 12:15am revealed:
-The Administrator was "not here often."
-"He never makes rounds."
-"I've only seen him 2 to 3 times since I've been here."
-"I've lived in the facility since September of last year."

Interview with a third resident on 7/24/17 at 9:00am revealed he believed the Administrator was here "about twice a month."

Interview with the Administrator on 7/24/17 at 10:30am revealed:
-He was in the facility at least 5 days a week.
-When he is in the facility, he checks on the

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overall operation of the facility.
-He "reviews new orders for residents."

A. Based on observations, interviews, and record reviews, the facility failed to assure all therapeutic diets for 4 of 4 sampled residents (Resident #1, #2, #7 and #9) were served as ordered related to puree and no concentrated sweets diet orders. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation.)]

B. Based on observations and interviews, the facility failed to protect all food being stored, prepared and served by the facility from contamination. [Refer to Tag 282 10A NCAC 13F.0904(a)(1) Nutrition and Food Service.]

C. Based on observations and interviews, the facility failed to develop a program of activities designed to promote the residents' active involvement with each other, their families and the community. [Refer to Tag 315 10A NCAC 13F .0905(a)(b) Activities Program.]

D. Based on observations and interviews the facility failed to ensure the facility had a current Activity Director (Staff A) that met all qualifications for the position of Activity Director. {Refer to 128 10A NCAC 13F .0404(1) Qualifications of Activity Director.]

E. Based on interviews and record review, the facility failed to clarify readmission orders with significant changes that were unclear or incomplete with a prescribing practitioner for 1 of 4 sampled residents (#1). (Novolog sliding scale insulin.) [Refer to Tag 344 10A NCAC 13F .1002(a) Medication Orders. (Type B Violation.)]

F. Based on observations, interviews, and record

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D980	Continued From page 99 reviews, the facility failed to ensure medications were administered to 4 of 6 sampled residents as evidenced by the failure to administer a pain medication, Percocet, to Resident # 5 when requested due to the facility's electronic medication administration system was not operating; failed to administer readmission medications (furosemide, lisinopril, Novolog, hydroxyzine and lactulose) from a hospitalization to Resident #1 as ordered due to the orders not being sent to the pharmacy until almost 3 weeks later; and failed to administer medications as ordered to 2 other sampled residents (Residents #3 and #9.) (Sertraline, fluticasone nasal spray, cyclobenzaprine.) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration. (Type A2 Violation.)] G. Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 2 of 6 (#1 and #5) sampled residents related to the medications Percocet and Flonase for Resident #5 and Novolog insulin for Resident #1 not being administered because they were not on the MARs due to the pharmacy computer system being down for 5 or more days. {Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration.] H. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records were available to account for the disposition of controlled substances (Hydromorphone and Alprazolam) and to ensure an accurate reconciliation of those controlled substances for 1 of 4 sampled residents (Resident #5) who were administered controlled medications. [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Unabated Type	D980		

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D980	Continued From page 100 B Violation.)] I. Based on observations and interviews, the facility failed to protect and ensure residents received care and services needed as evidenced by the failure to conduct an internal investigation and report allegations to the Health Care Personnel Registry for 1 of 1 staff (C) related to the impairment of Staff C, a supervisor, and questionable if the supervisor was able to perform duties on multiple days.. [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation.)] J. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper disinfection for 2 of 3 sampled residents, (#1 and #2) and maintaining a shared or common glucose meter without proper disinfection. [Refer to Tag 932 G.S. 131D- 4.4(A) ACH Infection Prevention Requirements (Type B Violation.)] K. Based on interviews and record reviews, the facility failed to assure 1 of 5 staff (Staff A) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 131 10A NCAC 13F .0406(a) Test for Tuberculosis.] L. Based on record reviews and interviews, the facility failed to assure that training on the care of diabetic residents was provided for 3 of 3 sampled Medication Aides (MA), (Staff C, D, and E) who administer insulin in the facility. [Refer to Tag 164 10A NCAC 13F .0505 Training on Care of Diabetic Residents.]	D980		

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D980	Continued From page 101 M. Based on interviews and record reviews, the facility failed to assure 3 of 5 sampled staff completed training in infection control within 30 days of hire on the policy and procedures of infection control (Staff A, D and E). [Refer to Tag 449 10A NCAC 13F .1211(b) Written Policies and Procedures.] N. Based on interviews and record reviews, the facility failed to assure 1 of 5 medication aides (Staff E) sampled completed the 15 hour medication training. [Refer to Tag 935 G.S. 131D-4.5(B) ACH Medication Aide; Training and Competency.] O. Based on observations, interviews, and record reviews, the facility failed to ensure all residents were treated with respect related to extra servings of coffee and treatment of a vegetarian resident (#10) after receiving regular diet plate containing pulled pork. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights.] P. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled residents (#2) had an injectable medication, Invega Sustenna, available for home health to administer and failed to try to obtain the medication resulting in the resident not receiving the medication for almost 2 months and failed to ensure the resident's physician was aware the medication was not administered as ordered. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Unabated Type B Violation.)]	D980		