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	HAL036004	A. BUILDING: _____ B. WING _____	R-C 11/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ASSISTED LIVING	721 NORTH MARIETTA STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Gaston County Department of Social Services conducted a follow-up survey and a complaint investigation on November 1, 2017 to November 6, 2017. The complaint investagation was initiated by the Gaston County Department of Social Services on October 12, 2017 and October 17, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the walls, baseboards, and window sills in residents' rooms (rooms #8, #12, #14), the common men's bathrooms, the dining room, the common snack area, the inside common smoking area, the air vents in the hallway, and the common living room, were kept clean and in good repair. The findings are: Observations during the facility tour on 11/1/17 from 10:30 am to 11:15 am revealed: -There was an entrance door that led to small foyer and another entrance door which led to the common living room area and the dining room area located in the facility.	D 074		

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D 074	Continued From page 1 -Throughout the foyer in all the corners there was a blackish thick buildup of dirt and dust. -There was a ceiling fan located in the foyer are that had a thick buildup of dirt on each of the fan blades. -On the left side of the foyer there was an enclosed common smoking area about 20 feet long and about 4 foot wide. -There were black scuff marks throughout the smoking room on the walls and around all the baseboards. -There was a blackish brown buildup of dirt in the corner by the entry of the smoking area room through the screen door on the right side of the floor. -There were two wooden benches on both sides of the smoking room and both benches had a blackish buildup of dirt underneath the benches. -There was a ceiling fan located in the smoking area near the screen door that had a thick buildup of dirt on each of the fan blades. Observation on 11/1/17 at 12:00 pm of room #8 revealed: -There were four beds in the room, but only two residents occupied the room. -One resident's bed was located near the left side of the room against the wall. -There were multiple paper trash items, a used crushed soda can, cable wires, plastic clothes hangers, and dust and cobwebs buildup between the nightstand and the wall. -There was a cable outlet about 14 inches from the floor near the resident's bed that was unsecured without a cover to hide the cable wires. -There were multiple dirty brownish colored smears of a substance on the wall directly above the resident's bed about 10 inches from the top of the bed.	D 074		

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-The floor in room #8 was dirty with a buildup of dirt, especially around the edges of the room along the walls.

Observation on 11/1/17 at 12:10 pm of resident room #12 revealed:
-There were two beds in the room.
-The window was opened near one of the beds.
-The windowsill was caked with a thick black buildup of cigarette ashes and 5-6 cigarettes butts in the corner of the window frame.

Interview on 11/1/17 at 4:00 pm with the resident residing in room #12 revealed:
-He did not smoke in the room, the cigarette butts in the window sill belonged to another resident who was no longer in the facility.
-He opened the window in his room "to get fresh air" sometimes at night.

Interview on 11/1/17 at 4:10 pm with a housekeeper revealed:
-She had worked at the facility for 1 month.
-Her duties included mopping the floors, cleaning the bathrooms, cleaning the furniture, and sweeping the rooms.
-She never cleaned inside the windowsills in the resident rooms.
-She was responsible for picking up and cleaning the "yard."
-She would pick up the cigarette butts and paper trash in the smoking area outside.

Observation on 11/1/17 at 12:22 pm of resident room #14 revealed:
-There was a black buildup of dirt on the baseboard near the entrance door.
-There was a resident's bed near the entrance door on the right and there were smears of a brownish substance on the wall directly above the

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D 074	Continued From page 3 bed. Interview on 11/1/17 at 3:00 pm with the resident in room #14 revealed: -He had not noticed the dirty build up on the floor and around the baseboard nor the brownish substance smears on the wall above his bed. -Housekeeping cleaned his room every day. -"I am not sure when they cleaned the walls or baseboards." Observation on 11/1/17 at 12:30 pm of the hallway ceiling air vents revealed: -There were four air vents located on the main hall of the facility. -The air vents panels were about 24 inches by 24 inches in size. -There was a thick buildup of dust and cobwebs layered on each ceiling air vent. Observation on 11/1/17 at 12:36 pm of the common vending machine snack area revealed: -The snack room had two vending machines in the room for residents and staff to use. -There was a telephone wiring box located on the left side of the room near one of the vending machine. -There were wires exposed and unsecured on the wall with no cover. Interview on 11/3/17 at 4:00 pm with the Administrator revealed she was aware of the uncovered exposed wires in the vending machine area and stated, "The wires are from an old telephone that use to be there, the wires are dead." Observation on 11/1/17 through 11/3/17 during the survey revealed at multiple times residents and staff obtained soda and snacks from the	D 074		

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common vending machine area during the day.

Observation on 11/1/17 at 12:45 pm of the hallway doors in the middle of the hallway revealed:
-There were two doors located on the hall that could be used to close off one section of the hallway.
-The door on the right was held open with a metal close hanger which was twisted around the handle of the door and secured to the back of the wall preventing the door to close.

Interview on 11/3/17 at 4:02 pm with the Administrator revealed she was unsure why the clothes hanger had been used to keep the hallway door open, the bottom of the door had a magnet that kept the door open.

Observation on 11/3/17 at 4:03 of the Administrator revealed she removed the clothes hanger and attempted to secure the door open using the bottom magnet; after several attempts the door stayed opened using the bottom of the door magnet to secure the door.

Observation on 11/1/17 at 1:10 pm of the dining room windows revealed:
-There were four large windows located on the inside of the dining room area.
-All four windows were closed to the outside air.
-All four windows had multiple dead flies and a buildup of blackish dirt in the corners.

Interview on 11/1/17 at 3:30 pm with the Dining Room Assistant revealed:
-She had served the lunch meal to the residents on 11/1/17.
-She was responsible for cleaning the dining room area, housekeeping cleaned the facility

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area.
-She was unaware there were dead flies in all four windows sills.
-She would immediately clean the windowsill and remove the dead flies and dirt.

Interview on 11/1/17 at 3:38 pm with the same Dining Room Assistant revealed she had "misspoken" in the prior interview, "the housekeeper was responsible for cleaning the dining room, not her."

Observation on 11/1/17 at 3:48 pm of the dining room windows revealed the dead flies and dirt was cleaned from all four window sills.

Observation on 11/1/17 at 4:00 pm of the men's common bathroom located on the hallway near room #12 revealed:
-The bathroom was divided into a bath area, and a toilet area.
-In the bath area the baseboards and the corners of the room were caked with a black buildup of dirt.
-Paint was chipped and missing from multiple areas on the baseboards.
-The window directly above the tub was opened about 2 inches.
-The window sill was caked with a thick brownish black buildup of dirt, cobwebs, and dead flies.
-The walls around the tub had black scuff marks and smears of brownish substance about 2 feet from the flooring.
-The toilet area had a buildup of dirt around the corners and on the top of the baseboards.

Interview on 11/1/17 at 11:14 am with the Administrator revealed:
-She was responsible for the day to day operations of the facility which included

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overseeing maintenance and housekeeping.
-She was aware the facility needed work on the walls, floors and painting.
-She was waiting on the new floors to be put down in the facility before she contacted the contractor to paint and repair the walls and baseboards.

Observation on 11/01/17 from 9:45 am to 11:30 am revealed:
-Resident room #2 had two residents
-There was dirt, trash, and torn paper, splattered paint, rolled up underwear in the corners of the room at about 1 feet from the baseboard.
-There was dirt and trash near the wall on the floor under the heat register.

Interview on 11/01/17 at 11:10 am with the resident in room #2 revealed:
-Her room was cleaned, but she was unaware how often.
-She did not know why housekeeping did not clean under the beds or sweep the corners of the room.

A second interview on 11/01/17 at 1:45 pm with the Administrator revealed:
-She was aware the housekeepers were not cleaning room #2.
-She was waiting for the new floors to be installed before she de-cluttered and deep cleaned the rooms.
-In July 2017, she was made aware the floors needed repair.
-She had to wait for the owner to order the new floors.
-The floors were ordered October 11, 2017.
-She recently hired a new housekeeper and had only instructed her to surface clean.
-She had instructed housekeeping not to do a

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deep cleaning to the rooms until the floors were put down.
-After the floors were installed housekeepers were to de-clutter rooms.
-Nothing was to take place until after the new floors were put down.
-She was unaware when the floors would be installed, as they were not ordered until 10/11/7.

Interview on 11/01/17 at 2:28 pm with the housekeeper revealed she worked at the facility for one month.
-She cleaned resident rooms.
-The Administrator told her to surface clean room #2 and the other resident rooms.
-She did not sweep the corners of the rooms, clear off or dust furniture, or sweep under beds.
-She only swept trash in the middle of the floor.

Observation on 11/01/17 from 9:45 am to 11:20 am revealed:
-Resident room #3 had three beds and two residents.
-There was trash and clothes underneath bed one by the door.
-There was trash and dirt alongside of the walls and in the corners of the room.

Interview on 11/01/17 at 11:03 am with a resident in room #3 revealed:
-Housekeepers swept her room emptied the trash can daily.
-She did not know why they did not clean underneath the beds or clean the trash by the baseboards.

Interview on 11/01/17 at 2:10 pm with the personal care aide (PCA) revealed:
-Housekeepers were responsible for sweeping and scrubbing the floors.

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D 074	Continued From page 8 -Dusting the rooms are sometimes done by the PCAs or housekeeping. -They also cleared emptied medication cups and debris from off the nightstands. Interview on 11/01/17 at 2:28 pm with the housekeeper revealed: -She worked at the facility for one month. -The Administrator told her to surface clean. -She did not sweep the corners of the rooms, clear off or dust furniture, or sweep under beds. -She only swept trash in the middle of the floor.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain furniture clean and in good repair in the common sitting area and resident room #19. The findings are: 1. Observations during the initial facility tour on 11/01/17 from 9:45 am to 12:00 pm revealed: In the common sitting area there were 13 chairs and a sofa, twelve burgundy and one green. -There was a 6 and 1/2 feet by 3 feet leather sofa in the common sitting area. -The leather on the sofa was cracked and peeling with the inner white cotton behind the leather	D 076		

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visible.
-There was a 2 and 1/2 feet by 2 feet piece of wood visible from the frame of the sofa.
-The leather seat of each burgundy chair was cracked with the white inner lining visible.
-The leather of green chair had a 3 inch long tear in the upper portion, four rips on one arm, multiple tears on the seat with one being 2 and 1/2 inches long by 1 inch wide.
-Through the rips and tears the white inner lining underneath the leather was visible.

Interview on 11/01/17 at 1:45 pm with the Administrator revealed:
-She was aware the sofa and chairs in the common sitting area were ripped and torn.
-She did not realize the wood was sticking out and visible allowing a resident to possibly hurt themselves on the uncovered wood.
-She thought the owner had ordered new furniture, she was unable to verify when the furniture would be delivered.
-She did not have a receipt or documentation to show the furniture had been ordered.

Interview with 4 staff members on 11/02/17 at 11:21 am and 3:21 pm and 11/03/17 at 6:39 am and 7:25 am revealed:
-Four staff noticed the chairs in the common sitting area had been ripped and torn for at least one year.
-Two staff revealed the sofa in the common sitting area was purchased earlier this year, maybe January 2017.
-One staff stated she had made the Administrator aware the sofa was ripped and torn, but had not noticed the wood sticking out.
-Three staff were aware the leather on the sofa was cracked and torn, but had not noticed the wood was sticking through.

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D 076	Continued From page 10 Confidential interviews with five residents revealed: -Two residents said the sofa in the common sitting area was bought new several months ago. -There were two residents that played on the sofa and that was what caused it to rip and tear. -Three residents said they sit on the sofa, but sit to one side to avoid the piece of wood that stuck out. Confidential interviews with seven residents revealed: -The chairs in the common sitting area had been in the facility for "a long time." -One resident had lived at the facility for more than 12 years. -The chairs had been ripped, cracked, and torn for over two years. -Two residents said the cracks in the chairs hurt their legs. -5 of 7 residents said when they sat in the chairs they sank down and struggled to get out because the springs were broken. Observation on 11/01/17 from 9:45 am to 11:30 am revealed: -The chair in resident room #19 was red with smooth black discoloration on both the arms and throughout the frame of the chair. -There was also food debris scattered throughout the chair. Interview on 11/01/17 at 1:45 pm with the Administrator revealed: -The owner had ordered new furniture, but was was unable to complete the purchase because sale had to be in-store. -She had not planned to replaced the furniture in the common sitting area until after the new floors	D 076		

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were put down.
-Once the floors were installed the furniture that was salvageable will be saved or if new furniture was needed it will be replaced.
-Nothing was to take place until after the new floors were put down.
-She was unaware when the floors would be installed, as they were not ordered until October 10/11/17.

2. The chair in resident room #19 was red with smooth black discoloration on both the arms and throughout the frame of the chair.
-There was also food debris scattered throughout the chair.
-The wood on the chest-of-drawer was faded and warped.
-There was a 4 ounce plastic cup with hair and old food.
-There was other debris scattered throughout the top of the chest.
-There was a 2 and 1/2 feet by 1 and 1/2 feet table on the side of the bed.
-The top of the table to was faded, warped with pieces of wood missing.
-There was an empty disposable plastic cup, plate, plastic hanger and other debris on the table.

Based on observation, record review and attempt interview on 11/01/17 it was determined the resident in room #19 was not interviewable.

Interview on 11/01/17 at 1:45 pm with the Administrator revealed:
-New furniture had been ordered she was waiting for the new floors to be installed.
-After the floors were installed she access where new furniture was needed and order furniture accordingly.

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D 076	Continued From page 12 -Nothing was to take place until after the new floors were put down. -She was unaware when the floors would be installed, as they were not ordered until October 10/11/17. 3. Resident room #2 had two residents. -The night stand with one 2 once plastic cup (three white pills inside, one oblong, one round, one oval), three 4 ounce plastic cups, and one six ounce plastic cup. -One had a red color substance. -The nightstand had multiple red, black and brown stains. Interview on 11/01/17 at 11:10 am with the resident in room #2 revealed: -Her room was cleaned, but she was unaware how often. -She did not know why housekeeping did not clean under the beds or sweep the corners of the room. Interview on 11/01/17 at 1:45 pm with the Administrator revealed: -She was aware the housekeepers were not cleaning room #2. -She recently hired a new housekeeper and had only instructed her to surface clean only because after the floors were installed housekeepers were going to de-deep clean the rooms. -Nothing was to take place until after the new floors were put down. -She was unaware of the exact date when the floors were to be installed, as they were not ordered until October 10/11/17. Interview on 11/01/17 at 2:28 pm with the housekeeper revealed she worked at the facility for one month.	D 076		

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D 076	Continued From page 13 -She cleaned resident rooms. -The Administrator told her to surface clean room #2 and the other resident rooms. -She did not clear off or dust furniture, or take away used cups on the night stands. -She only swept trash in the middle of the floor. 4. Resident room #3 had three beds and two residents. -There was dust on the chest and night stands. -On and around the television. Interview on 11/01/17 at 11:03 am with a resident in room #3 revealed: -Housekeepers swept her room emptied the trash can daily. -She did not know why they did not dust or clean other parts of the room. Interview on 11/01/17 at 1:45 pm with the Administrator revealed: -She was aware the housekeepers were not cleaning room #3. -She was waiting for the new floors to be installed and had instructed housekeepers to surface clean the rooms. -Only after the floors were installed housekeepers were to de-clutter rooms. -Nothing was to take place until after the new floors were put down. Interview on 11/01/17 at 2:28 pm with the housekeeper revealed she worked at the facility for one month. -She cleaned resident rooms, but had been instructed to only surface clean room #3. -She did not clear off or dust furniture.	D 076		

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D 270	Continued From page 14	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on the findings the previous Type A2 violation was not abated. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with 1 of 3 residents (#2) sampled residents leaving the facility sleeping outside. The findings are: Review of Resident #2's current FL2 dated 08/03/17 revealed: -Diagnoses included schizophrenia, alcoholism, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disease, and Crohns' disease. -The resident's was intermittently disorientation. Review Resident #2's Resident Register revealed the resident was admitted to the facility on 06/22/16. Review of Resident #2's Care Plan signed by the physician on 04/10/17 revealed: -The resident required extensive assistance with toileting, dressing and grooming.	D 270		

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D 270	Continued From page 15 -The resident needed supervision with ambulation. Review of Resident #2's hospital report dated 10/11/17 revealed: -At 12:22 am Resident #2 stopped EMS at the local gas station stating he needed help. -Resident #2 wanted a medical and psychiatric evaluation because he was hearing things, he believed animals, jets, and cars were speaking to him. -The resident told hospital staff he used alcohol, cocaine and marijuana, and he was homeless. -Resident #2's blood level alcohol was greater than 175 (reference range <10 mg/dL). -He tested positive for cocaine, reaching the detection limit of 300 ng/ml. -Resident #2 later told hospital staff he lived at the facility, signed out for 3 days and was drinking. -Resident #2 was discharged back to the facility on 11/11/17 at 10:25 am. Review of Resident #2's hospital report dated 10/14/17 revealed: -Resident #2 was brought to the hospital at 3:26 am by Emergency Medical Services (EMS). -He was found on the ground unresponsive by a bystander. -The bystander called EMS. -In the Emergency Room (ER) it was determined that Resident #2 was intoxicated. -His alcohol level was 207, the normal range was 80. -The resident was treated and released at 9:00 am on 10/14/17. -Resident #2 left the hospital against medical advice and no one was aware where he was going.	D 270		

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Review of Resident #2's hospital report dated 10/29/17 revealed:
-At 2:33 am on 10/29/17 Resident #2 flagged down the EMS.
-He told them he needed psychiatric treatment, he was hearing voices, but could not understand what they were saying.
-He heard audiovisual hallucinations, he saw aliens everywhere, but then denied hearing voices.
-Resident #2 smelled of alcohol, and expressed homicidal and suicidal ideation, "he is inattentive."
-Collection of history was limited due to clinical intoxication.
-Resident #2's alcohol level was 233.
-Resident #2 was discharged from the hospital on 10/29/17 at 11:56 am, with no indications where the resident's destination was going to be.

Review of Resident #2's nurse notes (eMARs printed) revealed:
-On 10/09/17 at 1:21 am "Res ... [#2] is out facility at this time."
-On 10/10/11 at 5:01 am "Res ...[#2] out of facility all of 11/7 (11:00 pm-7:00am) shift."
-On 10/11/17 at 2:46 pm the facility received a call from the local hospital stating Resident #2 had come to the hospital after mid-night.

Review of Resident #2's nurse notes (hand-written by staff) revealed:
-On 10/14/17 on the 7:00 pm to 7:00 am shift staff documented Resident #2 refused medications three times.
-On 10/21/17 on the 7:00 pm to 7:00 am shift staff documented Resident #2 was out of the facility the "entire shift."
-On 10/22/17 on the 7:00 pm to 7:00 am shift staff documented Resident #2 was out of the facility the "entire evening shift - so meds were

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D 270	Continued From page 17 not administered." Review of the facility's sign-in/out register for October 2017 revealed: -On 10/12/17 at 3:00 pm Resident #2 signed out (not in the resident's hand writing). There was no documented time to return and no destination documented. -On 10/13/17 Resident #2 was signed out (not in the resident's hand writing) 7:00 am to 7:00 pm with the comment the resident would be back in three days, "on a street behind the old windy." (Resident #2 was in the hospital from 3:26 am on 10/13/17 until 9:00 am on 10/14/17). -On 10/18/17 at 11:30 am Resident #2 signed out stating he would be gone for 2 days, and no destination documented. -On 10/28/17 Resident #2 signed out at 10:10 (am or pm not documented). The destination was "QT, homeless gone for three days." Review of the facility's 15-minute logs revealed: -Staff documented every 15-minutes their observation of Resident #2 in the facility. -If Resident #2 was not in the facility staff documented "oof" (out of facility). -The time listed on the 15-minute log started at 7:00 am - 3:00 pm (first shift), 3:00 pm to 11:00 pm (second shift), and 11:00 pm to 6:45 am (third shift - after midnight is the next day) Review of the facility's October 2017 15-minute check log sheet for Resident #2 revealed: -On 10/09/17 from 12:00 am until 10:00 am staff documented they had observed Resident #2 in the facility every 15 minutes. -On 10/09/17 from 3:00 pm until 11:59 pm staff documented they had observed Resident #2 in the facility every 15 minutes. -On 10/10/17 from 12:00 am until 1:00 pm staff	D 270		

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documented they had observed Resident #2 in the facility every 15 minutes.
-On 10/12/17 from 9:15 am until 11:59 pm staff documented Resident #2 had was "oof."
-On 10/13/17 from 12:00 am until 6:30 pm 10/13/17 staff documented Resident #2 was "oof."
-On 10/13/17 from 8:30 pm until 10:00 am on 10/14/17 staff documented the observation of Resident #2 every 15-minutes in the facility (Resident #2 was in the hospital 3:26 am on 10/13/17 until 9:00 am 10/14).
-On 10/15/17 from 9:15 am until 6:45 am 10/16/17 Resident #2 was oof.
-On 10/16/17 from 11:00 pm until 6:45 am on 10/17/17 Resident #2 was oof.
-On 10/20/17 from 10:15 until 8:30 pm Resident #2 was "oof."
-On 10/27/17 from 9:45 am until 6:45 am on 10/28/17 Resident #2 was oof.
-On 10/28/17 from 7:00 am until 11:59 pm facility staff documented they observed Resident #2 all day every 15-minutes in the facility (Resident signed out "homeless gone for three days).
-On 10/29/17 from 12:00 am (midnight) to 6:45 am (third shift) facility staff documented Resident #2 was observed in the facility every 15 minutes (Resident #2 was hospitalized on 10/29/17 from 2:33 am until 11:56 am).
-On 10/30/17 from 8:45 am until 2:45 pm, then out from 8:15 pm until 7:00 am on 10/31/17 Resident #2 was "oof."
-On 10/31/17 from 11:45 pm past 6:45 am 11/01/17 Resident #2 was "oof."

Review of reports from the local police department revealed:
-On 10/10/17 at 4:57 am Resident #2 signed out on Sunday (10/08/17) afternoon and had not come back.

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D 270	Continued From page 19 Review of a noticed posted on the medication room door revealed: -"All resident are to notify a staff member if they are leaving the building." -"Then sign out, in sign out book with name, date, destination, and return time." -"If you do not tell a staff member you are leaving before signing out staff will put a missing persons report out on the resident." -"911 will be called on you and you will be brought back to the facility." According to the facility's 15-minute log sheets there were more than 10 days from October 11, 2017 through October 31, 2017 that Resident #2 was oof and there was no documentation the police had been notified or Resident #2's whereabouts documented according to the facility's new policy. Review of police reports, facility reports and notes revealed there was no consistent documentation that showed facility staff followed protocol and made sure Resident #2 documented his departure/return time and destination. There was no documentation the police were notified after not seeing Resident #2 for two hours according to the facility's new policy. Interview on 11/01/17 at 9:40 am with Resident #2 revealed: -Every month he goes out and buy beer and got intoxicated. -Some nights he stayed in a tent in the woods. -There was a little trail to the woods where he stayed when he got drunk. -He sometimes stayed up there for three nights, sleeping on the ground. -Sometimes he went up there just to hang out.	D 270		

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-He had an addiction to "crack."
-When he left the facility he did not have plans to get crack but then ended up getting it, he could not help it.
-He smoked his crack in a pipe he kept hid in the facility.
-He smoked crack yesterday and he had to pay $15.00 for a rock, and it did not last long.
-When "I get crack, it knocked me out, and I fall wherever I am at."
-"After smoking crack he could not walk, talk or move, he had to sleep it off," "I dropped wherever I am at."
-When he woke up he came back to the facility.
-Sometimes it was a day or two later.
-He was supposed to sign out when he left the facility, but sometimes he forgot.

Interview on 11/02/17 at 10:40 am with the Administrator revealed:
-She issued Resident #2 a discharge notice on 10/11/17.
-She had a discussion with Resident #2 regarding the resident leaving and being in danger.
-She explained to Resident #2 that the facility was ultimately responsible for him if something happened to him and they needed to know the resident's whereabouts.
-It was agreed that Resident #2 would sign out each time he left the facility.
-The resident would document where he was going, and the expected time that he would return back to the facility.
-For Resident #2's safety he was to not stay away from the facility overnight.
-If Resident #2 was gone for more than two hours facility staff was to call 911 to report the resident missing.
-In August 2017, an investigation by the county revealed supervision a resident needed to be

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improved, so she increased supervision for several residents, which included Resident #2.
-Due to the increased supervision Resident #2 was put on 15-minute checks.
-The checks were so staff would observe Resident #2 at least every 15 minutes to ensure his safety.
-She had not ensured the 15-minute checks were being done accurately.

Observations on 11/03/17 looking for Resident #2 from 9:00 am to 12:57 pm revealed:
-The resident was not in the facility.
-The resident had not signed out informing the facility where he was going, expected time to return or his destination.

Interview on 11/03/17 at 12:48 pm with the first shift PCA revealed:
-Resident #2 was in the facility at breakfast time, but she had not seen the resident since.
-He was not outside and had not told her where he was going.

An interview on 11/03/17 at 3:28 pm 4:20 pm with Resident #2 revealed:
-There were "tents up there above buildings behind the graveyard.
-He sometimes slept where the tents were located.
-Sometimes he stayed out all night, and did not take medications.
-He felt that he did not need medications.
-There were 3 people on the street that said if they catch him they were going to "beat him up."

A second interview on 11/03/17 at 4:20 am with Resident #2 revealed:
-He left the facility this morning after he got coffee for breakfast.

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D 270	Continued From page 22 -He didn't sign out, he forgot. Interview with a resident on 11/06/17 at 10:00 am revealed: -Resident #2 did not always sign out when he left the facility. -Resident #2 would sometimes tell him to sign out for him, and note that he would be gone for three days. -Sometimes Resident #2 came back to the facility in 2 days, but he refused to sign in or out. -Resident #2 had told him that he was going to buy "crack." -The people that Resident #2 was around were dangerous and sometimes Resident #2 told him someone wanted to hurt him, so he told Resident #2 not to go out. -Resident #2 was sleeping with other people under the bridge on a local highway, but the police cleared them all out. -He was unaware where Resident #2 was sleeping now. -Resident #2 stayed out overnight and all day. -Resident #2 did know that he could get hurt, but was addicted to "crack," Interview on 11/02/17 at 12:10 pm with the Physician Assistant (PA) (mental health) revealed: -She was aware the resident left the facility and sometimes was gone for days. -She felt Resident #2 did not make good decisions, but that was not her call to make sure the resident had a guardian to make decisions for him. -She was afraid of the crowd that Resident #2 was around when he left the facility and the resident would be found somewhere dead. -She would not be shocked if the Resident #2 was found dead by a drug deal gone wrong. -Today the resident told her "they were after him,"	D 270		

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"those people" sometimes threatened to "beat him-up" for 75 cents.

Interview on 11/03/17 at 6:39 am with third shift MA/PCA revealed:
-Resident #2 stayed out all night.
-Staff documented 15-minute checks observing the resident in the facility or "oof."
-She believed Resident #2 was in the facility on Sunday night when she came to work, but was not sure, she was however sure the resident was in the facility on Monday night.
-When Resident #2 was "gone for a certain amount of time," then she called the police.
-A certain amount of time was more than 8 hours.
-She had not called the police to report Resident #2 missing on her shift, but she thought the shift before (second shift) had called the police a month ago regarding Resident #2 missing.

Interview on 11/03/17 at 7:25 am with a second MA revealed:
-She worked at the facility since April 2017.
-Her shift started at 11:00 pm, and sometimes Resident #2 was not in the facility.
-Resident #2 would sometimes come back in the middle of the night or he would leave in the middle of the night.
-The resident would tell staff that he was going to be gone for a day or two.
-If the resident was gone for a certain amount of time, she was supposed to call the police.
-A certain amount of time was more than 8 hours.
-If the resident was gone 1-2 days they had to call the police.
-She had never called the police regarding Resident #2 not being in the facility.
-When the resident slept outside of the facility she was not sure where the resident slept.
-He heard that sometimes he slept outside on the

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D 270	Continued From page 24 ground near a hotel. Interviews with three residents at 12:51 pm, 12:53 pm and 12:57 pm regarding Resident #2 revealed: -Three residents said that Resident #2 was in the facility at breakfast time. -One resident said, Resident #2 never ate breakfast, but always wanted coffee. -Two residents said, Resident #2 got his coffee this morning and shortly afterwards left the facility. -One resident revealed, Resident #2 usually left the facility for days at a time. -Last week, Resident #2 left the facility and was out of the facility for two days. Interview on 11/02/17 at 2:40 pm with a property owner revealed: -There were individuals (homeless) that slept in the woods near her home. -She did not see the individuals face and could not positively identify Resident #2 was one of the individuals. Observation on 11/02/17 at 2:48 pm of the area revealed: -The location was 1.5 miles from the facility. -The wooded area was an additional 200 feet from the owner's property with a sandy road approximately 6 feet wide that lead to a thicket of trees. -Behind the trees there were huge rock formations. -The items identified were shoes, cloths, plastic bags, towels, and a white tarp. -No one was in the area. Confidential interviews with four residents revealed:	D 270		

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-One resident said Resident #2 went out of the facility all the time.
-The resident came back drunk or high.
-Three residents stated Resident #2 stayed out of the facility all night last week.
-One resident said Resident #2 stayed out of the facility all night last week, the resident often stayed out all night.
-The resident was not sure where Resident #2 was staying when he stayed out all night.

Interview on 11/06/17 at 2:40 pm with the third shift MA revealed:
-Some days when she came to work Resident #2 was not in the facility and was not there for her whole shift.
-If the resident was gone for more than eight hours she called the police.
-Sometimes Resident #2 was gone for a day or two.
-If the resident was gone her whole shift, which was eight hours she did not call the police.
-The Administrator usually called to ask if the resident returned.
-Resident #2 usually came back drunk or "high."
-Resident #2 told her that he sometimes slept under the bridge or outside.
-She was not sure where outside the resident slept because the resident did not tell her and she did not ask.
-Resident #2 was homeless and sleeping outside for at least two years before being admitted to the facility.

Interview on 11/06/17 at 2:41 pm with the RCD revealed:
-She thought mental health had talked with Resident #6 about drug and alcohol addiction.
-She was aware the resident had a drug and alcohol addiction, but did not suggest any type of

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ROSEWOOD ASSISTED LIVING	721 NORTH MARIETTA STREET GASTONIA, NC 28052

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D 270	Continued From page 26 counseling. Interview on 11/06/17 at 4:06 pm with the second behavior health agency revealed: -The agency had recently received approval to provide behavioral services to Resident #2. -She had been to the facility twice and only had seen Resident #2 once because he was not in the facility when she visited. -Resident #2 informed her that he heard voices and had a drug and alcohol addiction. -The resident told her that he consumed alcohol and drugs because he was depressed, however the alcohol and drugs caused him to be further depressed. -The resident was not stable to move out of the facility on his own. -The agency had not recommended alcohol or drug treatment because that service was not part of their agency. -The service could be linked with another agency but that had not happened because she had only made two visits to the see the resident, and out of the two visits she only saw the resident once. _____ The facility failed to supervise a resident, who was known to leave the facility and spend nights unprotected in the woods. This failure puts Resident #2 at substantial risk for serious physical harm or death, and constitutes a Type A2 Violation. _____ The facility provided the following Plan of Protection on 11/02/17: -The facility had already issued Resident #2 a notice of discharge on 10/11/17. -Immediately the Administrator will have a meeting with Resident #2 to stress importance of his safety when his is out of the facility. -The Administrator will document all efforts and all	D 270		

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D 270	Continued From page 27 attempts to keep Resident #2 safe. -Staff will be inserviced on documentation and supervision of Resident #2 until he date of discharge. The facility provided a correction date of November 15, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previous Type B Violation has not been abated. Based on interviews and record reviews, the facility failed to notify the physician for 3 of 5 sampled residents (Resident #3, #2, and #6) regarding orders for elevated Finger Stick Blood Sugars (FSBS); Physical Therapy (PT) referral (#3), missed medication with no follow up with physician (#2), and refused medications with no follow up with the physician (#6). The findings are: 1. Review of Resident #3's current hospital FL2 dated 7/17/17 revealed: -Diagnoses included type 2 diabetes,	D 273		

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hypertension, chronic kidney disease, and chronic and acute renal failure.
-A medication order for Humalog insulin (a fasting acting insulin for reducing blood sugar levels) subcutaneous inject per Sliding Scale Insulin (SSI) as follows:
Check and record blood sugar (BS) three times daily and at night.
If BS is 150-200 give 2 units
If BS is 201-250 give 4 units
If BS is 251-300 give 6 units
If BS is 301-350 give 8 units
If BS is 351-400 give 12 units and recheck FSBS in 2 hours.

Review of the facility High Blood Sugar (BS) Procedure policy revealed:
-"Contact the Medical Doctor (MD) and follow MD orders."
-"If the resident has a blood sugar of 400 or above, it is a critical value, immediate action must be taken."
-'If the resident does not display any signs or symptoms of high blood sugar the blood sugar must be rechecked."
-For BS 400 or above, the medication Aide (MA) will use the "High" in back of the Medication Administration Record."
-"The resident's MAR will be checked and insulin will be administered as ordered.
-"If the resident has a BS above 500, call 911 immediately."
-"The resident's MD must be notified for any BS above 400."

Review of the Resident #3's August 2017 Electronic Medication Administration Record (eMAR) revealed:
-An entry documented FSBS to be obtained at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm.

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D 273	Continued From page 29 -Documented entry from August 1, 2017 to August 31, 2017 the FSBS had been 400 or above 19 times and on 5 occasion greater than 500 as follows: -August 1, at 4:30 pm BS=569 and at 8:00 pm BS=599 -August 2, at 4:30 pm BS=599 -August 3, at 4:30 pm BS=591 -August 5, at 4:30 pm BS=400 -August 9, at 4:30 pm BS=462 -August 10, at 4:30 pm BS=465 -August 11, at 4:30 pm BS=430 -August 13, at 4:30 pm BS=493 -August 14, at 4:30 pm BS=451 -August 20, at 4:30 pm BS=400 and at 8:00 pm BS= 473 -August 22, at 4:30 pm BS=422 -August 23, at 4:30 pm BS=422 -August 24, at 4:30 pm BS=460 -August 25, at 4:30 pm BS=450 -August 26, at 4:30 pm BS=500 -August 27, at 4:30 pm BS=430 and at 8:00 pm BS=480 -There was no documentation on the eMAR the physician had been notified the FSBS were 400 or above 19 times and on 5 occasions over 500. Review of the Resident #3's September 2017 Electronic Medication Administration Record (eMAR) revealed: -An entry documented FSBS to be obtained at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm. -Documented entry from September 1, 2017 to September 30, 2017 the FSBS had been 400 or above 20 times and on 1 occasion greater than 500 as follows: -September 4, at 8:00 pm BS=436 -September 6, at 4:30 pm BS=440 -September 7, at 4:30 pm BS=402 -September 8, at 4:30 pm BS=434	D 273		

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D 273	Continued From page 30 -September 10, at 4:30 pm BS=433 and at 8:00 pm 464 -September 11, at 4:30 pm BS=483 -September 14, at 4:30 pm BS=422 -September 16, at 4:30 pm BS=400 and at 8:00 pm 400 -September 17, at 8:00 pm BS=525 -September 20, at 4:30 pm BS=481 -September 21, at 7:30 am BS=498 and at 4:30 pm 414 -September 22, at 4:30 pm BS=412 -September 23, at 7:30 am BS=407 -September 24, at 4:30 pm BS=427 -September 26, at 4:30 pm BS=435 -September 27, at 7:30 am BS=414 -September 29, at 7:30 am BS=421 -There was no documentation on the eMAR the physician had been notified the FSBS were 400 or above 20 times and on 1 occasion greater than 500. Review of the Resident #3's October 2017 Electronic Medication Administration Record (eMAR) revealed: -An entry documented FSBS to be obtained at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm. -Documented entry from October 1, 2017 to October 31, 2017 the FSBS had been 400 or above 16 times and on 5 occasions greater than 500 as follows: -October 2, at 11:30 am BS=452 -October 3, at 8:00 pm BS=400 -October 4, at 4:30 am BS=520 -October 5, at 4:30 pm BS=460 -October 8, at 4:30 pm BS=400 and at 8:00 pm BS=530 -October 13, at 4:30 pm BS=400 -October 14, at 4:30 pm BS=485 -October 15, at 4:30 pm BS=436 -October 23, at 8:00 pm BS=500	D 273		

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D 273	Continued From page 31 -October 24, at 8:00 pm BS=401 -October 28, at 4:30 pm BS=466 and at 8:00 pm BS=414 -October 29, at 8:00 pm BS=441 -October 30, at 8:00 pm BS=526 -October 31, at 8:00 pm BS=512 -There was no documentation on the eMAR the physician had been notified the FSBS were 400 or above 16 times and on 5 occasion greater than 500. Review on 11/3/17 of the October 2017 Accident / Incident reports for Resident #3's record revealed: -Documentation on 10/4/17 Resident #3 was "noticed shaking in room unresponsive," FSBS 37 and Emergency Medical Services (EMS) was called by the Resident Care Director (RCD), the MD was contacted. -Documentation on 10/10/17 Resident #3's FSBS was 464, "insulin was given, and rechecked 2 hours was reading 140." -Documentation on 10/21/17 Resident #3's FSBS was 498, "gave insulin, rechecked FSBS 2 hours 135, MD was called." -Documentation on 10/23/17 Resident #3's FSBS was 407, "insulin was given and reading 2 hours after 105, MD called and guardian." -Documentation on 10/27/17 Resident #3's FSBS was 414, "insulin, recheck 2 hours reading at 122, MD called and guardian notified." Further review of Resident #3's October 2017 eMAR revealed none of the elevated FSBS documented on the incident reports for October 2017 were documented on the eMAR. Interview on 11/3/17 at 4:50 pm with Resident #3 revealed: -She had been a diabetic for a long time.	D 273		

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-The facility took her FSBS four times a day.
-Her FSBS "ran high" a lot.
-She was unaware if the facility contacted the MD when her BS was elevated.

Interview on 11/1/17 at 4:00 pm with the RCD revealed:
-She was the RCD and also the first shift Medication Aide (MA).
-She was aware of the facility policy for FSBS over 400 was to contact the MD and over 500 to contact 911.
-There was not a system in place for reviewing the eMAR for FSBS over 400.
-Third shift MA were responsible for comparing the eMAR to new orders.
-She was unaware Resident #3's FSBS were above 400 in September 2017 twenty times and once over 500.
-She was unaware Resident #3's FSBS were above 400 in October 2017 sixteen times and FSBS results five over 500.
-The MAs sometimes texted the physician and the Nurse Practitioner the FSBS results Resident #3's.

Interview on 11/1/17 at 4:30 pm with a MA revealed:
-She had worked in the facility for one month.
-She was aware of the facility policy to contact the physician for FSBS greater than 400 and to contact 911 for FSBS over 500.
-She would document on the eMAR and in the chart notes if a resident FSBS was greater than 400.
-She would contact the MD if a FSBS was over 400, but all the FSBS she obtained from the resident were not over 400 or 500.
-She was unaware Resident #3's FSBS were above 400 for September 2017 twenty times and

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once over 500.
-She was unaware Resident #3's FSBS were above 400 for October 2017 sixteen times and five times the FSBS results were over 500.

Interview on 11/3/17 at 4:38 pm with the facility Nurse Practitioner (NP) revealed:
-She was aware Resident was a diabetic.
-She was not aware Resident #3's FSBS were above 400 in September 2017 twenty times and once over 500 or above 400 in October 2017 sixteen times and five times the FSBS results were over 500.
-She could not say if every time the FSBS for Resident #3 was over 400 the facility had contacted her.
-The MA did text her on occasion, but she could not recall if they texted her every time Resident #3's FSBS was over 400.
-Resident #3 was seen in the office for her diabetes in October 2017, "she is non-complaint with her diabetes."
-"The facility should call the office for any concerns or problems with the residents, the facility may have contacted the office."

Telephone interview on 11/6/17 at 8:45 am with a representative from the NPs office revealed:
-The office had a 24 hour answering service.
-The facility were supposed to contact the office for any concern for a resident.
-The office kept a call log when the facility contacted the office.
-The facility contacted the office for Resident #3 twice in October 2017, and there was no contact in September 2017.

Interview on 11/6/17 at 12:30 pm with the Administrator revealed:
-She was aware Resident #3 was a diabetic.

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-She relied on the MAs to call when the FSBS for Resident #3 was over 400.
-She was not aware the FSBS for Resident #3 had been over 400 and 500 for October 2017 and August 2017.
-The facility policy was to contact the physician if the FSBS was over 400 and then follow the orders the MD had given.
-The MAs were to document the elevated FSBS on the eMAR and in the resident record.
-There was not a system in place for reviewing the eMAR for elevated FSBS and contacting the MD.
-She relied on the RCD and the MA to check FSBS and to contacted physician as needed.

2. Review of Resident #3's current hospital FL2 dated 7/17/17 revealed diagnoses included type 2 diabetes, hypertension, chronic kidney disease, and chronic and acute renal failure.

Review on 11/3/17 of Resident #3's record revealed:
-A subsequent signed physician order dated 9/29/17, " HH: PT abnormal gait, increased fall risk."
-There were no documented notes from Home Health (HH) or Physical Therapy (PT).

Interview on 11/6/17 at 9:46 am with Resident #3 revealed she had PT several years ago, but not recently.

Telephone interview on 11/6/17 at 4:00 pm with the HH agency revealed:
-An order was faxed by the facility to the office on 9/29/17 for Resident #3 to have a PT evaluation.
-The request for PT was forwarded to intake for approval.
-The PT was denied due to insurance purpose.

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D 273	Continued From page 35 -The office contacted the facility on 9/29/17 and informed them the PT had been denied for Resident #3. -"We do not contact the MD office when a denial is made, "It is the facility responsibility to contact the MD." Telephone interview on 11/8/17 at 8:25 am with Resident #3's physician's office revealed: -The facility had not contacted the office in regards to Resident #3 not getting the PT as ordered by the MD. -The HH agency had not contacted the office in regard to the denial of PT for Resident #3. -It was the facilities responsibility to follow the physician orders. Interview on 11/6/17 at 9:45 am with the Resident Care Director (RCD) revealed: -She was aware of the order dated 9/29/17 for Resident #3 to have a PT evaluation. -HH had denied the referral for PT due to insurance. -She could not recall contacting the MD for the denial of PT for Resident #3. Further review on 11/6/17 of Resident #3's record revealed: -The subsequent signed physician order dated 9/29/17 had additional documentation on the bottom of the order which was not present on 11/3/17. -The additional documentation, "Medicare will not cover PT visits." Interview on 11/6/17 at 12:30 pm with the Administrator revealed she relied on the RCD and the MA to follow up on orders and contact the MD as needed for resident concerns.	D 273		

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3. Review of Resident #2's current FL2 dated 08/03/17 revealed:
-Diagnoses included schizophrenia, alcoholism, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disease, and crohns disease.
-Physicians orders for levothyroxine 175 mcg daily (thyroid deficiency), Seroquel (manic depression/bipolar) 100mg at bed time, senna (stool softner) 8.6 once daily; and hydroxyz syrup 10mg as needed for anxiety/agitation.

Review of Resident #2's record revealed an order dated 08/09/17 for Prozac (obsessive-compulsive panic disorder) 20mg once daily, an order dated 09/11/17 for mirtazapine (depression) 30mg at bedtime, and Seroquel 300mg at twice daily.

Review of Resident #2's record revealed an order dated 08/31/17 for Clindamycin (bacterial infection) 300mg four times daily for 10 days, and Prolixin Decanoate (used to treat schizophrenia) inject 1.5 ML (37.5 mg) every 14 days.

Review of Resident #2's record revealed an order dated 10/2/17 that changed Seroquel 300mg to once daily at bedtime.

Review of Resident #2's record revealed an order signed by the physician on 09/28/17 to administer Resident #2's medications when he returned to the facility "if he was not drunk or suspected of drug use."

Review of Resident #2's August 2017 electronic Medication Administration Record (eMARS) revealed:
-An entry for Clindamycin 300mg four times daily for 10 days was scheduled for administration at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm, and

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documentation Resident #2 refused medications twice August 25, 26, 30, and 31, 2017, and once on August 27 and 28, 2017.
-An entry for Prozac 20mg once daily was scheduled for administration at 8:00 am, and documentation the resident refused or was not in the facility on August 11, 12, 13, 17, 18, 26, and 27, 2017.
-An entry for Levothyroxine 175 mcg once daily was scheduled for administration at 7:30 am, and documentation Resident #2 refused or was not in the facility on August 6, 11, 12, 17, 18, 26, 27, and 28, 2017.
-An entry for Seroquel (Quetiapine) 100mg was scheduled for administration at 8:00 am, and documentation the resident refused or was not in the facility on August 4, 10, 11, 15, 16, 17, 22, 23, 25, 28, and 29, 2017.
-An entry for Senna 8.6 mg was scheduled for administration at 8:00 am, and documentation Resident #2 refused or was not in the facility on August 11, 12, 13, 17, 18, 26, and 27, 2017.
-Documentation the resident was "LOA and hospital" August 30 and 31, 2017.

There was no documentation the facility had attempted to administer Resident #2's medications outside of the eMAR scheduled administration times or had followed-up with the physician to ensure medications could be administered when Resident #2 was in the facility.

Review of Resident #2's September 2017 eMARs revealed:
-An entry for Clindamycin 300mg four times daily for 10 days was scheduled for administration at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm, and documentation Resident #2 refused medications three times on September 1 and twice on September 2, 2017.

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D 273	Continued From page 38 -An entry for Prozac 20mg once daily was scheduled for administration at 8:00 am, and documentation the resident refused or was not in the facility on September 1, 4, 5, 8, 10, 16- 18, 22 - 26, 28, and 29, 2017. -An entry for Fluphenazine Decanoate 25 mg inject 37.5 mg was scheduled for administration every 14 days, and documentation Resident #2 refused on September 5, and 19, 2017. -An entry for Levothyroxine 175 mcg once daily was scheduled for administration at 7:30 am, and documentation Resident #2 refused or was not in the facility on September 1, 5, 7, 8, 14, 15, 16 -19, 22- 26, 28, and 29, 2017. -An entry for Mirtazapine 30mg at bedtime was scheduled for administration at 8:00 pm, and documentation the resident refused or was not in the facility on September 12, 14, 15, 16 -19, 22 - 26, 28, and 29, 2017. -An entry for Seroquel (Quetiapine) 100mg once daily was scheduled for administration at 8:00 pm, and documentation the resident refused or was not in the facility on September 1-10, 2017. -An entry for Seroquel 300mg twice daily was scheduled for administration at 8:00 am and 8:00 pm, and documentation the medication was refused or not administered at 8:00 am on September 16, 17, 18, 22-26, and 28-30, 2017. -Documentation the medication was not administered at 8:00 pm on September 12, 14, 15, 17-27, 29 and 30, 2017. -An entry for Senna 8.6 mg was scheduled for administration at 8:00 am, and documentation Resident #2 refused medications or was out of the facility on September 1, 4, 5, 8, 10, 16, 17, 22 - 26, 28, and 29, 2017. Review of Resident #2's nurse notes revealed: -On 09/24/17 facility staff documented Resident #2 returned to the facility at 1:30 am and	D 273		

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medications were administered.

Review of Resident #2's September 2017 eMARs dated 09/24/17 revealed staff documented Resident #2 "REFUSED" am and pm medications.

Review of the facility's 15-minute checks for Resident #2 dated 09/24/17 revealed staff documented Resident #2 was out of the facility "OOF" from 12:00 am to 7:00 am (7 hours) and from 1:00 pm on 09/24/17 until 7:00 am on 09/25/17.

There was no other documentation the facility had attempted to administer the medications outside of the eMAR scheduled administration times or had contacted the resident's physician to seek approval to administer the medications whenever Resident #2 was in the facility.

Review of Resident #2's October 2017 eMARs revealed:
-An entry for Prozac 20mg once daily was scheduled for administration at 8:00 am, and documented the resident refused medications or was out of the facility on October 4, 7, 9, 10, 11, 13, 14, 16-18, 23, and 29, 2017.
-An entry for Levothyroxine 175 mcg once daily was scheduled for administration at 7:30 am, and documentation the resident refused medications or was out of the facility on October 7, 9, 10, 11, 13, 14, 15, 16, 17, 23, and 29, 2017.
-An entry for Mirtazapine 30mg at bedtime was scheduled for administration at 8:00 pm, and documentation the resident refused medications or was out of the facility on October 1-14, 16, 17, 19-22, 24, 25, 27, 28, 30, and 31, 2017.
-An entry for Seroquel (Quetiapine) 300mg twice daily was scheduled for administration at 8:00 am

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and 8:00 pm, and documentation the resident refused medications or was out of the facility on October 1, 2, 2017.
-An entry for Seroquel 300mg at bedtime was scheduled for administration at 8:00 pm, and documentation the resident refused medications or was out of the facility on October 2-14, 16, 17, 19-22, 24, 25, 27, 28, 30 and 31, 2017.
-An entry for Senna 8.6 mg once daily was scheduled for administration at 8:00 am, and documentation Resident #2 either refused medications or was out of the facility on October 4, 7, 9-11, 13, 14, 16-18, 23, and 29, 2017.

Further review of Resident #2's August, September, and October 2017 eMARs revealed:
-The majority of Resident #2's medications were ordered once daily.
-There were no documented attempts to administer the medications outside times scheduled on the eMARs or within the 24 hour period.

Review of Resident #2's nurse notes revealed:
-A nurses note dated 10/07/17 (no time - signature by third shift staff) "Res (Resident #2) refused meds, Res was asked 3 different time if Res still wanted to take them all times Res refused." The eMARs documented "R" for am medications. On 10/07/17 staff documented on the 15-minute check sheet Resident #2 was "OOF" from 12:00 am to 7:00 am.
-Nurses note dated 10/14/17 (no time - signature by third shift staff) "Res (Resident #2) refused meds. Res was asked three times if he wanted to take his night meds. res stated they made him sleepy - Res refused all times." On 10/14/17 eMARs staff documented Resident #2 was LOA - out of the facility for am and pm medications.

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D 273	Continued From page 41 Review of Resident #2's record revealed there was no other documentation facility staff had contacted the resident's physician to seek approval to administer the medications regardless of the time Resident #2 returned to the facility. Review of a lab report in Resident #2's record dated 9/20/17 revealed: -The resident's TSH (measures the thyroid stimulating hormone in the blood) level "19.71 H", normal range was (0.4-4.50 mIU/L). -The resident's T4 (used to help evaluate thyroid function) level was "0.6 L", normal range was (0.8-1.8 ng/dl). The high TSH level was reflective of Resident #2 not receiving his Levothyroxin. Interview on 11/02/17 at 9:03 am with Resident #2's primary care physician revealed: -He was aware Resident #2 was in and out of the facility a lot. -He expected facility staff to administer the resident's medications whenever the resident was in the facility regardless of the time the resident returned. Interview on 11/02/17 at 10:45 am with the Administrator revealed: -In September 2017 she informed staff if a resident came back after the medication administration time scheduled on the eMARs, they were to call the physician to ask if it was okay to give the resident's medications late. -It was the facility's policy if a resident missed 3 dosages of medications or refused three dosages of medications the physician was to be notified. -She expected staff to document the notification. -There was no system in place to ensure the policy was followed.	D 273		

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D 273	Continued From page 42 Interview with the contracted pharmacist on 11/03/17 at 4:02 pm and 11/06/17 at 10:41 am revealed: -Resident #2's medications, with the exception of the as needed medication were cycle filled, meaning every month the resident's medications were automatically refilled and dispensed without the facility calling to request a refill. -If medications were not used they were sent back to the pharmacy. No credit was given for medication opened or partially used. -Levothyroxine (Synthroid) was dispensed on 9/26/17 and 10/27/17, 30 tablets were dispensed each time. -Seroquel was not filled in October 2017 due to a new order on 9/26/17 that changed the Seroquel to 300mg twice daily, 60 tablets were dispensed. An order changed the medications again on 10/2/17 to 300mg at bedtime, 30 tablets were dispensed. -The facility should have had several of these medications left due to the order change. -Mirtazapine (Remeron) was filled 9/27/17 and 10/27/17, 30 tablets were dispensed each time. -Prozac was filled 9/26/17 and 10/27/17, 30 tablets were dispensed each time. -Resident #2's medications were ordered once daily could be administered any time within a 24 hour period, however some medications had specifics regarding administration. -For example: "Levothyroxine had to be administered with food. -If facility staff was going to administer this medication at 12:00 am or whatever time they had to make sure the resident ate something before consuming the medication." -Missing dosages of Levothyroxine prohibited the medication effectiveness and would cause a deficiency with harmful side effects. -Medications like Prozac should not be stopped	D 273		

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abruptly or dosage missed as this medication had withdrawal side effects, like agitation and irritability.
-Being inconsistent administering this medication limited the benefits of the medication.
-Seroquel (quetiapine) was a antipsychotic medications used for depression and can decrease hallucinations. If not consistently consumed there could be reoccurrences of symptoms (see hospital reports).
-Remeron (mirtazapine) was also an antidepressant used to treat irritability and depression. It will not be as effective if not taken as ordered, meaning the individual will still have the same symptoms of depression (see hospital reports).
-Most medications worked better if taken at the same time every day.
-It was common for facility's to schedule medications in a way that was convenient to their schedule, but medications ordered once daily can be administered anytime within a 24 hour period.

Interview on 11/03/17 at 3:30 pm with the second shift MA revealed:
-If Resident #2 was not in the facility when she administered medications, she waited one more hour past the scheduled administration time to see if the resident showed up.
-If the resident returned more than one hour past the scheduled administration time she did not administer the resident's medications, because "it was against the law" to administer medications more than one hour after the scheduled medication time.
-Resident #2 sometimes came back 2 or more hours past the scheduled medication time.
-She had not contacted Resident #2's physician or the physician assistant to see if it was okay to administer the medications more than one hour

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D 273	Continued From page 44 past the scheduled medication time. Interview on 11/02/17 at 12:10 pm with the Physician Assistant (PA) (mental health) revealed: -She was aware the resident left the facility and sometimes was gone for days. -She was not aware the resident was in and out of the facility and medications were not administered because the resident returned outside of scheduled administration time. -She wanted staff to give the resident's medications as much as possible, she wanted Resident #2's medications administered whenever the resident returned back to the facility. -If facility staff had called her to inform the resident was returning to the facility outside of scheduled medication times she would have informed staff to administer the medications regardless of the time Resident #2 returned to the facility. -For example: "if Resident #2 missed 8:00 pm scheduled medications and returned to the facility at 2:00 am or later she wanted medications administered." -No one at the facility had ever contacted her regarding administering Resident #2's medications when the resident returned to the facility, regardless of the scheduled medication time. -She expected facility to administer the resident's medications when the resident was at the facility regardless of the time. -Resident #2 did not make good decisions, but that was not her call to make sure the resident had a guardian to make decisions for him. -Her last two visits (September and October 2017) at the facility Resident #2 was out of the facility and she had informed facility staff if the resident was not there for her next visit she was	D 273		

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not going to reorder the resident's medications.
-She was aware Resident #2 was in and out of the facility or refused Levothyroxin due to being "high" or intoxicated.
-Resident #2's last TSH level was high, so today she ordered another TSH level.

Interview on 11/02/17 at 11:49 am with the physician assistant nurse (mental health) revealed:
-The PA was in the facility 4 weeks ago on 10/04/17 and Resident #2 was not in the building.
-The previous month when the PA was there to see Resident #2 he was not in the building.
-On 10/04/17 the PA told facility staff if the resident was not there during her next visit (11/02/17) she would not refill the resident's medication.
-She usually accompanied the PA when visiting the facility.
-To her knowledge no one at the facility had contacted the PA regarding administering Resident #2's medications missed outside of the scheduled administration times.
-She was able to see notes from her computer and did not see where facility staff called the office to inquire if it was okay to administer medications outside of scheduled administration times.

Interview on 11/03/17 at 5:06 pm with third shift MA/PCA revealed:
-Each month Resident #2's medications were cycle filled.
-When the new medications were delivered she checked them with the eMARs and removed the unused medications from the medication cart.
-She sent unused medications back to the pharmacy.
-Each month Resident #2 always had "a lot" of

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unused medications.
-She documented the unused medication on the facility's "Medication Disposition Record (MDR).
-She documented the entries on 09/24/17, 10/07/17, 10/14/17, but was unable to recall the specifics of the entries.

Review of the facility's MDR dated September 3, 2017 revealed Resident #2 had the following medications left from August 2017:
-Prozac 20mg - 20 tablets left.
-Levothyroxine 175 mcg - 10 tablets left.
-Seroquel 100mg - 9 tablets left.
-Senokot 8.6 mg - 9 tablets left.
-Seroquel 100mg (am) - 25 tablets left.
-Seroquel 100mg (pm) - 20 tablets left.
-Synthroid 137 mcg - 29 tablets left.

Review of the facility's MDR dated October 4, 2017 revealed Resident #2 had the following medications left from September 2017:
-Prozac 20mg - 15 tablets returned.
-Levothyroxine 175 mg - 18 tablets returned.
-Remeron 30mg - 16 tablets returned.
-Seroquel 300mg - 27 tablets returned.
-Senna 8.6 mg - 15 tablets returned.

Review of the facility's MDR dated November 2, 2017 revealed Resident #2 had the following medications left from October 2017:
-Prozac 20mg - 12 tablets returned.
-Levothyroxine 175 mcg - 11 tablets returned.
-Remeron 30mg - 26 tablets returned.
-Seroquel 300mg - 25 tablets returned.
-Senna 8.6 mg - 12 tablets returned.

C. Review of Resident #6's current FL2 dated 03/16/17 revealed: -Diagnoses included type II diabetes mellitus, chronic renal failure, asthma, chronic obstructive pulmonary disease,

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pulmonary hypertension, bipolar mood disorder, hyperlipidemia, leukocyte disorder, left ventricular hypertrophy, psychosis, eczema, and respiratory failure.
-Physician orders included asmanex (shortness of breath) 60 AER 220 mg 1 puff daily, aspirin (heart attack or stroke) 81mg every morning, carvedilol (hypertension) 3.125 mg twice daily, fingerstick blood sugars (FSBS) (monitor blood sugars) twice daily, clotrimazole cream (fungus infection) 1% once daily, colchicine (gout) 0.6 mg every morning, daliresp (severe COPD) 500 mcg every morning, Digoxin (congestive heart failure) 0.25 mg daily, escitalopram oxalate (depression and anxiety) 10mg once daily furosemide (hypertension) 80mg twice daily (7 hours apart), Levemir (control high blood sugars) inject 28 units subcutaneously at bedtime, Lisinopril 5mg twice daily, loratadine (allergies) 10mg twice daily, lorazepam (anxiety) 1 mg twice daily, magnesium 400 mg, daily, metformin (high blood sugars) 500mg every day, metolazone (high blood pressure) 5mg once daily, montelukast (asthma) 10mg at bedtime, pantorazole sodium (acid reflux) 40mg every morning, potassium chloride (potassium deficiency) 20meq, 2 tablets (40meq) every day with breakfast, Pravastatin (lower cholesterol) 40mg every morning, Risperidone (anxiety/depression) sol 1 mg/ml take 2-2 mg twice daily, Spiriva (shortness of breath) 18 mcg once daily, triamcinolon cream (eczema) 0.1% twice daily, and Albuterol nebulizer 0.083% every 4 hours as needed for wheezing.

Review of Resident #6's record revealed a physician order sheet that re-ordered the above medication on 08/04/17.

Review of Resident #6's August, September, October, and November 2017 electronic

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Medication Administration Records (eMARs) revealed documentation the resident refused medications on the following dates:
-Resident #6 refused medications 18 days out of 31 days, August 1, 2, 4, 6, 9, 13, 14, 17, 18, 19, 21, 22, 23, 25, 26, 27, 30, and 31, 2017.
-There was no documentation the physician was notified of the refusal of medications for the month of August 2017.
-Resident #6 refused medications 15 days out of 21 days, September 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, and 19, 2017. The resident was in the hospital from September 20-29, 2017.
-There was no documentation the physician was notified of the refusal of medications for the month of September 2017.
-Resident #6 refused medications 16 days out of 31 days, October 4, 5, 6, 7, 8, 9, 10, 14, 17, 18, 19, 20, 21, 25, 26, and 28, 2017
-There was no documentation the physician was notified of the refusal of medications for the month of October 2017.
-Resident #6 refused medications 1 out of 3 days, November 1, 2017.

Interview on 11/06/17 at 12:21 pm with the Resident Care Director (RCD) revealed:
-She had previously notified Resident #6's regarding the resident's refusal of medications in a text message she sent the physician on 10/05/17.
The text stated " ....(Resident #6) refused morning medications, but asked for Ativan at 1:35 pm, can I give Ativan?"
-The RCD did not specifically address the resident's refusal of medications.

Review of nurse notes revealed:
-On 10/08/17 the RCD documented Resident #6 refused medications and she had notified the

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physician and mental health.
-There was no follow-up documented from the physician or mental health that acknowledged the awareness that Resident #6 refused medications.

Interview on 11/06/17 at 11:40 am with Resident #6 revealed:
-She sometimes refused her medications.
-She refused her medications because she did not want to get out bed to eat breakfast.
-She had to eat something before she took her medications.
-If she did not eat before taking her medications, the medications would make her sick on her stomach.
-The medication aide did not offer her something to eat and did not give the medication later.
-She was not sure the physician was aware because the physician had not said anything to her regarding not taking her medications.

Interview on 11/06/17 at 2:30 pm with third shift MA revealed:
-She had worked at the facility for several months.
-She worked third shift hours between 11:00 pm to 7:00 am.
-She administered morning medications to Resident #6 between 6:00 and 7:00 am.
-Resident #6 sometimes had refused her medications.
-Sometimes, she was able to stay a little late, and attempted 1-2 more times to get Resident #6 to take her medications.
-If the resident still refused her medications she left a note for the RCD explaining Resident #6 refused morning medications.
-It was the facility's policy if a resident refused medications three times the physician was notified, she did not contact the physician but she

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left a note for the RCD.
-The RCD was responsible for contacting the physician.

Interview on 11/06/17 at 2:58 pm with a second third shift MA revealed:
-If Resident #6 refused medications on her shift she passed it on to the next shift.
-She never called, faxed, or texted a physician regarding the resident's refusal of medications.
-She was unable to recall the last time that Resident #6 refused medications on her shift.

Interview on 11/06/17 at 3:15 pm with the nurse at Resident #6's physician office revealed:
-According the notes, Resident #6 was last seen on 10/19/17 to receive an injection.
-There were no notes, faxes, or other communication in the records from the facility regarding Resident #6's refusal of medications.

_____

The facility failed notify the physician for 3 of 5 sampled residents (Resident #3, #2, and #6) Resident #3 regarding orders for elevated Finger Stick Blood Sugars (FSBS) and Physical Therapy (PT) order, Resident #2 missed medication with no follow up with the physician (#2), and refused medications with no follow up with the physician (#6). This failure was detrimental to the health and safety of the residents which constitutes an Unabated Type B Violation.

_____

The facility provided the following Plan of Protection on 11/01/17:
-Immediately the facility followed-up with Physician Assistant and received instructions that no matter what time Resident #2 returned to the facility she wanted staff to encourage the resident to take his medications.
-All Medication Aides will be inserviced to

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ROSEWOOD ASSISTED LIVING	721 NORTH MARIETTA STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 51 document all attempts to get Resident #2 to take his medication. -All Medication Aides will follow the facility's policy on refusals or missed dosages of medications by contacting the resident's primary care physician and the PA. -The RCD and Administrator will follow-up weekly by checking the eMARs and document in the resident's record. -If issues arise the RCD will contact both physicians and the Administrator will issue a notice. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 22, 2017.	D 273		
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	D 344		

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D 344	Continued From page 52	D 344		

Based on observations, interviews, and record reviews, the facility failed to assure for verification or clarification of orders for medications and treatments for 2 of 5 sampled residents (Resident #1 and #6) Resident #1 administered insulin without obtaining a Finger Stick Blood Sugar (FSBS) reading, and Resident #6's continued to administered medications that had been discontinued.

The findings are:

1. Review of Resident #1's current FL2 dated 1/18/17 revealed:
-Diagnoses include diabetes, hypertension, and renal insufficiency.
-An order for Lantus (a long acting insulin used to control blood sugars levels) insulin 26 units subcutaneous (SQ) in the am and Lantus 52 units SQ in the pm.
-An order for Humalog (a fasting acting insulin for reducing blood sugar levels) insulin 17 units SQ in the am and Humalog 15 units SQ in the pm.
-An order for Finger Stick Blood Sugars (FSBS) three times daily and inject SQ Humalog Sliding Scale insulin (SSI) as follows:
If FSBS is 200-249 give 5 units
If FSBS is 250-299 give 6 units
If FSBS is 300-349 give 8 units
If FSBS is 350-400 give 10 units
If FSBS is greater than 400 give 12 units

Review of Resident #1's record revealed:
-A Resident Register with an admission date of 1/11/17.
-A subsequent signed physician order dated 8/4/17 which included the following:
Lantus insulin 26 units every morning and Lantus 54 units at bedtime.
Humalog insulin 17 units SQ two times daily.

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D 344	Continued From page 53 FSBS three times daily and inject Humalog SSI as follows: If FSBS is 200-249 give 5 units If FSBS is 250-299 give 6 units If FSBS is 300-349 give 8 units If FSBS is 350-400 give 10 units If FSBS is greater than 400 give 12 units Review of the Resident #1's August 2017 electronic Medication Administration Record (eMAR) revealed: -A computer generated entry for Humalog SSI check blood sugar three times daily at 8:00 am, 12:00 pm, and at 5:00 pm inject per SSI as follows: If FSBS is 200-249 give 5 units If FSBS is 250-299 give 6 units If FSBS is 300-349 give 8 units If FSBS is 350-400 give 10 units If FSBS is greater than 400 give 12 units -A computer generated entry for Lantus insulin 26 units at 8:00 am and Lantus 54 units at 8:00 pm. -A computer generated entry Humalog insulin 17 units two times daily at 8:00 am and at 4:00 pm. -Documented entries FSBS range from August 1, 2017 to August 31, 2017 between 99 and 457. Review of Resident #1's record revealed: -A subsequent signed physician order dated 9/11/17, "Increase pm Lantus to 64 units daily." -A subsequent signed physician order dated 9/28/17, "D/C Humalog Start novolog inject 17 units SQ 1 time per day in the morning." Review of the Resident #1's September 2017 electronic Medication Administration Record (eMAR) revealed: -A computer generated entry for Humalog SSI check blood sugar three times daily and inject per SSI as follows:	D 344		

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D 344	Continued From page 54 If FSBS is 200-249 give 5 units If FSBS is 250-299 give 6 units If FSBS is 300-349 give 8 units If FSBS is 350-400 give 10 units If FSBS is greater than 400 give 12 units -A computer generated entry for Lantus insulin 26 units at 8:00 am and Lantus 54 units SQ at 8:00 pm. -A computer entry "DC'd" Lantus 54 units SQ 9/11/17 at 8:00 pm -A computer generated entry Humalog insulin 17 units SQ two times daily at 8:00 am and at 4:00 pm. -A computer entry "DC'd "Humalog 17 units SQ daily and the Humalog SSI on 9/28/17. -Documentation FSBS ranged from 99-400 September 1, 2017 to September 28, 2017. -There were no additional documentation for FSBS after 9/28/17 at 12:00 pm. Further review of Resident #1's the September 2017 eMAR revealed: -Documentation on 9/29 and 9/30 Novolog insulin 17 units was administered at 8:00 am. -Documentation on 9/29 and 9/30 Lantus insulin 26 units was administered at 8:00 am. -Documentation on 9/29 and 9/30 Lantus insulin 64 units was administered at 8:00 pm. -There were no documentation FSBS had been completed prior to administering insulin on 9/29 or 9/30. Review of Resident #1's the October 2017 eMAR revealed: -Documentation on October 1, 2017 through October 31, 2017 Novolog insulin 17 units was administered at 8:00 am. -Documentation on October 1, 2017 through October 31, 2017 Lantus insulin 26 units was administered at 8:00 am.	D 344		

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D 344	Continued From page 55 -Documentation on October 1, 2017 through October 31, 2017 Lantus insulin 64 units was administered at 8:00 pm. -There were no documented entry a FSBS had been completed prior to administering insulin on October 1, 2017 through October 31, 2017. Telephone interview on 11/3/17 at 3:15 pm and on 11/6/17 at 10:05 am with the facility contracted pharmacy revealed: -Resident #1's current insulin orders included the following: Novolog insulin 17 units daily Lantus insulin 26 units in the am Lantus insulin 64 units in the pm -The pharmacy received an order for Resident #1 from the facility on 9/28/17 to "DC Humalog". -At that time Resident #1 had an order for Humalog Sliding Scale Insulin (SSI) which include FSBS check three time daily, and another order Humalog 2 times daily scheduled. -When the pharmacy received the order to discontinue Humalog on 9/28/17 they discontinued all the Humalog orders, which include the FSBS three times daily. -"Not sure we have an order to discontinue the FSBS, but usually if the SSI is discontinued so are the FSBS." -The pharmacy was not responsible for contacting the physician to clarifying the orders, the facility was responsible for contacting the physician for clarifying orders. -The facility had not contacted the pharmacy in regard to clarifying the order or obtaining a new order for FSBS for Resident #1. -"Definitely Resident #1 should be getting FSBS checks since he is on insulin." Interview on 11/1/17 at 4:00 pm with the Resident Care Director (RCD) revealed:	D 344		

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D 344	Continued From page 56	D 344		

-She was the RCD and also the Medication Aide (MA) on first shift.
-She was responsible for reviewing and clarifying physician orders.
-She faxed new orders to the pharmacy, the pharmacy would fax the physician's office if there was a problem with an order.
-The MA on third shift was responsible for reviewing the monthly eMARs and comparing them to the orders.
-The MAs on second and third shift would call or text the RCD when they faxed orders to the pharmacy.
-"The Humalog insulin was discontinued by the physician for Resident #1 in September 2017."
-The FSBS were also discontinued then for Resident #1.
-She was aware Resident #1 had not been receiving a FSBS since 9/28/17.
-"I am not sure what happened, I know you cannot give insulin without checking a blood sugar."
-She had not contacted the physician's office to clarify Resident #1's order on 9/28/17.

Interview on 11/1/17 at 4:30 pm with a Medication Aide revealed:
-Her responsibility included administering medications and checking blood sugars at 8:00 pm.
-She had administered insulin to Resident #1 at 8:00 pm.
-There was not an order to check Resident #1's FSBS prior to giving the 8:00 pm insulin.
-"If there is not an order we cannot do a FSBS."

Interview on 11/6/17 at 2:55 pm with a second MA revealed:
-The RCD was responsible for reviewing orders and reviewing the resident records.

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D 344	Continued From page 57 -If she obtained a new order from the physician, she would fax it to the pharmacy, and then either call or text the RCD what she had done. -There was no written documentation the order had been processed after she texted or called the RCD. -She had administered insulin to Resident #1. -She had not obtained a FSBS on Resident #1 prior to administering the insulin. -Resident #1 did not have an order to check FSBS prior to giving insulin. -"I never thought about taking Resident #1's FSBS before I gave the insulin, I am not going to lie." Telephone interview on 11/8/17 at 8:25 am with Resident #1's Physician's office revealed: -The physicians and the nurse practitioners were not aware Resident #1 was not receiving FSBS from 9/28/17 until 11/6/17. -The facility contacted the office on 11/6/17 to obtain an order for FSBS for Resident #1. -The office was aware Resident #1 was receiving insulin daily. -The office received a recommendation on 9/28/17 from the pharmacy, "Humalog was no longer covered on Resident #1's insurance and please consider changing to Novolog. -The physician wrote an order dated 9/28/17 to DC Humalog Start novolog, inject 17 units SQ one time per day in the morning. -The physician had not written an order to DC FSBS. -"It's a safety issue, if the resident was given the insulin with a low blood sugar it could be detrimental to his health." -The facility had not contacted the office for clarification of the order written for Resident #1 on 9/28/17.	D 344		

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D 344	Continued From page 58 Review of Resident #1's record revealed a laboratory result for a hemoglobin A1C (a laboratory value to indicate diabetes) a result date 7/17/17 of 9.6 "high" reference range is less than 5.7. Interview on 11/6/17 at 10:42 am with the Administrator revealed: -The RCD was responsible for faxing new orders to the pharmacy. -The RCD was responsible for clarifying the new orders and comparing to the eMAR. -She was not aware Resident #1 had not received FSBS since 9/28/17. -She was aware Resident #1 was currently receiving insulin. -"How can they administer insulin and not know the FSBS." -She was unsure how the FSBS dropped off the eMAR. -"Staff knew better then to give insulin and not check a FSBS, what if it had been low when they gave the insulin." -All the MAs had an in-service on diabetic care last month in October 2017. -She would immediately conduct a meeting to find out what happened with Resident #1's FSBS. -She would immediately have the RCD call the physician's office and obtain order for FSBS for Resident #1. 2. Review of Resident #6's current FL2 dated 03/16/17 revealed: -Diagnoses included asthma, chronic obstructive pulmonary disease, and respiratory failure. -Physician orders included Spiriva (shortness of breath) 18 mcg once daily, and Asmanex (shortness of breath) 60 AER 220 mcg 1 puff daily.	D 344		

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D 344	Continued From page 59 Review of Resident #6's record revealed a physician's order sheet signed on 08/04/17 that re-ordered Spiriva 18 mcg once daily and Asmanex 60 AER 220 mcg 1 puff daily. Review of Resident #6's record revealed: -The resident was hospitalized from 09/20/17 through 9/29/17. -There was no documentation of a new FL2 or a hospital discharge summary report regarding changes, new or discontinued medications. Review of Resident #6's discharge summary report dated 9/29/17 revealed: -"Discontinue these medications" Asmanex 220 mcg (60 doses) Aerosol Powder breath activated 1 puff daily and Spiriva 18 mcg once daily. Review of Resident #6's September 2017 electronic Medication Administration Records (eMARs) revealed: -An entry for Asmanex 60 AER 220 mcg once daily was scheduled for administration at 6:00 am, and documented administered on September 30, 2017 at 6:00 am -An entry for Spiriva Handhaler 18 mcg once daily was scheduled for administration at 6:00 am, documented administered September 30, 2017 at 6:00 am. Review of Resident #6's October 2017 eMARs revealed: -An entry for Asmanex 60 AER 220 mcg once daily was scheduled for administration at 6:00 am, and documented administered 19 times from October 1- 31, 2017, the resident refused the medication 12 times. -An entry for Spiriva Handhaler 18 mcg once daily was scheduled for administration at 6:00 am, and documented administered 19 times from October	D 344		

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D 344	Continued From page 60 1-31, 2017, the resident refused the medication 12 times. Review of Resident #6's November 2017 eMARs revealed: -An entry for Asmanex 60 MER 220 mcg once daily was scheduled for administration at 6:00 am, and documented administered 3 times from November 1-3, 2017. -An entry for Spiriva Handhaler 18 mcg once daily was scheduled for administration at 6:00 am, and documented administered 3 times from November 1-3, 2017. Interview on 11/03/17 at 4:02 pm and 11/06/17 at 12:10 pm with the Resident Care Director (RCD) revealed: -When Resident #6 was discharged from the hospital on 9/29/17, she picked the resident up. -The hospital did not provide much paperwork. -The paperwork did not include a new a FL2 or discharge summary report with the listed medications that were changed, discontinued or continued. -She did not call the hospital and ask for the report because she did not think she could ask for the report. -She did not know Spiriva and Asmanex had been discontinued. -There were hand written scripts for new medications, but no prescriptions to discontinue medications. -She did not attempt to call the hospital and ask for the discharge medication list. Interview on 11/06/17 at 12:28 pm with the Administrator revealed: -The RCD knew the hospital should have sent a discharge summary report with a medication list. -She expected the RCD to call the hospital and	D 344		

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D 344	Continued From page 61 ask for the discharge summary report with the medication orders and paper work. -They called the hospital all the time and asked for missing documents when a resident was discharged. -She was unaware the RCD did not call to obtain the missing report. Interview on 11/06/17 at 11:48 am with the contract Pharmacist revealed: -The last order received for Spiriva was dated 5/8/17. -The medications was last filled on 11/01/17. -The last order he received for Asmanex was dated 5/8/17, and was last filled on 11/01/17. -The facility usually sent the pharmacy a medication discharge summary list from the hospital, they just had to make sure it was signed by the physician. -The pharmacy had not received a hospital discharge summary dated 9/29/17 for Resident #6. -The pharmacy had not received any orders to discontinue Spiriva or Asmanex. Interview on 11/03/17 at 3:43 pm with Resident #6 revealed: -She had asthma and chronic obstructive pulmonary disease. -She wore oxygen continuously and had inhalers that she used daily. -She was in the hospital in September 2017, but was unaware that some of her medications were discontinued. -As of this morning she was administered Spiriva and Asmanex, she did not think they were discontinued because facility staff gave her the medications daily. The facility failed to obtain clarification from the	D 344		

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D 344	Continued From page 62 prescribing practitioner for orders in regard to FSBS in which insulin administration for Resident #1 without monitoring FSBS from September 28, 2017 to November 3, 2017, and the facility failure to obtain Resident #6's hospital discharge summary report (list of medications) and continued to administer medications had been discontinued. The facility's failure was detrimental affecting the health and safety of the residents which constitutes a Type B Violation. The facility provided the following Plan of Protection on 11/06/17: -Immediately the RCD will contact the physician to clarify the order for obtaining FSBS for Resident #1. -The RCD will review all residents' records to assure clarification by comparing all orders to the eMAR. -The Administrator will ensure all resident records were reviewed by the RCD and were in-compliance with the rule areas for the next month and randomly thereafter. -A mandatory staff meeting by the Administrator was scheduled for 11/6/17 at 2:00 pm to discuss clarification of orders, documentation, diabetic education and infection control. -The RCD and the Administrator will put in place a system for new orders to be reviewed; all new orders will be faxed to the Administrator for review for the next 3 months and then as needed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 22, 2017.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 63 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure documentation of administration of medications as ordered by a licensed prescribing practitioner, for 1 of 5 residents (Resident #2) regarding failed attempts to administer medications when the resident was at the facility. The findings are: Review of Resident #2's current FL2 dated 08/03/17 revealed: -Diagnoses included schizophrenia, alcoholism, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disease, and crohns disease. -Physicians orders for levothyroxine 175 mcg daily (thyroid deficiency), Seroquel (manic depression/bipolar) 100mg at bed time, senna (stool softener) 8.6 ounces daily, and hydroxyz syrup 10mg as needed for anxiety/agitation. Review of Resident #2's record revealed an order dated 08/09/17 for Prozac (obsessive-compulsive panic disorder) 20mg once daily, an order dated	D 358		

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09/11/17 for mirtazapine (depression) 30mg at bedtime, and Seroquel 300mg at twice daily.

Review of Resident #2's record revealed an order dated 08/31/17 for Clindamycin (bacterial infection) 300mg four times daily for 10 days, and Prolixin Decanoate (used to treat schizophrenia) inject 1.5 ML (37.5 mg) every 14 days.

Review of Resident #2's record revealed an order dated 10/2/17 that changed Seroquel 300mg to once daily at bedtime.

Review of Resident #2's record revealed an order signed by the physician on 09/28/17 to administer Resident #2's medications when he returned to the facility "if he was not drunk or suspected of drug use."

Review of Resident #2's September 2017 electronic Medication Administration Records (eMARs) revealed medications not administered due to the resident being "OUT OF THE FACILITY/LOA (OOF) or REFUSED (R)" as follows:
-On 09/01/17 am and pm - OOF; 09/02/17 pm - OOF; 09/03/17 pm; 09/04/17 am and pm - OOF; 09/05/17 am - OOF; 09/06/17 pm - OOF; 09/07/17 am (Levothyroxine only) and pm - OOF; 09/08/17 am and pm - OOF; 09/09/17 pm - OOF; 09/10/17 am - OOF and pm - R; 09/12/17 pm - OOF; 09/14/17 am and pm - OOF; 09/15/17 am (OOF - Levothyroxine only) and pm - OOF; 09/16/17 am - OOF; 09/17/17 am - OOF; 09/18/17 am and pm - OOF; 09/19/17 am and pm - OOF; 09/20/17 pm - OOF; 09/21/17 pm - OOF; 09/22/17 am and pm - OOF; 09/23/17 am and pm - OOF; 09/24/17 am and pm - OOF; 09/25/17 am and pm - OOF; 09/26/17 am and pm - OOF; 09/27/17 pm - OOF; 09/28/17 am - OOF;

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09/29/17 am - OOF and pm -R; and 09/30/17 am (R - Quetiapine only) and pm - OOF.

Review of Resident #2's nurse notes revealed:
-On 09/24/17 facility staff documented Resident #2 returned to the facility at 1:30 am and medications were administered.

Review of the September 2017 eMARs revealed on 09/24/17 staff documented Resident #2 "REFUSED" am and pm medications.

Review of the facility's 15-minute check log for Resident #2 revealed on 09/24/17 staff documented Resident #2 was out of the facility "OOF" from 12:00 am to 7:00 am (7 hours) and from 1:00 pm on 09/24/17 until 7:00 am on 09/25/17.

According to the September 2017 eMARs out of 152 opportunities staff documented Resident #2 did not receive his medications 107 times with no documented attempts to administer the resident's medications throughout a 24 hour period.

Review of Resident #2's October 2017 eMARs revealed medications not administered due to the resident being "OUT OF THE FACILITY/LOA (OOF) OR REFUSED (R)" as follows:
-On 10/01/17 pm - R; 10/02/17 am - R and pm - OOF; 10/03/17 pm - OOF; 10/04/17 am - R and pm - OOF; 10/05/17 pm - R; 10/06/17 pm - OOF; 10/07/17 am - R and pm - OOF; 10/08/17 pm - OOF; 10/09/17 am and pm - OOF; 10/10/17 am and pm - OOF; 10/11/17 am and pm - OOF; 10/12/17 pm - OOF; 10/13/17 pm - OOF; 10/14/17 am and pm - OOF; 10/15/17 am -R (Levothyroxine only); 10/16/17 am - R and pm - OOF; 10/17/17 am and pm - OOF; 10/18/17 am - R; 10/19/17 pm - OOF; 10/20/17 pm - OOF;

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D 358	Continued From page 66 10/21/17 pm - OOF; 10/22/17 am - OOF; 10/23/17 am - OOF; 10/24/17 pm - R; 10/25/17 pm - R; 10/27/17 - OOF; 10/28/17 pm - OOF; 10/29/17 am - OOF; 10/30/17 pm - OOF; and 10/31/17 pm - OOF. According to the October 2017 eMARs out of 153 opportunities staff documented Resident #2 did not receive his medications 90 times with no documented attempts to administer the resident's medications throughout a 24 hour period. Observation on 11/02/17 at 4:35 pm of Resident #2's medications on hand at the facility revealed: -Levothyroxine 175 mcg once daily was available for administration. -Seroquel 100mg at bedtime was available for administration. -Senna 8.6 mg once daily was available for administration. -Mirtazapine 30mg at bedtime was available for administration. -Prozac 20mg once daily was available for administration. -All the above medications were cycle filled and had a dispense date of 11/02 with 30 tablets dispensed available on the medication cart. Review of a lab report in Resident #2's record dated 9/20/17 revealed: -The resident's TSH (measures the thyroid stimulating hormone in the blood) level "19.71 H", normal range was (0.4-4.50 mIU/L). -The resident's T4 (used to help evaluate thyroid function) level was "0.6 L", normal range was (0.8-1.8 ng/dl). The high TSH level was reflective of Resident #2 not receiving his Levothyroxine. Review of Resident #2's hospital report dated 10/11/17 revealed:	D 358		

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D 358	Continued From page 67 -At 12:22 am Resident #2 stopped EMS at the local gas station stating he needed help. -Resident #2 wanted a medical and psychiatric evaluation because he was hearing things, he believed animals, jets, and cars were speaking to him. Review of Resident #2's hospital report dated 10/29/17 revealed: -At 2:33 am on 10/29/17 Resident #2 flagged down the EMS. -He told them he needed psychiatric treatment, he was hearing voices, but could not understand what they were saying. -He heard audiovisual hallucinations, he saw aliens everywhere, but then denied hearing voices. -Resident #2 smelled of alcohol, and expressed homicidal and suicidal ideation, "he is inattentive." Interview on 11/02/17 at 9:03 am with Resident #2's primary care physician revealed: -He was aware Resident #2 was in and out of the facility a lot. -He expected facility staff to administer the resident's medications whenever the resident was in the facility regardless of the time the resident returned. Interview on 11/02/17 at 10:45 am with the Administrator revealed in September 2017 she informed staff if a resident came back after the medication administration time scheduled on the eMARs, they were to call the physician to ask if it was okay to give the resident's medications late. This was verbal instructions and there was nothing written in the policy. Interview on 11/02/17 at 9:56 am with the Resident Care Director (RCD) revealed:	D 358		

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D 358	Continued From page 68 -When it was time for the medications Resident #2 was usually out of the facility. -They did not give the medication when the resident returned. -She was aware that Resident #2 had an order to administer the medications when the resident returned to the facility. -She did not think it was an on-going order because the physician wrote the order during a visit when Resident #2 refused to see the physician and left the facility. -She wrote the order and the physician signed it. -She had never clarified the order with Resident #2's physician. Interview with the contract pharmacist on 11/03/17 at 4:02 pm and 11/06/17 at 10:41 am revealed: -Resident #2's medications, with the exception of the as needed medication were cycle filled, meaning every month the resident's medications were automatically refilled and dispensed without facility calling to request a refill. -If medications were not used they were sent back to the pharmacy. -No credit was given for medication opened or partially used, the medications were destroyed. -Levothyroxine (Synthroid) was dispensed on 9/26/17 and 10/27/17, 30 tablets were dispensed each time. -Seroquel was not filled in October 2017 due to a new order on 9/26/17 that changed the medication to 300mg twice daily, 60 tablets were dispensed. An order changed the medications again on 10/2/17 to 300mg at bedtime, 30 tablets were dispensed. -The facility should have had several of these medications left due to the order change. -Mirtazapine (Remeron) was filled 9/27/17 and 10/27/17, 30 tablets were dispensed each time.	D 358		

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D 358	Continued From page 69 -Prozac was filled 9/26/17 and 10/27/17, 30 tablets were dispensed each time. -Resident #2's medications were ordered once daily and could be administered any time within a 24 hour period. -Missing doses of Levothyroxine decreased the medication effectiveness and could cause a deficient thyroid hormone level which caused harmful side effects. -Medication like Prozac should not be stopped abruptly or dosages missed as this medication had withdrawal side effects, like agitation and irritability. -Being inconsistent administering this medication limited the benefits of the medication. -Seroquel (Quetiapine) was a antipsychotic medications used for depression and can decrease hallucinations. If not consistently consumed there could be reoccurrences of symptoms (see hospital reports). -Remeron (mirtazapine) was also an antidepressant used to treat irritability and depression. It will not be as effective if not taken as ordered, meaning the individual would still have the same symptoms of depression (see hospital reports). -Most medications worked better if taken at the same time every day. -It was common for facilities to schedule medications in a way that was convenient to facility staff schedule, but medications ordered once daily could be administered anytime within a 24 hour period. Interview on 11/03/17 at 3:30 pm with the second shift Medication Aide (MA) revealed: -If Resident #2 was not in the facility when she administered medications, she waited one more hour past the scheduled administration time to see if the resident showed up.	D 358		

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D 358	Continued From page 70 -If the resident returned more than one hour past the scheduled administration time she did not administer the resident's medications, because "it was against the law" to administer medications more than one hour after the scheduled medication time. -Resident #2 sometimes came back 2 or more hours past the scheduled medication time. -She had not contacted Resident #2's physician or the physician assistant to see if it was okay to administer the medications more than one hour past the scheduled medication time. Interview on 11/02/17 at 12:10 pm with the Physician Assistant (PA) (mental health) revealed: -She was aware that sometimes Resident #2 was out of the facility for extended periods of time. -She was unaware sometimes the resident returned to the facility outside of the scheduled medication administration time and medications were not being administered because they were outside of the scheduled time frame. -She wanted staff to give Resident #2 his medications as much as possible, she wanted Resident #2's medications administered whenever the resident returned back to the facility. -For example: If Resident #2 missed the 8:00 pm scheduled medications and returned to the facility at 2:00 am or later she wanted the medications administered. -She expected facility to administer the resident's medications when the resident was at the facility regardless of the time. -"Resident #2 did not make good decisions, but that was not her call to make sure the resident had a guardian to make decisions for him." Interview on 11/03/17 at 5:06 pm with third shift Medication Aide/Personal Care aide (MA/PCA)	D 358		

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D 358	Continued From page 71 revealed: -Resident #2 was out of the facility a lot during her shift. -Sometimes she attempted to administer Resident #2's medications when the resident returned to the facility, or offer refused medications more than once, but she did not document the date and time of each attempt. Interview on 11/06/17 at 4:06 pm with the second behavior health agency revealed: -The agency had recently received approval to provide behavioral services to Resident #2. -She had been to the facility twice and only had seen Resident #2 once because he was not in the facility when she visited. -Resident #2 informed her that he heard voices and had a drug and alcohol addiction. -The resident told her that he consumed alcohol and drugs because he was depressed, however the alcohol and drugs caused him to be further depressed. Based on observations, interviews, and record reviews, the inconsistent administration of medications resulted in less effectiveness of antidepressant, antipsychotic, and thyroid deficiency, which resulted in high TSH levels, continued depression and hallucinations. The facility's failure to administer medications as ordered was detrimental to the health and safety of Resident #2 and constitutes a Type B Violation. The facility submitted a Plan of Protection on 11/02/17: -Today Resident #2's physician was notified to clarify medications being administered when the resident returned to the facility. -Immediately, RCD will fax the order from the physician to the pharmacy to have the order	D 358		

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D 358	Continued From page 72 transcribed on the eMARs. -All Medication Aides will be in-serviced to make them aware to administer Resident #2's medications regardless of the time and documented all attempts. -The RCD and Administrator will follow-up weekly to check all eMARs and document any issues or concerns and the RCD will notify the primary care physician and the psych-physician of the issues and the Administrator will issue a notice. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 22, 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 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	D 367		

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administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure medication administration record (MAR) shall be accurate and included Finger Stick Blood Sugars (FSBS) omissions, for 1 of 5 sampled residents (Resident #3,) ordered FSBS four times daily.

The findings are:

A. Review of Resident #3's current hospital FL2 dated 7/17/17 revealed:
-Diagnoses included type 2 diabetes, hypertension, chronic kidney disease, and chronic and acute renal failure.
-An order to check and record FSBS three times daily and at night.

Review of a physician's order dated 08/04/17 for Resident #3 revealed an order to check FSBS three times daily and at night.

Review of the Resident #3's August 2017 Electronic Medication Administration Record (eMAR) revealed:
-A computer generated entry for Humalog SSI as follows:
Check BS before meals and at bedtime inject insulin per SSI.
If BS is 150-200 give 2 units
If BS is 201-250 give 4 units
If BS is 251-300 give 6 units
If BS is 301-350 give 8 units
If BS is 351-400 give 10
Greater than 400 give 12 units
-There were documented entry times for FSBS at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm.
-On August 2 through August 4 there were no

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D 367	Continued From page 74 FSBS documented at 8:00 pm. -On August 7 through August 18 there were no FSBS documented at 8:00 pm. -On August 21 through August 28 there were no FSBS documented at 8:00 pm. -On August 28 there was no documented FSBS for 8:00 pm. -On August 30 and 31 there were no documented FSBS for 8:00 pm. -On the eMAR exception documentation "Resident Refused" was documented for the above dates for FSBS at 8:00 pm. -There was no documentation on the eMAR notes the MD had been notified Resident #3 had refused the FSBS. Review of the Resident #3's September 2017 eMAR revealed: -A computer generated entry for Humalog SSI as follows: Check BS before meals and at bedtime inject insulin per SSI. If BS is 150-200 give 2 units If BS is 201-250 give 4 units If BS is 251-300 give 6 units If BS is 301-350 give 8 units If BS is 351-400 give 10 Greater than 400 give 12 units -There were documented entry times for FSBS at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm. -On September 1 there was no FSBS documented at 8:00 pm. -On September 6 through September 8 there were no FSBS documented at 8:00 pm. -On September 11 and 12 there were no FSBS documented at 8:00 pm. -On September 14 and 15 there were no FSBS documented at 8:00 pm. -On September 18 through September 23 there were no FSBS documented at 8:00 pm.	D 367		

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D 367	Continued From page 75 -On September 25 through September 29 there were no FSBS documented at 8:00 pm. -On the eMAR exception documentation "Resident Refused" was documented for the above dates for FSBS at 8:00 pm. -On the eMAR exception documentation for September 1, 2017, "Hospital" was documented. -On the exception documentation for September 2017 "Resident Refused" was documented for the additional above dates for FSBS at 8:00 pm. -There was no documentation on the eMAR notes the MD had been notified Resident #3 had refused FSBS. Review of the Resident #3's October 2017 eMAR revealed: -A computer generated entry for Humalog SSI as follows: Check BS before meals and at bedtime inject insulin per SSI. If BS is 150-200 give 2 units If BS is 201-250 give 4 units If BS is 251-300 give 6 units If BS is 301-350 give 8 units If BS is 351-400 give 10 Greater than 400 give 12 units -There were documented entry times for FSBS at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm. -On October 2, there was no FSBS documented at 8:00 pm. -On October 4 through the 6, there were no FSBS documented at 8:00 pm. -On October 9, 11, and 13 there was no FSBS documented at 8:00 pm. -On October 17 through 21 there were no FSBS documented at 8:00 pm. -On October 26 and the 27, there were no FSBS documented at 8:00 pm. -On the exception documentation for October 2017 "Resident Refused" was documented for	D 367		

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the above dates for FSBS at 8:00 pm.
-There was no documentation on the eMAR notes the physician had been notified Resident #3 had refused the FSBS.

Review on 11/3/17 of the October 2017 Accident / Incident reports for Resident #3's record revealed:
-Documentation on 10/10/17 Resident #3 FSBS was 464, "insulin was given, and rechecked 2 hours was reading 140."
-Documentation on 10/21/17 Resident #3 FSBS was 498, "gave insulin, rechecked FSBS 2 hours 135, MD was called."
-Documentation on 10/23/17 Resident #3 FSBS was 407, "insulin was given and reading 2 hours after 105, MD called and guardian."
-Documentation on 10/27/17 Resident #3 FSBS was 414, "insulin, recheck 2 hours reading at 122, MD called and guardian notified."

Further review of Resident #3's October 2017 eMAR revealed none of the elevated FSBS documented on the incident reports for October 2017 were documented on Resident #3's eMAR.

Telephone interview with a representative from Resident #3's Physician office on 11/8/17 at 8:25 am revealed:
-The doctor or the Nurse Practitioner were not aware Resident #3's FSBS were not obtained as ordered by the MD.
-The facility had not contacted the MD office to discuss Resident #3's refusal of the FSBS in August, September, or October 2017.
-The facility was to call the office any time "24/7", with all issues or problems concerning the residents.

Interview on 11/3/17 at 4:50 pm with Resident #3

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revealed:
-She had been a diabetic for a long time.
-The facility took her FSBS four times a day.
-Her FSBS "ran high" a lot.
-She refused her BS sometimes, "I get tired of being stuck."
-She was unaware if the facility contacted the MD when she refused her FSBS.

Interview on 11/1/17 at 4:00 pm with the Resident Care Director (RCD) revealed:
-She was the RCD and also the first shift Medication Aide (MA).
-She was aware the facility had a policy, "If a resident refused meds for 3 consequetive days the MA are to call the MD."
-She was not aware Resident #3 had refused multiple times FSBS at 8:00 pm in August, September and October 2017.
-There was not a system in place for reviewing the eMAR for "holes" monthly.
-Third shift MA were responsible for comparing the eMAR to new orders.
-The MAs sometimes texted the physician and the NP for Resident #3's FSBS.

Interview on 11/1/17 at 4:30 pm with a MA revealed:
-She had worked in the facility for one month.
-She would document on the eMAR and in the record notes if a resident refused a med or FSBS
-She would contact the physician if the resident refused more than "3 days in a row."
-Resident #3 had always let the MA obtain her FSBS at 4:30 pm when she worked.

Interview on 11/3/17 at 4:38 pm with the facility Nurse Practitioner (NP) revealed:
-She was aware Resident was a diabetic.
-She could not say if the facility had contacted her

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every time the FSBS were not obtained at 8:00 pm for Resident #3 in August, September and October 2017.
-The MAs and the RCD had texted her on occasions, but she could not recall if they texted her every time Resident #3's did not have a FSBS obtained in August, September or October 2017.
-Resident #3 was seen in the office for her diabetes in October 2017, "She is non-complaint with her diabetes."
-"The facility should call the office for any concern or problems with the residents, the facility maybe contacted the office."

Telephone interview on 11/6/17 at 8:45 am with a representative from the NP office revealed:
-The office had a 24 hour answering service.
-The facility were supposed to contact the office for any concern for a resident.
-The office kept a call log when the facility contacted the office.
-The facility contacted the office for Resident #3 twice in October 2017, and there were no contacts in September 2017.

Interview on 11/6/17 at 10:42 am and at 3:39 pm with the Administrator revealed:
-The facility policy for the omission of medications and treatments were if the resident missed 3 consecutive days of refusing medications or treatment the MA were to contact the physician.
-The RCD was responsible for assuring the MA completed the eMAR and documented correctly in the record.
-The RCD was responsible for comparing new orders to the eMAR.
-All the MAs had an in-service on diabetic care last month in October 2017.
-There was no current system in place to assure the MAs were contacting the MD for refusal of

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D 367	Continued From page 79 medications after 3 consecutive days. -The RCD was also a MA working full time in the facility, she would pull the RCD off the medication cart to assure the RCD had time to complete the tasks the RCD was responsible for.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Supervision, Health Care referral and follow-up, Medication Orders, Medication Administration, Infection Prevention Requirements, and Implementation. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 1 of 3 residents (#2) sampled residents leaving the facility sleeping outside.[Refer to tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type A2 Violation)].	D912		

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D912	Continued From page 80 B. Based on interview and record review, the facility failed to notify the physician for 2 of 5 sampled residents (Resident #3, #2, and #6) Resident #3 regarding orders for elevated Finger Stick Blood Sugars (FSBS), Physical Therapy (PT) order, Resident #2 failed to administer medications or had followed-up with the physician, Resident #6 refused medications. [Refer to tag 273,10A NCAC 13F .0902(b) Health Care (Unabated Type B Violation)]. C. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up to meet the routine and acute healthcare needs for 2 of 5 sampled residents (Resident #1 and #6) Resident #1 administered insulin without obtaining a Finger Stick Blood Sugar (FSBS) reading, and Resident #6's continued to administered medications that had been discontinued. [Refer to tag 344, 10A NCAC 13F .1002(a) Medication Orders (Type B Violation)]. D. Based on observations, interviews, and record reviews, the facility failed to assure documentation of administration of medications as ordered by a licensed prescribing practitioner, for 1 of 5 residents (Resident #2) regarding failed attempts to administer medications when the resident was at the facility. [Refer to tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. E. 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 between residents for 6 of 6 sampled residents, (#1, #3, #6, #8, #9, and #10). [Refer to tag 932, G.S. 131D-4.4A Adult	D912		

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D912	Continued From page 81 Care Home Infection Prevention Requirements (Type B Violation)]. F. Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to housekeeping and furnishings, physical environment, supervision, health care, medication administration, medications orders clarification, pharmaceutical care, and infection prevention requirements.[Refer to tag 980, G.S. 131D-25 Implementation (Unabated Type A2 Violation)].	D912		
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	D932		

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D932	Continued From page 82 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, 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 glucometers between residents for 6 of 6 sampled residents, (#1, #3, #6, #8, #9, and #10). The CDC (Center for Disease Control and Prevention) guidelines for infection control recommends blood glucose monitoring devices (glucometers) should not be shared between	D932		

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residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.

Review of the owner's manual for Brand A glucometer revealed:
-The glucometer should only be used by a single patient and it should not be shared.
-Do not share them with anyone.
-"Do not use on multiple patients!"
-All parts of the kit are considered bio hazardous and can potentially transmit infectious disease, even after you have performed cleaning and disinfection.
-Users should wash hands thoroughly with soap and water after handling the meter, lancing device, or test strips.
-One person can poses risk for transmitting blood-borne pathogens.

Telephone interview on 11/03/17 at 12:38 pm with the glucometer Brand A manufacturer revealed:
-The machine was designed for one person use, by a single individual.
-The machine should not be shared with multiple patients.
-The machine should be disinfected by approved germicidal wipes between after each use.

Interview on 11/03/17 at 2:24 pm with the Administrator revealed:
-None of the residents in that facility had a communicable disease, HIV or hepatitis B or C.
-She was aware how to access blood sugars readings from the glucometers.
-The facility did not have a system of checking glucometers readings and documented blood

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D932	Continued From page 84	D932		

sugars on the MARs to ensure they matched.
-Weekly, the glucometers were wiped down using alcohol.
-When medication aides checked blood sugars the glucometers were right there on the cart, so Medication Aides should not be sharing glucometers between residents.
-The machines were for single one person use single use that was why they were labeled with each resident's name.
-Staff should not be sharing glucometers between residents.
-The facility had bleach disinfectant wipes, but did not have EPA approved disinfectant wipes because the glucometers were not to be shared between residents.
-She thought she had a certificate that approved her testing fingerstick blood sugars.
-She was unable to locate the certificate, so she registered for a new certificate.
-She checked the MARs to make sure the right amount of insulin was administered, but she did not check glucometers with MARs.

Review on 11/3/17 between 1:50 pm and 2:15 pm of 22 resident records revealed one resident (#9) who received FSBS had a diagnoses of hepatitis B a blood borne pathogen disease.

Interview with the Resident Care Director (RCD) on 11/03/17 at 11:15 am revealed:
-She worked as a Medication Aide (MA) and also was the RCD.
-The facility policy was for each resident to have a glucometer assigned to the resident, and used only on the assigned resident.

Review of three sampled MAs staff records revealed all three had successfully completed the state approved mandatory annual infection

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D932	Continued From page 85	D932		

control training with additional diabetic training care of the diabetic resident on 9/9/17 signed by a Registered Nurse.

Observation on 11/03/17 at 10:30 am of the facility's medication cart revealed:
-A white basket on top of the medication cart that had Brand A glucometers, none of the glucometers were in a pouch covering.
-There were 13 diabetic residents currently residing in the facility who required blood sugar monitoring.
-Each resident had their own Brand A glucometer that was labeled with the resident's name.
-There was 1 glucometer in the basket which was not labeled with a resident's name.
-Review of 6 of 14 glucometer blood sugars readings had current readings in the glucometers had memory that did not match documented blood sugar readings as follows:

1. Review of Resident #1's current FL2 dated 1/18/17 revealed:
-Diagnoses include diabetes.
-An order for Finger Stick Blood Sugars (FSBS) three times daily.

Review of Resident #1's record revealed a Resident Register revealed an admission date of 1/11/17.

Review of Resident #1's record revealed a signed physician order. "D/C Humalog start novolog inject 17 units subcutaneous (SQ) one time daily in the morning.

Review of Resident #1 eMAR for September 2017, October 2017, and November 2017, revealed there were no documented entry for FSBS after 9/28/17 at 12:00 pm.

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D932	Continued From page 86 Observation of Resident #1's Brand A glucometer on 11/03/17 at 10:25 am revealed: -The glucometer was stored in the basket on top of the medication cart with 13 other glucometers. -The glucometer was not stored in a separate pouch, it was labeled with Resident #1's name. Review of the memory for Resident #1's Brand A glucometer on 11/03/17 revealed: -The date on the glucometer did not reflect the current date and time (11/3/17 at 10:25 am). -The date in the glucometer was 9/24 at 7:19 am. -There were 23 readings in the memory of the glucometer dated from 9/05 at 7:26 am to 8/13 at 1:09 am. -The readings ranged from 104 to 389. -There were no readings recorded in the memory for FSBS documented on Resident #1's eMARs: -9/22/17 at 12:00 pm 140 and at 5:00 pm 232 -9/24/17 at 8:00 am 200 -9/25/17 at 8:00 am 162 -9/26/17 at 12:00 pm 122 -9/27/17 at 12:00 pm 130 and at 5:00 pm 186 -9/28/17 at 12:00 pm 150 -Resident #1 had no other documented FSBS on the eMAR after 9/28/17 at 12:00 pm. -Eleven of the FSBS readings recorded in the glucometer memory did match Resident #1's FSBS's documented on the September eMARs. -The last matched FSBS recorded in the memory was 8/19/17 at 1:44 am FSBS 144 matched the eMAR documented entry FSBS on 9/28/17 at 8:00 am 144. -There were 9 additional readings recorded in the glucometer memory after the FSBS matched on 9/28/17 at 8:00 am 144, there were no FSBS documented on the eMAR after 9/28/17 at 12:00 pm FSBS 150 (FSBS 150 on 9/28/17 at 12:00 pm was not found in the glucometer history).	D932		

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D932	Continued From page 87 -Twelve of the glucometer readings labeled did not match the documented FSBS on the eMAR for September 2017. -There were two readings in the glucometer memory dated 8/21/17 at 1:21 pm FSBS 149 and at 3:58 pm FSBS 389, neither FSBS matched the FSBS documented on the eMAR for Resident #1. -The reading for 8/21/17 at 3:58 pm 389 matched the documented entry on the eMAR for Resident #10 on 9/30/17 at 8:00 pm 389. Interview on 11/6/17 at 11:05 am with Resident #1 revealed: -The facility staff checked his FSBS four times a day at meals and at night. -The staff had worn gloves when they checked his FSBS. -He was not aware which glucometer they used or if he had his own glucometer. Based on review of Resident #1's glucometer's history compared to the eMARS for September 2017, Resident #1 had eight missing FSBS, twelve extra readings, and one matched reading (Resident #10) for FSBS values in September 2017. Refer to interview on 11/3/17 at 11:15 am with a Medication Aide. Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide. Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director. 2. Review of Resident #3's current hospital FL2 dated 7/17/17 revealed: -Diagnoses included type 2 diabetes.	D932		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 88 -An order to check and record FSBS three times daily and at night. Review of a physician's order dated 08/04/17 for Resident #3 revealed an order to check FSBS three times daily and at night. Observation of Resident #3's Brand A glucometer on 11/03/17 at 9:45 am revealed: -The glucometer was stored in the basket on top of the medication cart with 13 other glucometers. -The glucometer was not stored in a separate pouch, it was labeled with Resident #3's name. Review of the memory for Resident #3's Brand A glucometer revealed: -The date on the glucometer did not reflect the current date and time (11/3/17 at 9:45 am). -The date in the glucometer was 11/2/17 at 2:53 am. -There were 165 readings recorded in the glucometer memory dated from 11/2/17 at 12:28 am to 8/30/17 at 3:37 am. -The FSBS readings ranged from 47 to 600. -There were 55 readings in the glucometer memory for September and 48 of the readings matched the September eMAR documented FSBS for Resident #3. -There were 98 documented FSBS on Resident #3's eMAR for September 2017 with only 48 of the FSBS matching the history in the glucometer. -There were 110 readings recorded in the glucometer history for October and 22 of the readings matched Resident #3's October 2017 eMAR documented FSBS. -In the glucometer history dated 10/6 there were 6 readings: -On 10/6/17 at 5:47 am FSBS 182 -On 10/6/17 at 10:40 am FSBS 290 -On 10/6/17 at 12:42 pm FSBS 90	D932		

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D932	Continued From page 89 -On 10/6/17 at 12:49 pm FSBS 135 -On 10/6/17 at 12:55 pm FSBS 282 -On 10/6/17 at 10:31 pm FSBS 293. -The glucometer reading recorded on 10/6/17 at 5:47 am 182 and at 10:40 am 290 matched the documented FSBS on the eMAR for Resident #3 on 10/7/17 at 11:30 am 182 and at 4:30 pm 290. -The glucometer reading recorded on 10/6/17 at 12:49 pm 135, 10/6 at 12:42 pm 90, and 10/6 at 12:55 pm 282 were not documented on Resident #3's October 2017 eMAR. -The glucometer reading recorded on 10/6/17 at 12:55 pm 282 matched the documented FSBS on the eMAR for Resident #10 on 10/7/17 at 8:00 pm 282. -In the glucometer history dated 10/23 there were 3 readings: -On 10/23/17 at 11:36 am FSBS 203 -On 10/23/17 at 1:45 pm FSBS 401 -On 10/23/17 at 9:56 am FSBS 233 -The glucometer reading recorded on 10/23/17 at 1:45 pm 401 matched the documented FSBS on the eMAR for Resident #3 on 10/24/17 at 8:00 pm 401. -The glucometer reading recorded on 10/24/17 at 9:56 am 233 matched the documented FSBS on the eMAR for Resident #10 on 10/24/17 at 4:30 pm 233. Interview on 11/3/17 at 4:50 pm with Resident #3 revealed: -She had been a diabetic for a long time. -The facility took her FSBS four times a day. -The staff had worn gloves when they took her FSBS. -The staff used a glucometer, but she was unsure if the glucometer was hers or not. Based on review of Resident #3's glucometer's memory compared to the eMARS for September	D932		

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D932	Continued From page 90	D932		

2017, Resident #3 had forty nine extra readings for FSBS values in September 2017.

Based on review of Resident #3's glucometer's memory compared to the eMARS for October 2017, Resident #3 had 61 extra readings, and 2 matched readings (Resident #10) for FSBS values in September 2017.

Refer to interview on 11/3/17 at 11:15 am with a Medication Aide.

Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide.

Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director.

3. Review of Resident #8's current FL2 dated 7/5/17 revealed diagnoses included diabetes.

Review of a physician's order dated 08/04/17 for Resident #8 revealed an order to check FSBS once daily at 8:00 am.

Observation of Resident #8's Brand A glucometer on 11/03/17 at 10:53 am revealed:
-The glucometer was stored in the basket on top of the medication cart with 13 other glucometers.
-The glucometer was not stored in a separate pouch, it was labeled with Resident #8's name.

Review of the memory for Resident #8's Brand A glucometer on 11/3/17 revealed:
-The date on the glucometer did not reflect the current date and time (11/3/17 at 10:53 am).
-The date in the glucometer was 11/3 at 9:39 am.
-There were 33 readings recorded in the memory of the glucometer dated from 11/2 at 3:58 am to

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D932	Continued From page 91 10/15 at 10:37 pm. -The FSBS readings ranged from 20 to 221. -There were 31 readings in the glucometer memory for October and 11 of the readings matched Resident #8's October 2017 eMAR documented FSBS. -There were 5 readings in the glucometer 10/30 history: -On 10/30/17 at 3:29 am 103 -On 10/30/17 at 3:30 am 121 -On 10/30/17 at 3:34 am 221 -On 10/30/17 at 3:34 am 94 -On 10/30/17 at 3:36 am 104. -The glucometer reading recorded on 10/30/17 at 3:36 104 matched the eMAR for Resident #8 10/30/17 at 6:30 am 104. -The additional glucometer memory on 10/30/17 that matched the FSBS documented on the October eMAR were as follows: -On 10/30/17 at 3:30 121 matched Resident #9's eMAR 10/30/17 at 6:30 am FSBS 121 -On 10/30/17 at 3:34 221 matched Resident #3's eMAR 10/30/17 at 7:30 am FSBS 221 -On 10/30/17 at 3:37 103 matched Resident #10's eMAR 10/30/17 at 7:30 am FSBS 103. -There were 3 readings recorded in the glucometer 10/16/17: -On 10/16/17 at 2:16 am FSBS 117 -On 10/16/17 at 4:17 am FSBS 115 -On 10/16/17 at 2:06 pm FSBS 405. -None of the three readings on 10/16/17 matched the FSBS documented on the October eMAR for Resident #8. -The glucometer reading recorded 10/16/17 at 4:17 am 115 matched Resident #10 eMAR 10/16/17 at 7:30 am 115. -There were 2 readings recorded in the glucometer memory 10/15/17 at 20:37 am 106 and 10/15/17 at 11:39 am 99. -Neither of the two readings recorded on 10/15	D932		

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D932	Continued From page 92	D932		

matched the FSBS documented on the eMAR for Resident #8 of 98.
-The glucometer reading recorded on 10/15 at 11:39 am 99 matched Resident #9 eMAR 10/16 at 6:30 am 99.

Interview on 11/6/17 at 11:05 am with Resident #8 revealed:
-"They check my blood sugar in the morning."
-The third shift MA checked her FSBS in every morning.
-The staff wore gloves when they checked her FSBS.
-"They use my machine" when checking her FSBS.

Based on review of Resident #8's glucometer's memory compared to the eMARS for October 2017, Resident #8 had 22 extra readings, and 5 matched readings (Resident #3, #9 and #10) for FSBS results in October 2017.

Refer to interview on 11/3/17 at 11:15 am with a Medication Aide.

Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide.

Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director.

4. Review of Resident #9's current FL2 dated 6/18/17 revealed diagnoses included diabetes and acute HBV infection (Hepatitis B).

Review of a physician's order dated 08/04/17 for Resident #9 revealed an order to check FSBS once daily at 6:30 am.

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D932	Continued From page 93 Observation of Resident #9's Brand A glucometer on 11/03/17 at 11:38 am revealed: -The glucometer was stored in the basket on top of the medication cart with 13 other glucometers. -The glucometer was not stored in a separate pouch, it was labeled with Resident #9's name. Review of the memory for Resident #9's Brand A glucometer revealed: -The date on the glucometer did not reflect the current date and time (11/3/17 at 11:38 am). -The date in the glucometer was 8/02 at 2:58 am. -There were 35 readings recorded in the glucometer memory dated from 8/1/17 at 6:38 pm to 6/28/17 at 5:02 pm. -The FSBS readings ranged from 71 to 494. -There were 32 readings recorded in the glucometer memory for October and 14 of the readings matched the October 2017 eMAR documented FSBS. -There were 8 readings in the glucometer memory for 7/5/15 as follows: -On 7/5/17 at 5:13 pm FSBS 82 -On 7/5/17 at 5:14 pm FSBS 71 -On 7/5/17 at 5:15 pm FSBS 100 -On 7/5/17 at 5:15 pm FSBS 123 -On 7/5/17 at 5:16 pm FSBS 88 -On 7/5/17 at 5:17 pm FSBS 106 -On 7/5/17 at 5:18 pm FSBS 88 -On 7/5/17 at 5:19 pm FSBS 135 -The glucometer reading recorded on 7/5/17 at 5:15 pm 100 matched the FSBS documented on the eMAR for Resident #9 10/7/17 at 6:30 am 100. -The additional FSBS recorded in the glucometer memory on 7/5/17 did not match the documented results on Resident #9's eMAR were as follows: -7/5/17 at 5:13 pm 82 matched the FSBS documented on the eMAR for Resident #8 10/7/17 at 8:00 am 82.	D932		

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D932	Continued From page 94 -7/5/17 at 5:14 pm 71 matched the FSBS documented on the eMAR for Resident #10 10/7/17 at 7:30 am 71. -7/5/17 at 5:15 pm 123 matched the FSBS documented on the eMAR for Resident #6 10/7/17 at 8:00 am 123. -7/5/17 at 5:16 pm 88 matched the FSBS documented on the eMAR for Resident #3 10/7/17 at 7:30 am 88. Interview on 11/3/17 at 3:25 pm with Resident #9 revealed: -Third shift checks her FSBS every morning. -The staff had worn gloves when they checked her FSBS. -The staff used "her machine" when they checked her FSBS. Telephone interview on 11/6/17 at 1:50 pm with Resident # 9's legal guardian revealed: -She last saw Resident #9 about 3 months ago. -She had been Resident #9 guardian less than a year. -She was aware Resident #9 was a diabetic and had FSBS checked by the facility staff. -She was aware Resident #9 had hepatitis B. Based on review of Resident #9's glucometer's recorded memory compared to the eMARS for October 2017, Resident #9 had 14 extra readings recorded, and 4 matched consecutive readings (Resident #3, #6, #8, and #10) for FSBS results in October 2017. Refer to interview on 11/3/17 at 11:15 am with a Medication Aide. Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide.	D932		

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D932	Continued From page 95 Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director. 5. Review of Resident #10's current FL2 dated 3/29/17 revealed diagnoses included diabetes. Review of a physician's order dated 08/04/17 for Resident #10 revealed an order to check FSBS before meals and at bedtime. Observation of Resident #10's Brand A glucometer on 11/03/17 at 11:25 am revealed: -The glucometer was stored in the basket on top of the medication cart with 13 other glucometers. -The glucometer was not stored in a separate pouch, it was labeled with Resident #10's name. Review of the memory for Resident #10's Brand A glucometer revealed: -The date on the glucometer did not reflect the current date and time (11/3/17 at 11:25 am). -The date in the glucometer was 10/20/17 at 1:25 am. -There were 30 readings recorded in the glucometer memory dated from 10/19/17 at 7:00 pm to 10/13/17 at 6:47am. -The FSBS readings ranged from 69-466. -There were 30 readings in the glucometer memory for October and 19 of the readings matched Resident #10's October 2017 eMAR documented FSBS. -There were 4 readings recorded in the glucometer memory on 10/16/17 as follows: -10/16/17 at 7:09 am FSBS 356 -10/16/17 at 9:36 am FSBS 367 -10/16/17 at 7:34 pm FSBS 129 -10/16/17 at 7:46 pm FSBS 272. -Two of the glucometer readings recorded 10/16/17 at 7:09 am 356 and 10/16/17 at 9:36 am	D932		

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D932	Continued From page 96 367 matched the FSBS documented on Resident #10's eMAR on 10/31/17 at 4:30 pm 356 and at 8:00 pm 367. -The glucometer reading recorded 10/16/17 at 7:34 pm 129 matched Resident #9's eMAR 10/31/17 at 6:30 am 129. -There were 4 readings recorded in the glucometer memory on 10/15/17 as follows: -10/15/17 at 1:51 am FSBS 108 -10/15/17 at 7:06 am FSBS 289 -10/15/17 at 7:18 am FSBS 298 -10/15/17 at 9:40 am FSBS 356. -Three of the glucometer readings recorded 10/15/17 at 1:51 am 108, 10/15/17 at 7:18 am 298, and 10/15/17 at 9:40 am 356 matched the FSBS documented on Resident #10 eMAR on 10/29/17 at 11:30 am 108, at 4:40 pm 289, and on 10/29/17 at 8:00 pm 427. -The glucometer reading recorded 10/29/17 at 7:18 am 298 matched the FSBS documented on Resident #3's eMAR 10/29/17 at 11:30 am 298. Based on review of Resident #10's recorded glucometer's memory compared to the eMARS for October 2017, Resident #10 had 11 extra readings, and 2 matched recorded documented FSBS results (Resident #3, and #9) for FSBS results in October 2017. Refer to interview on 11/3/17 at 11:15 am with a Medication Aide. Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide. Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director. Observation on 11/3/17 at 9:20 am of the	D932		

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D932	Continued From page 97 medication cart located in the medication room revealed: -There was an unlabeled glucometer stored in the basket on top of the medication cart with 13 other glucometers. -The glucometer was not stored in a separate pouch. Review of the memory for the unlabeled Brand A glucometer revealed: -The date on the glucometer did not reflect the current date and time (11/3/17 at 10:42 am). -The date in the glucometer was 10/8/17 at 12:19 pm. -There were 23 readings recorded in the glucometer history from 9/8 at 5:53 am to 7/23 at 5:48 pm. -The FSBS readings ranged from 87-325. -There were 4 readings recorded in the glucometer memory on 8/20/17 as follows: -8/20/17 at 9:35 am FSBS 325 -8/20/17 at 9:57 am FSBS 233 -8/20/17 at 3:06 pm FSBS 501 -8/20/17 at 3:15 pm FSBS 315. -The glucometer readings 8/20/17 at 9:35 am 325 matched the FSBS documented on the eMAR for Resident #1 on 8/20/17 at 12:00 pm 325. -The glucometer readings 8/20/17 at 9:57 am 233 matched the FSBS recorded on the eMAR for Resident #3 on 8/20/17 at 11:30 pm 233. -The glucometer readings 8/20/17 at 3:15 pm 315 matched the FSBS recorded on the eMAR for Resident #10 on 8/20/17 at 11:30 pm 315. -There were 11 readings recorded in the glucometer memory on 7/24/17 as follows: -7/24/17 at 3:04 am FSBS 113 -7/24/17 at 3:10 am FSBS 278 -7/24/17 at 3:11 am FSBS 264 -7/24/17 at 3:14 am FSBS 102 -7/24/17 at 3:15 am FSBS 92	D932		

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D932	Continued From page 98 -7/24/17 at 3:15 am FSBS 275 -7/24/17 at 3:16 am FSBS 121 -7/24/17 at 3:17 am FSBS 110 -7/24/17 at 3:19 am FSBS 302 -7/24/17 at 9:47 am FSBS 87 -7/24/17 at 9:54 am FSBS 274 -The glucometer readings 7/24/17 at 3:11 am 264 matched the FSBS documented result on the eMAR for Resident #1 on 7/24/17 at 8:00 am FSBS 264. -The glucometer readings 7/24/17 at 3:15 am 275 matched the FSBS documented result on the eMAR for Resident #10 on 7/24/17 at 7:30 am FSBS 275. -The glucometer readings 7/24/17 at 3:16 am 121 matched the FSBS documented result on the eMAR for Resident #9 on 7/24/17 at 6:30 am FSBS 121. -The glucometer readings 7/24/17 at 3:17 am 110 matched the FSBS documented result on the eMAR for Resident #8 on 7/24/17 at 8:00 am FSBS 110. -The glucometer readings 7/24/17 at 3:19 am 302 matched the FSBS documented result on the eMAR for Resident #3 on 7/24/17 at 7:30 am FSBS 302. Based on review of the unlabeled glucometer's history compared to the eMARS from July 13, 2017, and August 2017, the unlabeled glucometer history had multiple consecutive matched readings (Resident #1, #3, #6, #8, #9 and #10) for FSBS values. Refer to interview on 11/3/17 at 11:15 am with a Medication Aide. Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide.	D932		

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D932	Continued From page 99 Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director. 6. Review of Resident #6's current FL2 dated 03/16/17 revealed: -Diagnoses included type II diabetes mellitus. -Orders included fingerstick blood sugars (FSBS) twice daily. Review of a physician's order dated 08/04/17 for Resident #6 revealed an order to check fingerstick blood sugars (FSBS) twice daily at 8:00 am and 8:00 pm. Observation of Resident #6's Brand A glucometer on 11/03/17 at 11:05 am revealed: -The glucometer was stored in the basket on top of the medication cart with 14 other glucometers. -The glucometer was not stored in a separate pouch, it was labeled with Resident #6's name. Review of the memory for Resident #6's Brand A glucometer on 11/03/17 revealed: -The date and time on the glucometer did not reflect the current date and time (11/03/17 at 11:14 am). -The date in the glucometer was October 31 at 7:37 am. -There were 41 readings recorded in the glucometer memory from 10/30 at 4:38 pm to 8/30 at 4:45 pm. -The FSBS readings ranged from 90 to 476. -There were no recorded readings in the memory for FSBS documented on the eMARs 8:00 am on September 1-20, 2017 (refused on September 2, 4, 9, and 17, 2017), (hospitalized September 20-29, 2017); October 1-11, 13-19, and 21-31, 2017 (refused on October 5 and 28, 2017); and November 1-3, 2017 at 8:00 am.	D932		

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D932	Continued From page 100 -There were no recorded readings in the memory for FSBS documented on the eMARs at 8:00 pm on September 2, 4-15, and 30, 2017 (refused on September 7, 8, 10, 11 and 16-19, 2017) (hospitalized September 20-29, 2017); October 1-5, 12, 14, 15, 21, 22, 28, 2017 (refused on 6, 7, 8, 10, and 28, 2017); November 1 and 3, 2017 FSBS were refused at 8:00 pm. Review of Resident #6's FSBS recorded readings in the glucometer memory revealed the follows: There were twelve record readings in September 2017 as follows: -On 09/01/17 at 3:57 pm FSBS 162, -On 09/02/17 at 3:08 am FSBS 107, -On 09/05/17 at 7:09 am FSBS 47, -On 09/06/17 at 2:36 am FSBS 112, -On 09/09/17 at 7:34 am FSBS 230, -On 09/10/17 at 3:22 pm FSBS 185, -On 09/12/17 at 3:47 pm FSBS 100, -On 09/13/17 at 4:40 pm FSBS 165, -On 09/27/17 at 4:22 pm FSBS 165, -On 09/28/17 at 2:02 am FSBS 110. -Comparison of sampled residents eMARS it could not be determined which residents the ten FSBS recorded readings belonged to. There were twenty-eight recorded readings in October 2017. Out of the twenty-eight recorded readings twenty-one did not match FSBS documented on Resident #6's October 2017 eMARs as follows: -10/02/17 at 4:15 pm FSBS 168, -10/03/17 at 4:24 pm FSBS 244, -10/07/17 at 4:41 pm FSBS 255, -10/08/17 at 4:37 pm FSBS 302, -10/09/17 at 2:43 am FSBS 91, -10/10/17 at 4:27 pm FSBS 135, -10/11/17 at 2:10 am FSBS 110,	D932		

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D932	Continued From page 101 -10/12/17 at 5:22 pm FSBS 205, -10/13/17 at 3:37 pm FSBS 173, -10/14/17 at 4:14 pm FSBS 180, -10/15/17 at 4:15 pm FSBS 140, -10/16/17 at 4:32 pm FSBS 104, -10/17/17 at 2:17 am FSBS 90, -10/20/17 at 4:04 pm FSBS 151, -10/21/17 at 3:52 pm FSBS 143, -10/22/17 at 4:22 pm FSBS 185, -10/24/17 at 4:15 pm FSBS 188, -10/27/17 at 4:07 pm FSBS 134, -10/27/17 at 7:39 am FSBS 293, -10/28/17 at 4:35 pm FSBS 137, -10/30/17 at 4:38 pm FSBS 135. -The glucometer readings recorded on 10/27 at 7:39 am 293 matched the documented FSBS on Resident #3's eMAR on 10/30/17 at 12:00 am FSBS 293. -Comparison of sampled residents eMARS it could not be determined which residents the other twenty FSBS recorded readings belonged to, readings as follows: Interview on 11/03/17 at 12:26 pm with Resident #6 revealed: -She was diabetic and her blood sugars were checked twice daily, before breakfast and at night. -When her blood sugars were checked she believed it as checked using the glucometer that had her name on the back. -She did not see the name, but though it was her name on the glucometer. Refer to interview on 11/3/17 at 11:15 am with a Medication Aide. Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide.	D932		

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D932	Continued From page 102 Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director. 7. Observation on 11/3/17 at 9:20 am of the medication cart located in the medication room revealed: -There was an unlabeled glucometer stored in the basket on top of the medication cart with 13 other glucometers. -The glucometer was not stored in a separate pouch, it was unlabeled. Review of the memory for the unlabeled Brand A glucometer on 11/3/17 at 10:42 am revealed: -The date on the glucometer did not reflect the current date and time (11/3/17 at 10:42 am). -The date in the glucometer was 10/8 at 12:19 pm. -There were 23 readings recorded in the glucometer memory from 9/8 at 5:53 am to 7/23 at 5:48 pm. -The readings ranged from 87-325. -4 readings recorded in the glucometer memory as follows: -8/20 at 9:35 am FSBS 325 -8/20 at 9:57 am FSBS 233 -8/20 at 3:06 pm FSBS 501 -8/20 at 3:15 pm FSBS 315. -The glucometer readings recorded on 8/20 at 9:35 am 325 matched the documented FSBS on Resident #1's eMAR on 8/20 at 12:00 pm 325. -The glucometer readings recorded on 8/20 at 9:57 am 233 matched the documented FSBS on Resident #3's eMAR on 8/20 at 11:30 pm 233. -The glucometer readings recorded on 8/20 at 3:15 pm 315 matched the documented FSBS on Resident #10's eMAR on 8/20 at 11:30 pm 315. -There were 11 recorded readings in the glucometer memory on 7/24 as follows:	D932		

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D932	Continued From page 103 -7/24 at 3:04 am FSBS 113 -7/24 at 3:10 am FSBS 278 -7/24 at 3:11 am FSBS 264 -7/24 at 3:14 am FSBS 102 -7/24 at 3:15 am FSBS 92 -7/24 at 3:15 am FSBS 275 -7/24 at 3:16 am FSBS 121 -7/24 at 3:17 am FSBS 110 -7/24 at 3:19 am FSBS 302 -7/24 at 9:47 am FSBS 87 -7/24 at 9:54 am FSBS 274 -The glucometer readings recorded on 7/24 at 3:11 am 264 matched the documented FSBS on Resident #1's eMAR on 7/24 at 8:00 am FSBS 264. -The glucometer readings recorded 7/24 at 3:15 am 275 matched the documented FSBS on Resident #10's eMAR on 7/24 at 7:30 am FSBS 275. -The glucometer readings recorded on 7/24 at 3:16 am 121 matched the documented FSBS on Resident #9's eMAR on 7/24 at 6:30 am FSBS 121. -The glucometer readings recorded on 7/24 at 3:17 am 110 matched the documented FSBS on Resident #8's eMAR on 7/24 at 8:00 am FSBS 110. -The glucometer readings recorded on 7/24 at 3:19 am 302 matched the documented FSBS on Resident #3's eMAR on 7/24 at 7:30 am FSBS 302. Based on review of the unlabeled glucometer's recorded memory compared to the eMARS from July 13, 2017, and August 2017, the unlabeled glucometer memory had multiple consecutive FSBS that matched readings (Resident #1, #3, #6, #8, #9 and #10) for FSBS values. Refer to interview on 11/3/17 at 11:15 am with a	D932		

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D932	Continued From page 104 Medication Aide. Refer to interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide. Refer to interview on 11/03/17 at 2:34 pm with the Resident Care Director. _____ Interview on 11/3/17 at 11:15 am with a Medication Aide revealed: -She obtained FSBS and administered insulin daily on first shift to the diabetic residents. -She was aware each resident had their own glucometer, and the glucometer was not to be used for anyone but that resident. -There was a house glucometer, but it was never used. -She cleaned the glucometers weekly with alcohol. -The facility did not have approved EPA germicidal wipes for disinfecting the glucometers. Interview on 11/06/17 at 2:50 pm with a second third shift Medication Aide/Personal Care Aide revealed: -She worked the medication cart occasionally. -Every resident had their own glucometer. -She had never seen anyone use the same glucometer for multiple residents. -When she checked blood sugars she used the glucometer with the resident's name on the back, she did not share glucometers between residents. -She was unable able to explain why blood sugars on the MARs initialed by her for Resident #6 had readings from Resident #9 glucometer. Interview on 11/03/17 at 2:34 pm with the Resident Care Director revealed: -She was unaware how to access the memory of	D932		

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D932	Continued From page 105 the glucometers. -She thought all glucometers were set to the correct date and time. -Glucometers date and time may be off because she recently changed the batteries. -There was no system of checking glucometers and MARs to ensure meters were not used for more than one resident. The facility failed to implement proper infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control for 6 of 6 sampled residents with orders for FSBS monitoring. By allowing the sharing of glucometers between residents, including Resident #9 with a diagnosis of hepatitis B, without proper disinfection, the facility exposed residents to the risk of contracting serious blood borne illnesses, including hepatitis, which is detrimental to the health and safety of the residents which constitutes a Type B Violation. The facility provided the following Plan of Protection on 11/03/17: -Immediately the Administrator will remove all glucometer from the medication cart. -The RCD will order new glucometers for each diabetic residents. -The Administrator will conduct an in-service for all MAs on the glucometers and call a diabetic consult to in-service the MA on infection control training. The Administrator will contact the local health department and inform them of the possibility that glucometers had been shared between residents. -Each MA will do a glucometer check prior to using the glucometer on their shift. -The RCD will be responsible for daily glucometer checks and the Administrator will check behind the MAs and the RCD weekly for 3 months and	D932		

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D932	Continued From page 106 continuous randomly after that. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 22, 2017.	D932		
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: Based on these findings, the previously Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to housekeeping and furnishings, supervision, health care, medication administration, medication orders clarification, accuracy of the medication administration record, and infection prevention requirements. Non-compliance identified during the survey included: Interview on 11/6/17 at 3:00 pm with a housekeeper revealed: -She reported to the Medication Aide on duty if she had a concern with a residents. -If she had a housekeeping concern she reported to the Housekeeper who trained her.	D980		

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D980	Continued From page 107 -The Administrator was available all day if she needed to talk to her in the office. Interview on 11/6/17 at 3:00 pm with a Personal Care Aide revealed: -She worked in the facility for 25 years. -She relied on the MA to assist her with residents if she needed help. -If she a problem she would go the Resident Care Director or the Administrator. -The RCD and the Administrator phone numbers were posted for staff if they needed to contact them after hours. Interview on 11/6/17 at 3:10 pm with the RCD revealed: -She was the RCD and worked every day in the facility. -She was over the MA and PCA to assure they were completing their jobs. -The MA had her phone number for afterhours if they needed to contact her. -The Administrator was available 24/7 by phone or in person. -The owner was in the facility maybe a year ago, she could not recall the date, "It's been a while." Interview on 11/6/17 at 3:35 pm with the Administrator revealed: -She was the Administrator of the facility. -She was responsible for the total operations of the facility. -She communicated by phone with the owner of the facility if an issue came up and she needed to speak to her. Telephone interview on 11/3/17 at 3:00 pm with the facility owner revealed the interview was unsuccessful.	D980		

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D980	Continued From page 108 A. Based on observations, interviews and record reviews, the facility failed to assure the walls, baseboards, and window sills in residents' rooms (rooms #8, #12, #14), the common men's bathrooms, the dining room, the common snack area, the inside common smoking area, the air vents in the hallway, and the common living room, were kept clean and in good repair. [Refer to Tag 74, 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings]. B. Based on observations and interviews, the facility failed to maintain furniture clean and in good repair in the common sitting area and resident room #19.[Refer to tag 76, 10A NCAC 13F .0306 Housekeeping And Furnishings]. C. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 1 of 3 residents (#2) sampled residents leaving the facility sleeping outside.[Refer to tag 270, 10A NCAC 13F .0901 Personal Care and Supervision Unabated (Type A2 Violation)]. D. Based on interview and record review, the facility failed to notify the physician for 2 of 5 sampled residents (Resident #3, #2,and #6) Resident #3 regarding orders for elevated Finger Stick Blood Sugars (FSBS), Physical Therapy (PT) order, Resident #2 failed to administer medications or had followed-up with the physician, Resident #6 refused medications. [Refer to tag 273,10A NCAC 13F .0902 Health Care Referral and Follow-up(b) Unabated (Type B Violation)]. E. Based on observations, interviews, and record reviews, the facility failed to assure for verification	D980		

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D980	Continued From page 109 or clarification of orders for medications and treatments for 2 of 5 sampled residents (Resident #1 and #6) Resident #1 administered insulin without obtaining a Finger Stick Blood Sugar (FSBS) reading, and Resident #6's continued to administered medications that had been discontinued.[Refer to tag 344,10A NCAC 13F .1002(a) Medication Orders (Type B Violation)]. F. Based on observations, interviews, and record reviews, the facility failed to assure documentation of administration of medications as ordered by a licensed prescribing practitioner, which included FSBS omissions, for 1 of 5 residents (Resident #2) regarding failed attempts to administer medications when the resident was at the facility. [Refer to tag 358, 10A NCAC 13F .1004(a)(1) Medication Administration (Type B Violation)]. G. Based on observations, interviews, and record reviews, the facility failed to assure medication administration record (MAR) shall be accurate and included Finger Stick Blood Sugars (FSBS) omissions, for 1 of 5 sampled residents (Resident #3,) ordered FSBS four times daily. [Refer to tag 367, 10A NCAC 13F .1004(j)(7) Medication Administration]. H. 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 between residents for 6 of 6 sampled residents, (#1, #3, #6, #8, #9, and #10). [Refer to tag 932,G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation)]. Failure of management to provide oversight and	D980		

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D980	Continued From page 110 monitor the facility for all licensure rule areas resulted in failure to assure walls and ceilings were kept clean and in good repair for residents bedrooms, bathrooms, hallway, dining room area and smoking area, furniture was clean and in good repair related to living room furniture in the common area, also the failure supervise Resident #2 for unknown whereabouts, health care referral and follow-up to meet the care for Resident # 2, #3 and #6, medication orders clarification for Resident #1and #6, medication administration for Resident #2, and #3, and infection prevention requirements related to glucometers for 6 of 13 diabetic residents with one diabetic resident with a diagnoses of Hepatitis B. The failure of management to provide oversight in these areas constitutes a Type A2 Violation. _____ The facility provided the following Plan of Protection on 11/06/17: -Immediately the RCD will be pulled from the med cart and just work as the RCD. -Staff concerns will follow the chain of command and the RCD will contact the Administrator which is available 24/7 via phone or in person. -The Administration will continue the open door policy for issue or concerns. -A resident council meeting is scheduled for 11/7/17, the Administrator will inform of changes and the chain of command. -The Administrator has an open door policy for all staff and residents for any issues related to health care, supervision housekeeping or any concerns. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, DECEMBER 7, 2017.	D980		