

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2017
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
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C 000	Initial Comments	C 000		
C 105	<p>10A NCAC 13G .0317(d) Building Service Equipment</p> <p>10A NCAC 13G .0317 Building Service Equipment</p> <p>(d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C).</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures at 2 of 2 fixtures (sinks and bathtub/showers) used by 6 residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F.</p> <p>The findings are:</p> <p>Observation during the initial tour of the facility on 12/20/17 from 9:10 am to 9:30 am revealed:</p> <ul style="list-style-type: none"> -The facility had a total of six residents and two common bathrooms. -Each bathroom had a sink and shower/bathtub combination. -At 9:15 am the hot water temperature coming from the sink in the residents' common bathroom #2 was 124 degrees F. -At 9:18 am the hot water temperature coming from the bathtub/shower combination was 124 	C 105		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 105	<p>Continued From page 1</p> <p>degrees F.</p> <p>-At 9:25 am the hot water temperature in the residents' common bathroom #1 using the surveyor's thermometer was 132 degrees F.</p> <p>-The hot water temperature at the same fixture using the facility's thermometer was 120 degrees F.</p> <p>On 12/20/17 at 9:45 am the Supervisor-in-charge (SIC) was informed of the hot water temperatures and signs were posted to inform residents to seek staff assistance when accessing the hot water.</p> <p>Calibration on 12/20/17 at 9:34 am of the facility's thermometer and the surveyor's thermometer revealed:</p> <p>-The facility's thermometer calibrated at 0, the lowest reading on the thermometer.</p> <p>-The surveyor's thermometer calibrated at 30 degrees, requiring to add 2 degrees to hot water temperature readings.</p> <p>Interview on 12/20/17 at 9:22 am with the SIC revealed:</p> <p>-She was aware the hot water temperatures were above 116 degrees F.</p> <p>-On the days that she worked she checked the hot water temperature in both common bathrooms, the kitchen and the laundry room.</p> <p>-She always got a temperature of 120 degrees F.</p> <p>-She was aware she needed to contact someone.</p> <p>-She had contacted the maintenance person and he told there was not much he could do to adjust the hot water temperatures.</p> <p>-She had not informed the Administrator the hot water temperatures were continually above 116 degrees F.</p> <p>Review on 12/20/17 of the facility's December 2017 hot water temperature log revealed:</p>	C 105		

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C 105	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Documentation on the log that instructed staff as follows: -"Temperature should not be lower than 100 degrees." -"Temperature should not be lower than 116 degrees." -"Contact maintenance if temperature is not within the range of 100-116 degrees." -Staff were to circle the words "yes or no" if maintenance was contacted. -Staff documented on the log that hot water temperatures were checked daily from December 1, through December 20, 2017. -There was no documentation of the time hot water temperatures were checked. -Staff documented every day the hot water temperatures were 120 degrees F. -Staff circled the word "yes" 8 times that maintenance had been notified of the hot water temperature. <p>Observation on 12/20/17 at 9:25 am of the facility's thermometer revealed, it was a candy thermometer with instructions documented the thermometer worked best with hot temperatures above 160 degrees F.</p> <p>Interview on 12/20/17 at 10:42 am with the Maintenance worker revealed:</p> <ul style="list-style-type: none"> -Today, he was called to come to the facility to adjust the hot water temperature. -Today, he adjusted the hot temperatures down on the hot water tank. -The facility staff were supposed to notify him when the hot water temperatures were above 116 degrees F. -Today, was the first time facility staff had called him to inform the hot water temperatures were above 116 degrees. -The hot water tank was new, it was less than six 	C 105		

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C 105	<p>Continued From page 3</p> <p>month old.</p> <ul style="list-style-type: none"> -Initially, there were issues with the hot water not getting above 100 degrees F. -He did not know the hot water temperatures were above 116 degrees F. -He was running the hot water to cool off the temperature in the tank. <p>A third check on 12/20/17 at 11:48 am of the hot water temperatures coming from the sink in the resident's common bathroom #1 was 115 degrees F.</p> <p>A fourth check on 12/20/17 at 3:29 pm of the hot water temperatures coming from the sink in the residents' common bathroom #1 was 128 degrees F.</p> <p>Observation on 12/20/17 at 4:00 pm revealed signs were re-posted to warn residents of the hot water temperatures.</p> <p>Interview on 12/20/17 at 4:18 pm with the Supervisor revealed:</p> <ul style="list-style-type: none"> -She was the assistant to the Administrator, and visited the facility almost daily. -She did not know the hot water temperatures were above 116 degrees F. -Today, she had communicated with the Administrator and was informed if the maintenance person was unable to get the hot water temperatures down, then the person that installed the hot water system should be contacted. -The maintenance person had left for today because he thought the hot water temperatures were okay. -She would instruct staff to leave the signs posted in both bathrooms used by the residents. -She would obtain another thermometer and 	C 105		

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C 105	<p>Continued From page 4</p> <p>instruct the SIC to check hot water temperatures every hour until she went to bed.</p> <p>Review on 12/21/17 of the facility's hot water temperature log revealed: -The SIC checked hot water temperatures on 12/20/17 as follows: -At 5:30 pm the hot water temperature was 130 degrees. -At 6:30 pm the hot water temperature was 135 degrees. -At 7:30 pm the hot water temperature was 140 degrees. -At 8:30 pm the hot water temperature was 140 degrees.</p> <p>Interview on 12/21/17 at 9:00 am with the maintenance person revealed: -Today, he again adjusted the hot water temperatures down. -Currently, he was running the hot water to get all the hot water out of the tank. -If that did not work he was going to contact the person that installed the hot water system.</p> <p>A fifth check on 12/21/17 at 3:00 pm of hot water temperatures coming from the sink in the common bathroom #1 revealed hot water temperatures of 130 degrees.</p> <p>Interview on 12/21/17 at 3:30 pm with the person that installed the hot water system revealed: -The maintenance person was turning down the wrong knob. -The heater on the hot water tank was set at 150 degrees F. -He adjusted the temperature down and was currently running the hot water to decrease the temperature.</p>	C 105		

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C 105	<p>Continued From page 5</p> <p>A sixth check on 12/21/17 of the hot water temperatures coming from the sink in the common bathroom #2 revealed 112 degrees F.</p> <p>Interviews on 12/20/17 from 9:20 am to 3:42 pm with six residents revealed:</p> <ul style="list-style-type: none"> -Three residents stated they had not noticed the hot water temperatures being too hot. -They always adjusted cold to their comfort level. -Two residents said the water was not too hot for them and they had never gotten burn or discomforted due to the hot water. -One resident said the water was too hot sometimes, but he adjusted it by using cold water. <p>Based on observations and interviews, the facility failed to assure hot water temperatures hot water temperatures at 2 of 2 fixtures (sinks and bathtub/showers) used by 6 of 6 residents were maintained. A water temperature of 140 degrees F can result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. The facility's failure to ensure water temperatures were between 100 - 116 degrees F was detrimental to the safety, health and welfare of the residents and constitutes a Type B Violation.</p> <p>The facility provided the following Plan of Protection on 12/20/17:</p> <ul style="list-style-type: none"> -Immediately, staff posted caution signs to warn the residents of the hot water temperatures. -The maintenance person was notified to adjust the hot water temperatures down. -The Administration will monitor hot water temperatures daily to ensure it's not too hot. -Administration will provide new thermometers for staff to check hot water temperatures. <p>CORRECTION DATE FOR THE TYPE B</p>	C 105		

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C 105	Continued From page 6 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2018.	C 105		
C 145	<p>10A NCAC 13G .0406(a)(5) Other Staff Qualifications</p> <p>10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall:</p> <p>(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 4 sampled staff (Administrator) had no substantiated findings listed on the Health Care Personnel Registry (HCPR) prior to employment at the facility.</p> <p>The findings are:</p> <p>Review of the Administrator's personnel record revealed: -There was a hire date of 10/01/10. -There was no hire date listed for the current facility. -There was no documentation a HCPR check had been completed.</p> <p>Interview on 12/21/17 at 9:02 am and 4:30 pm with the Administrator revealed: -He was the facility owner and served as the Administrator since the facility opened on 8/14/17. -He was not sure if he had completed or had a copy of his HCPR check.</p>	C 145		

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C 145	Continued From page 7 -If he did have his HCPR check completed then he probably mailed it to Raleigh when he submitted the application for the facility license. -He was responsible for maintaining staff personnel records and for ensuring that all HCPR checks were completed. Review of a HCPR check for the Administrator completed on 12/21/17 revealed no substantiated findings.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 4 sampled staff (Administrator) had a criminal background check completed prior to conditional offer of employment at the facility. The findings are: Review of the Administrator's personnel record revealed: -The Administrator was hired on 10/01/10. -There was no hire date listed for the current facility. -There was no documentation a criminal background check had been completed.	C 147		

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C 147	<p>Continued From page 8</p> <p>Interview on 12/21/17 at 9:02 am and 4:30 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -He was the facility owner and served as the Administrator since the facility opened on 8/14/17. -He was not sure if he had completed or had a copy of his criminal background check. -If he did complete a criminal background check then he probably mailed it to Raleigh when he submitted the application for the facility license. -He was responsible for maintaining staff personnel records and for making sure that criminal background checks were completed. <p>A criminal background check was requested for the Administrator was completed on 12/21/17 with pending results.</p>	C 147		
C 249	<p>10A NCAC 13G .0902(c)(3)(4) Health Care</p> <p>10A NCAC 13G .0902 Health Care</p> <p>(c) The facility shall assure documentation of the following in the resident's record:</p> <p>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</p> <p>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to implement physician's orders for 5 of 6 sampled residents (Residents #1, #2, #3, #4, and #6) with orders for blood pressures.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated</p>	C 249		

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C 249	<p>Continued From page 9</p> <p>12/13/17 revealed: -Diagnoses included hypertension and schizophrenia. -A physician order for blood pressure checks twice weekly.</p> <p>Review of Resident #2's Resident Register revealed an admission date of 12/13/17.</p> <p>Review of Resident #2's December 2017 Medication Administration Record (MAR) revealed: -There were no entries for blood pressures on the MAR. -There were no blood pressures documented from 12/13/17 and 12/21/17.</p> <p>Review of Resident #2's record revealed there were no documented blood pressures since the resident's admission to the facility on 12/13/17.</p> <p>Interview on 12/21/17 at 4:00 pm with Resident #2 revealed: -He lived at the facility for a little more than one week. -The facility staff did not check his blood pressure. -He had hypertension, but did not know why his blood pressure was ordered to be checked twice weekly.</p> <p>Refer to interview on 12/20/17 at 9:42 am with the Medication Aide (MA).</p> <p>Refer to interview on 12/21/17 at 10:48 with the Administrator.</p> <p>Refer to interview on 12/21/17 at 10:58 am with the Nurse Practitioner.</p>	C 249		

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C 249	<p>Continued From page 10</p> <p>B. Review of Resident #6's current FL2 dated 08/08/17 revealed: -Diagnoses included coronary artery disease, hyperlipidemia, vitamin B12 deficiency, dementia, hypothyroidism, and hypertension. -A physician order for blood pressure check once monthly.</p> <p>Review of Resident #6's Resident Register revealed an admission date of 08/14/17.</p> <p>Review of Resident #6's October, November and December 2017 MARs revealed: -There were no entries for blood pressure on the MARs. -There were no blood pressures documented for the months of October, November and December 2017.</p> <p>Review of Resident #6's record revealed there were no documented blood pressures since the resident's admission to the facility on 08/14/17.</p> <p>Interview on 12/21/17 at 3:53 pm with Resident #6 revealed: -He lived at the facility a few months. -Staff did not check his blood pressure. -He did not know why blood pressure checks were ordered.</p> <p>Refer to interview on 12/20/17 at 9:42 am with the Medication Aide (MA).</p> <p>Refer to interview on 12/21/17 at 10:48 with the Administrator.</p> <p>Refer to interview on 12/21/17 at 10:58 am with the Nurse Practitioner.</p> <p>C. Review of Resident #1's current FL2 dated</p>	C 249		

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C 249	<p>Continued From page 11</p> <p>11/15/17 revealed: -Diagnoses included hypertension, schizophrenia, hyperlipidemia, and gout. -A physician order for blood pressure checks, with no frequency documented.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 11/06/17.</p> <p>Review of Resident #1's November and December 2017 MARs revealed: -There were no entries for blood pressures on the MARs. -There were no blood pressures documented for the months of November and December 2017.</p> <p>Review of Resident #1's record revealed there were no documented blood pressures since the resident's admission to the facility on 11/06/17.</p> <p>Interview on 12/21/17 at 11:44 am with Resident #1 revealed: -Facility staff did not check his blood pressure. -He did not know why blood pressure checks were ordered.</p> <p>Refer to interview on 12/20/17 at 9:42 am with the Medication Aide (MA).</p> <p>Refer to interview on 12/21/17 at 10:48 with the Administrator.</p> <p>Refer to interview on 12/21/17 at 10:58 am with the Nurse Practitioner.</p> <p>D. Review of Resident #3's current FL2 dated 08/08/17 revealed: -Diagnoses included hypertension, chronic edema, stage III kidney disease, congestive heart failure, and hyperlipidemia.</p>	C 249		

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C 249	<p>Continued From page 12</p> <p>-A physician order for blood pressure checks "per facility."</p> <p>Review of Resident #3's Resident Register revealed an admission date of 08/14/17.</p> <p>Review of Resident #3's October, November and December 2017 MARs revealed: -There were no entries for blood pressures on the MARs. -There were no blood pressures documented for the months of October, November and December 2017.</p> <p>Review of Resident #3's record revealed there were no documented blood pressures since the resident's admission to the facility on 08/14/17.</p> <p>Interview on 12/21/17 at 4:01 pm with Resident #3 revealed: -He lived at the facility for several months. -He had hypertension, but did not know why blood pressures checks were ordered. -No one at the facility had checked his blood pressure since he moved into the facility.</p> <p>Refer to interview on 12/20/17 at 9:42 am with the Medication Aide (MA).</p> <p>Refer to interview on 12/21/17 at 10:48 with the Administrator.</p> <p>Refer to interview on 12/21/17 at 10:58 am with the Nurse Practitioner.</p> <p>E. Review of Resident #4's current FL2 dated 11/15/17 revealed: -Diagnoses included hypertension and high blood pressure, anxiety disorder, Schizoaffective disorder and insomnia.</p>	C 249		

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C 249	<p>Continued From page 13</p> <p>-A physician order for blood pressure checks , with no frequency documented.</p> <p>Review of Resident #4's Resident Register revealed an admission date of 11/06/17.</p> <p>Review of Resident #4's November and December 2017 MARs revealed: -There were no entries for blood pressure on the MARs. -There were no blood pressures documented for the months of November and December 2017.</p> <p>Review of Resident #4's record revealed there were no documented blood pressures since the resident's admission to the facility on 11/06/17.</p> <p>Interview on 12/21/17 at 3:48 pm with Resident #4 revealed: -He had high blood pressure and was taking blood pressure medications. -He did not know why blood pressure checks were ordered. -No one at the facility had checked his blood pressure since he was admitted to the facility in November 2017.</p> <p>Refer to interview on 12/20/17 at 9:42 am with the Medication Aide (MA).</p> <p>Refer to interview on 12/21/17 at 10:48 with the Administrator.</p> <p>Refer to interview on 12/21/17 at 10:58 am with the Nurse Practitioner.</p> <p>_____ Interview on 12/20/17 at 9:42 am with the Medication Aide revealed: -She knew some residents had orders for blood pressure checks.</p>	C 249		

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C 249	<p>Continued From page 14</p> <p>-She did not check the residents' blood pressure because the facility did not have a blood pressure cuff.</p> <p>-The Administrator knew the facility did not have a blood pressure cuff to check blood pressures.</p> <p>Interview on 12/21/17 at 10:48 am with the Administrator revealed:</p> <p>-He knew the facility did not have a blood pressure cuff.</p> <p>-A few months ago a sister facility needed a blood pressure cuff, so they borrowed the one from this facility.</p> <p>-He had planned to buy a new blood pressure cuff for the facility and had forgot.</p> <p>Interview on 12/21/17 at 10:58 am with the Nurse Practitioner revealed:</p> <p>-She signed FL2s, and did not realize some FL2s did not document frequency to obtain each residents' blood pressure.</p> <p>-If there was no frequency documented on the order for blood pressures she expected facility staff to check the residents' blood pressure at least once a month.</p> <p>-If the frequency was ordered, then facility staff should check the resident's blood pressure as ordered.</p>	C 249		
C 259	<p>10A NCAC 13G .0904(a)(4) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes:</p> <p>(4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets.</p>	C 259		

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C 259	<p>Continued From page 15</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure there was a three-day supply of perishable food available at the facility based on the menus for the 6 residents who resided at the facility.</p> <p>The findings are:</p> <p>The facility had a census of 6 residents.</p> <p>Review of the 6 residents' diet orders signed by the physician revealed: -Five residents were ordered a regular diet -One resident was ordered a low sodium diet.</p> <p>Observation on 12/20/17 at 9:30 am of the facility's food supply revealed the following items were not available in the facility for serving as compared to the regular and low sodium diet menus: -On 12/20/17 for breakfast: orange juice, eggs -On 12/20/17 for lunch: tomatoes, potatoes, zucchini, coconut pie -On 12/20/17 for dinner: coleslaw, fresh orange -On 12/21/17 for breakfast: orange juice, eggs -On 12/21/17 for lunch: chocolate cake -On 12/21/17 for dinner: lettuce, tomatoes, pickles, onion, french fries</p> <p>Interview with the Medication Aide (MA)/Personal Care Aide (PCA) on 12/20/17 at 9:42 am revealed: -The Supervisor-in-Charge (SIC) was responsible for grocery shopping for food for the facility every two weeks. -She let the SIC know what food to buy for the facility. -She usually told the SIC to buy food based upon</p>	C 259		

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C 259	<p>Continued From page 16</p> <p>what food she ran out of, not based on what was to be served on the menu. -The SIC was supposed to grocery shop for food on today, 12/20/17.</p> <p>Observation of the facility on 12/20/17 between 9:45 pm and 4:15 pm revealed there were no groceries brought into the facility for preparation of meals.</p> <p>Observation of the lunch meal service on 12/20/17 at 12:00 pm revealed residents were served the following food items: -One chicken drumstick -One serving of greenbeans -One serving of instant mashed potatoes -One slice of bread -tea -water</p> <p>A second interview with the MA/PCA on 12/20/17 at 12:07 pm revealed she did not serve the tomatoes, potatoes, zucchini, or coconut pie for the lunch meal service on 12/20/17 because she did not have those those items available in the facility.</p> <p>Interview with the Administrator on 12/21/17 at 9:02 am revealed: -The SIC was responsible for grocery shopping for the facility, but he did not know how often the SIC did the grocery shopping. -The SIC shopped for foods that were low in the facility. -The staff let the SIC know what foods to shop for. -The SIC shopped according to the menu.</p> <p>Interview with a resident on 12/21/17 at 3:31 pm on revealed:</p>	C 259		

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C 259	<p>Continued From page 17</p> <ul style="list-style-type: none"> -He had never had orange juice or any other kind of juice since he was admitted to the facility. -He would drink juice if it was served daily. -He did not remember the last time he was served eggs. -He would eat eggs if they were served daily. <p>Interview with a second resident on 12/21/17 at 3:35 pm revealed:</p> <ul style="list-style-type: none"> -He remembered having eggs about 3 or 4 days ago. -He had never seen any orange juice, any other kind of juice or any fresh fruit in the facility. -He would drink the orange juice and eat fresh fruit if served daily. -He would eat eggs if they were served daily. <p>Interview with a third resident at 3:40 pm revealed:</p> <ul style="list-style-type: none"> -The last time he remembered having eggs was on Sunday or Monday. -He would eat eggs if they were served daily. -He had never had orange juice or any other kind of juice since he was admitted to the facility. -The last time he had fresh fruit was around the last of October 2017. -He would drink juice and eat fresh fruit daily if it was available for him. <p>Observation of the facility on 12/21/17 at 3:46 pm revealed there had been no additional groceries brought into the facility.</p> <p>Interview with the SIC on 12/21/17 at 4:30 pm revealed:</p> <ul style="list-style-type: none"> -She was responsible for purchasing food for the facility. -She sometimes grocery shopped for the facility once a week and sometimes twice a week. -She used the menu to grocery shop. 	C 259		

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C 259	Continued From page 18 -Staff called her when items were low in the facility and she would purchase the items. -She last shopped for groceries for the facility one day last week.	C 259		
C 274	<p>10A NCAC 13G .0904(d)(3)(B) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the daily menus served for regular diets included 2 servings of fruit, with one being of citrus fruit or a single strength juice daily.</p> <p>The findings are: The facility had a census of 6 residents.</p> <p>Observation of the kitchen area on 12/20/17 at 9:30 am revealed: -There was no 100% juice of any variety in either the refrigerator or kitchen cabinets. -There was no fresh citrus fruit available. -There were four 20 ounce cans of pineapple with</p>	C 274		

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C 274	<p>Continued From page 19</p> <p>4 and 1/2 servings in each can. -There was no other canned fruit available.</p> <p>Review of the menu for the facility on 12/20/17 for the current week revealed: -Orange juice was listed to be served daily for breakfast. -A fresh orange was to be served for dinner on 12/20/17. -Diced pears was listed to be served for dinner on 12/22/17. -Fruit was not listed on the menu to be served at any other meal between breakfast on 12/20/17 and dinner on 12/23/17.</p> <p>Observation of the lunch meal on 12/20/17 at 12:30 pm revealed no juice or citrus fruit was served to residents.</p> <p>Interview with the Administrator on 12/21/17 at 9:02 am revealed: -He was knew that residents should be served 2 servings of fruit daily. -He was not aware that residents were not be reciving 2 servings of fruit daily. -He had oranges that he purchased from a fundraiser that he meant to bring to the facility from one of his other facilities. -He was going to have a talk with his staff.</p> <p>Observation of the lunch meal on 12/20/17 at 12:38 pm revealed no juice or citrus fruit was served to residents.</p> <p>Interview with a resident on 12/21/17 at 3:31 pm on revealed: -He had never been served orange juice or any other kind of juice since he was admitted to the facility. -He would drink juice if it was served daily.</p>	C 274		

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C 274	<p>Continued From page 20</p> <p>"We used to have apples and oranges on the table for lunch and dinner, but we have not had them in a while."</p> <p>Interview with a second resident on 12/21/17 at 3:35 pm revealed:</p> <ul style="list-style-type: none"> -He had never seen any orange juice, any other kind of juice in the facility. -He had never been served any oranges or any other fresh fruit in the facility. -He would drink the orange juice and eat fresh fruit if served daily. <p>Interview with a third resident at 3:40 pm revealed:</p> <ul style="list-style-type: none"> -He had never been served orange juice or any other kind of juice since he was admitted to the facility. -He had never been served oranges in the facility. -The last time he had fresh fruit, bananas and apples, was around Halloween. -He would drink juice and eat fresh fruit daily if it was available in the facility for him. <p>Interview with the MA/PCA on 12/21/17 at 4:30 pm revealed:</p> <ul style="list-style-type: none"> -She usually had peaches, fruit cocktail, pears, mandarin oranges available to serve to residents. -She never had fresh oranges to serve to residents, but did have apples at times. -She knew residents were to be served two servings of fruit daily. -She knew orange juice was on the menu to be served for breakfast daily. -She never had orange juice or any other type of juice in the facility since it opened in August 2017. -She never put orange juice on her grocery list and did not know why she never asked the SIC to buy orange juice or any type of juice for residents. -She made her grocery list by what she ran out of 	C 274		

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C 274	Continued From page 21 and not by what was listed to be served on the menu.	C 274		
C 315	<p>10A NCAC 13G .1002(a) Medication Orders</p> <p>10A NCAC 13G .1002 Medication Orders (a) A family 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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify medication orders for 1 of 6 residents sampled (#4) with orders for Risperdal.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL2 dated 12/15/17 revealed: -Diagnoses included schizophrenia and anxiety disorder. -A physician's order for Risperdal (used to treat behaviors and psychosis) 4 mg twice daily.</p> <p>Review of Resident #4's record revealed a subsequent physician's order dated 12/05/17,</p>	C 315		

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C 315	<p>Continued From page 22</p> <p>which changed Risperdal 4 mg to once daily.</p> <p>Review of Resident #4's December 2017 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> -An entry for Risperdal 4 mg twice daily at 8:00 am and 8:00 pm. -Risperdal was documented as administered daily at 8:00 am and 8:00 pm from 12/05/17 through 12/21/17. <p>Observation on 12/21/17 at 11:50 am of Resident #4's medications on hand at the facility revealed:</p> <ul style="list-style-type: none"> -Risperdal 4 mg once daily was available for administration. -There was no additional Risperdal available for administration. -The medication was filled on 12/07/17 and a quantity of 30 tablets were dispensed. -There were 17 tablets on hand at the facility. <p>Interview on 12/21/17 at 3:48 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -He was ordered Risperdal for anxiety. -He did not know how often the medication was ordered. -He knew facility staff administered the medication, but did not know how often the medication was administered. <p>Interview on 12/21/17 at 10:33 am with the contract pharmacy revealed:</p> <ul style="list-style-type: none"> -They received an order dated 12/05/17 which changed Risperdal 4 mg from twice daily to once daily. -On 12/07/17 they dispensed 30 tablets. -The facility did send FL2's to the pharmacy, but they had not received Resident #4's FL2 dated 12/15/17. -The last FL2 they had for Resident #4 was dated 	C 315		

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C 315	<p>Continued From page 23</p> <p>11/15/17.</p> <ul style="list-style-type: none"> -The facility staff should have sent the current FL2 to the pharmacy, and should have called the resident's physician to clarify the order for Risperdal. -If facility staff were documenting the MARs twice daily for the administration of Risperdal 4 mg, the medication was not available. <p>Interview on 12/21/17 at 2:21 pm with the nurse at Resident #4's physician's office revealed:</p> <ul style="list-style-type: none"> -Resident #4 was seen by the physician on 12/05/17. -The physician changed the Risperdal 4 mg from twice daily to once daily. -The physician did not change the Risperdal 4 mg back to twice daily. -The resident should be administered the medication once daily. -If there was an order or FL2 that changed the Risperdal 4 mg to twice daily it was not signed by Resident #4's physician. <p>Interview on 12/21/17 at 3:38 pm with the Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -She administered Risperdal 4 mg to Resident #4 once daily at 8:00 am. -There was two entries on the MAR, but the medication was only administered once daily. -The pharmacy dispensed 30 tablets for the medication to be administered once daily. -The Administrator prepared the FL2s and when the Nurse Practitioner visited once monthly she signed the FL2s. -MA's did not check FL2s with the medication orders in the Resident's record to ensure the FL2 had the current medication orders. -After the Nurse Practitioner signed the FL2, the MA on duty was supposed to fax the FL2 to the pharmacy. 	C 315		

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C 315	<p>Continued From page 24</p> <p>-She did not know why Resident #4's last FL2 dated 12/15/17 was not faxed to the pharmacy.</p> <p>Interview on 12/21/17 at 10:58 am with the Nurse Practitioner revealed:</p> <p>-She visited the facility once monthly.</p> <p>-The Administrator prepared FL2s, and she signed them when she visited the facility.</p> <p>-She did not read the FL2s and did not compare FL2s with the resident's current medication orders.</p> <p>-She did not order psychotropic medications such as Risperdal.</p> <p>-Although, she signed Resident #4's FL2 on 12/15/17, she was not the physician that ordered the Risperdal.</p> <p>-She counted on the facility staff to make sure FL2s were current with the last the medication orders.</p> <p>-She did not know that signing the FL2 on 12/15/17 changed Resident #4's Risperdal 4 mg from once daily to twice daily.</p> <p>Attempted telephone interview with the Administrator on 12/21/17 at 5:00 pm was unsuccessful.</p>	C 315		
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p>	C 330		

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C 330	<p>Continued From page 25</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication was administered as ordered by licensing prescribing practitioner for 1 of 6 sampled residents (Resident #4) with orders for lorazepam.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL2 dated 11/15/17 revealed: -Diagnoses included schizophrenia and anxiety disorder. -A physician orders for lorazepam (anxiety) 0.5 mg twice daily.</p> <p>Review of Resident #4's Resident Register revealed an admission date of 11/06/17.</p> <p>Review of Resident #4's record revealed a subsequent physician's order signed by the physician on 12/05/17 that changed Lorazepam 0.5 mg to once daily at bedtime.</p> <p>Review of Resident #4's December 2017 MAR revealed: -An entry for lorazepam 0.5 mg twice daily at 8:00 am and 8:00 pm. -The lorazepam was documented as administered daily at 8:00 am and 8:00 pm from 12/08/17 through 12/21/17.</p> <p>Observation on 12/21/17 at 11:50 am of Resident #4's medications on hand at the facility revealed: -Lorazepam 0.5 mg twice daily was available for administration. -The medication was filled on 12/07/17 for a quantity of 60 tablets.</p>	C 330		

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
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C 330	<p>Continued From page 26</p> <p>-There were 47 tablets remaining.</p> <p>Interview on 12/21/17 at 3:48 pm with Resident #4 revealed: -He was administered medications twice daily. -He knew that he was ordered medications for anxiety, but he was unaware how often the medication was administered. -He recently saw the physician, but was unable to recall the exact date or what was discussed.</p> <p>Interview on 12/21/17 at 10:33 am with the pharmacy revealed: -The pharmacy received an order dated 12/05/17 from Resident #4's physician that decreased lorazepam 0.5 mg to once daily at bedtime. -By error the pharmacy dispensed 60 tablets of lorazepam 0.5 mg to be administered twice daily. -The facility staff should have called the pharmacy to inform of the error prior to administering the medication to the resident, and sent the medication back to the pharmacy. -Facility staff also should have administered the medication as ordered by the physician once daily. -The pharmacy would correct the error today and dispense the medication as ordered.</p> <p>Interview on 12/21/17 at 2:21 pm with the nurse at Resident #4's physician's office revealed the resident was seen by the physician on 12/05/17 and the physician decreased lorazepam 0.5 mg to once daily at bedtime.</p> <p>Interview on 12/21/17 at 3:38 pm with the Medication Aide (MA) revealed: -She knew there was an order in Resident #4's record for the lorazepam, but she could not read the order. -She contacted the pharmacy to help her</p>	C 330		

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C 330	Continued From page 27 understand the order. -She received the medication from the pharmacy and did not realize the medication was different than the order dated 12/5/17. -She continued to administer lorazepam 0.5 mg twice daily as dispensed by the pharmacy. Attempted telephone interview with the Administrator on 12/21/17 at 5:00 pm was unsuccessful.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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 administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and	C 342		

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C 342	<p>Continued From page 28</p> <p>interviews, the facility failed to assure accuracy of Medication Administration record for 1 of 6 (#4) sampled resident's related to documenting administration of Risperdal and Prolixin.</p> <p>The findings are:</p> <p>1. Review of Resident #4's current FL2 dated 12/15/17 revealed -Diagnoses included hypertension and high blood pressure, anxiety disorder, Schizoaffective disorder and insomnia. -A physician's order for Risperdal (used to treat behaviors and psychosis) 4 mg twice daily.</p> <p>Review of Resident #4's record revealed a subsequent physician's order dated 12/05/17, which changed Risperdal 4 mg to once daily.</p> <p>Review of Resident #4's December 2017 Medication Administration Record (MAR) revealed: -An entry for Risperdal 4 mg twice daily at 8:00 am and 8:00 pm. -Risperdal was documented as administered daily at 8:00 am and 8:00 pm from 12/05/17 through 12/21/17.</p> <p>Observation on 12/21/17 at 11:50 am of Resident #4's medications on hand at the facility revealed: -Risperdal 4 mg once daily was available for administration. -There was no other Risperdal available for administration. -The medication was filled on 12/07/17 and a quantity of 30 tablets were dispensed. -There were 17 tablets on hand at the facility.</p> <p>Interview on 12/21/17 at 3:48 pm with Resident #4 revealed:</p>	C 342		

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C 342	<p>Continued From page 29</p> <ul style="list-style-type: none"> -He was ordered Risperdal for anxiety. -He did not how often the medication was ordered. -He knew facility staff administered the medication, but did not know how often the medication was administered. <p>Interview on 12/21/17 at 10:33 am with the contract pharmacy revealed:</p> <ul style="list-style-type: none"> -They received an order dated 12/05/17 which changed Risperdal 4 mg from twice daily to once daily. -On 12/07/17 they dispensed 30 tablets. -The facility did send FL2s to the pharmacy, but they had not received Resident #4's FL2 dated 12/15/17. -The last FL2 they had for Resident #4 was dated 11/15/17. -The pharmacy had no orders for Risperdal after 12/05/17. -If facility staff were documenting the MARs twice daily for the administration of Risperdal 4 mg, it was just that; documentation, because no medication should be available. <p>Interview on 12/21/17 at 2:21 pm with the nurse at Resident #4's physician's office revealed:</p> <ul style="list-style-type: none"> -Resident #4 was seen by the physician on 12/05/17. -The physician changed the Risperdal 4 mg from twice daily to once daily. -The physician did not change the Risperdal 4 mg back to twice daily. -The resident should be administered the medication once daily. -If there was an order or FL2 that changed the Risperdal 4 mg to twice daily it was not signed by Resident #4's physician. <p>Interview on 12/21/17 at 3:38 pm with the</p>	C 342		

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C 342	<p>Continued From page 30</p> <p>Medication Aide (MA) revealed: -She administered Risperdal 4 mg to Resident #4 once daily at 8:00 am. -There were two entries on the MAR for Risperdal 4 mg twice daily at 8:00 am and 8:00 pm. -She administered the medication once daily to the resident. -The pharmacy dispensed 30 tablets, so there was no medication to administer at 8:00 pm. -She knew it was not right to document on the MAR, but did not know what else to do.</p> <p>Refer to interview on 12/21/17 at 10:40 am with the Administrator.</p> <p>2. Review of Resident #4's current FL2 dated 12/15/17 revealed: -Diagnoses of schizophrenia and anxiety disorder. -A physician's order for fluphenazine (Prolixin) (used to treat and manage symptoms of schizophrenia) 5 mg once daily.</p> <p>Review of Resident #4's December 2017 MAR revealed: -An entry for fluphenazine 5 mg once daily at 8:00 am. -There was documentation of administration of fluphenazine 5 mg daily at 8:00 am from 12/01/17 through 12/21/17.</p> <p>Observation on 12/21/17 at 11:50 am of Resident #4's medications on hand at the facility revealed fluphenazine 5 mg was not available for administration.</p> <p>Interview on 12/21/17 at 3:48 pm with Resident #4 revealed: -He knew some of his medications ordered by the physician, but did not know if fluphenazine</p>	C 342		

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C 342	<p>Continued From page 31</p> <p>(Prolixin) was a medications ordered.</p> <p>Interview on 12/21/17 at 10:33 am with the contract pharmacy revealed: -The pharmacy did not dispense fluphenazine 5 mg in December 2017 because the physician had not renewed the order. -Two week ago the pharmacist requested the physician to either renew or discontinue the fluphenazine order, but as of today's date the physician had not responded back with an order. -Unless the physician sent the pharmacy an order to discontinue fluphenazine 5 mg it would continue to be printed on the MAR, and the medication would not be dispensed to the facility. -There should be no fluphenazine tablets in the facility for staff to administer. -If staff was documenting the administration of fluphenazine on the MAR, it was just that; documentation, because the pharmacy had not dispensed the medication.</p> <p>Interview on 12/21/17 at 3:38 pm with the Medication Aide (MA) revealed: -She knew fluphenazine 5 mg was not in the facility. -She knew MAR documentation was for medications that had been administered. -She did not know why she documented the administration of fluphenazine when the medication was not available in the facility.</p> <p>Interview on 12/21/17 at 2:21 pm with the nurse at Resident #4's physician's office revealed: -Resident #4 was seen by the physician on 12/05/17. -The nurse did not know why the physician would not discontinue or renew the order for fluphenazine, but she would follow-up with the physician today.</p>	C 342		

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C 342	Continued From page 32 Refer to interview on 12/21/17 at 10:40 am with the Administrator. Interview on 12/21/17 at 10:40 am with the Administrator revealed: -He previously had conversations with the medication aides regarding MAR documentation. -He had informed staff MAR documentation was to occur when the medication was administered. -The facility did not have a routine system of checking MARs to ensure staff documented when medications were administered. -He would have another conversation with staff regarding MAR documentation.	C 342		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related hot water temperatures and medication aides training. The findings are: Based on observations, interviews and record reviews, the facility failed to assure hot water	C 912		

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C 912	Continued From page 33 temperatures at 2 of 2 fixtures (sinks and bathtub/showers) used by 6 of 6 residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. [Refer to Tag 105, 10A NCAC 13G .0317(d) Building Service and Equipment (Type B Violation).] 2. Based on interviews and record reviews the facility failed to assure that 2 of 4 sampled staff (Staff C and D) had completed the 5-10 or 15 hour Medication Aide training or verification of employment as a Medication Aide within the previous 24 months. [Refer to Tag 935 G.S. 131D-4.5B(b) Ach Medication Aides Training and Competency (Type B Violation).]	C 912		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which	C935		

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C935	<p>Continued From page 34</p> <p>bleeding occurs or the potential for bleeding exists.</p> <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <p>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ol style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews the facility failed to assure that 2 of 4 sampled staff (Staff C and D) had completed the 5-10 or 15 hour Medication Aide training or verification of employment as a Medication Aide within the previous 24 months.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Review of Staff C's personnel record revealed: <ul style="list-style-type: none"> -Staff C was hired on 8/08/17 a Medication Aide (MA)/Personal Care Aide (PCA). -Staff C completed a Medication Aide Clinical Skills Competency Checklist on 9/15/17. -Staff C completed the written Medication exam 	C935		

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C935	<p>Continued From page 35</p> <p>on 10/07/16.</p> <ul style="list-style-type: none"> -There was no documentation the 5-10 or 15 hour Medication training was completed. -There was not a MA employment verification form in Staff C's personnel record. <p>Review of the October, November and December 2017 Medication Administration Records (MARs) for 6 of 6 residents revealed Staff C documented the administration of medication on 10/03/17-10/10/17, 10/17/17-10/24/17, 11/01/17-11/07/17, 11/14/17-11/21/17, 12/01/17-12/07/17 and 12/12/17-12/18/17.</p> <p>Telephone interview with Staff C on 12/21/17 at 3:52 pm revealed:</p> <ul style="list-style-type: none"> -She had worked at the facility since August 2017. -She was responsible for administering medication to residents during her shift. -She remembered completing the 15 hour Medication Aide training after the facility opened. -She kept a copy of all her training and would bring it in to the facility. -"Everything should be in my staff folder." <p>Interview with the Supervisor-in-Charge (SIC) on 12/21/17 at 11:36 revealed:</p> <ul style="list-style-type: none"> -All staff completed the 15 hour Medication training since August 2017. -The Administrator scanned all documents, including the training certificates, into his computer. -She would check to see if the Administrator could send her documentation for the 15 hour Medication Aide training. <p>Documentation of the 15 hour Medication training was not provided by the facility for Staff C prior to exit.</p>	C935		

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C935	<p>Continued From page 36</p> <p>Attempted interview with the supervision on 12/21/17 at 3:50 pm.</p> <p>2. Review of Staff D's personnel record revealed: -Staff D was hired on 08/08/17 as a MA/PCA. -Staff D completed a Medication Aide Clinical Skills Competency Checklist on 9/15/17. -Staff D completed the written Medication exam on 4/22/05. -There was no documentation the 5-10 or 15 hour Medication Aide training was completed. -There was not a MA employment verification form in Staff D's personnel record.</p> <p>Review of the October, November and December 2017 MARs for 6 of 6 residents revealed Staff D documented the administration of medications on 10/01/17-10/03/17, 10/10/17-10/17/17, 10/24/17-10/31/17, 11/07/17-11/14/17, 11/21/17-11/28/17, 12/05/17-12/12/17, and 12/19/17-12/20/17.</p> <p>Interview with Staff D on 12/21/17 at 11:34 am revealed: -She had been working at the facility since August 2017. -She was responsible administering medication to residents during her shift. -She had completed the 15 hour training, but did not know if she had completed the training since she started working at the facility in August 2017. -She did not have a copy of the 15 hour training certificate.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 12/21/17 at 11:36 revealed: -All staff completed the 15 hour Medication training after the facility opened in August 2017. -The Administrator scanned all documents, including the training certificates, into his</p>	C935		

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C935	<p>Continued From page 37</p> <p>computer. -She would check to see if the Administrator could send her documentation for the 15 hour Medication Aide training.</p> <p>Documentation of the 15 hour Medication training was not provided by the facility for Staff D prior to exit.</p> <p>Attempted telephone interview with the Administrator on 12/21/17 at 5:00 pm was unsuccessful.</p> <p>_____</p> <p>The facility provided the following Plan of Protectoin: -</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2018.</p>	C935		