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GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 000	Initial Comments The Adult Care Licensure Section and the Davidison County Department of Social Services conducted and annual survey and complaint investigation on February 19-22, 2019. The complaint investigation was initiated by the Davidson County Department of Social Services on February 15, 2019.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by storage of oxygen tanks in an unsafe manner in a resident's room. The findings are: Observation of resident room #408 on 02/20/19 at 11:00am revealed: -There was a 28-inch oxygen tank and a 9-inch oxygen tank sitting in an upright position and unracked. -The 9-inch oxygen full tank was sitting near the oxygen refill machine and under the window closest to the head of the resident's bed.	D 079		

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-The 28-inch full oxygen tank was sitting near the refrigerator.

Interview with the resident in room #408 on 02/20/19 at 11:30am revealed:
-He had resided at the facility for about 8 days.
-His family member brought the 28-inch oxygen tank to the facility.
-He had a refill oxygen machine.
-The 9-inch oxygen tank was sitting on the floor because it was full of oxygen.
-The 9-inch oxygen tank was stored in the refill holder of the oxygen machine when it was empty.

Interview with a personal care aide (PCA) on 02/21/18 at 1:20pm revealed:
-She did not know two oxygen tanks were sitting in room #408 unracked.
-If PCA had known, she would have asked the medication aide (MA) what to do.

Interview with the maintenance staff (MS) on 02/20/19 at 1:25pm revealed:
-He did not know two oxygen tanks were sitting in room #408 unracked.
-He could see how the tall oxygen tanks might fall over, and they should be racked.
-The MS removed the 28-inch oxygen tank from room #408 on 02/2019 at 1:25pm, and he took the tank to the therapy room to be racked in the storage area.

Interview with the Director on 02/21/19 at 11:07am revealed:
-She did not know there were two oxygen tanks sitting in Resident #16's room unracked.
-The oxygen tanks should have been in racks to prevent falling over.
-The staff knew oxygen tanks should be racked.
-The staff should have looked for oxygen tanks

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D 079	Continued From page 2 stored on the floor. Interview with the Resident Care Coordinator (RCC) on 02/21/19 at 12:50pm revealed: -She did not know there were two oxygen tanks sitting in Resident #16's room unracked. -She would have told the staff to rack the oxygen tanks. -The oxygen tanks could leak, and it would not be safe. Observation of resident room #408 on 02/20/19 at 4:30pm revealed the 28-inch oxygen tank had been removed from the room. Observation of resident room #408 on 02/21/19 at 1:25pm revealed the 9-inch oxygen tank was still sitting under the window closest to the head of the bed. Interview with the Executive Director (ED) on 02/21/19 at 6:45pm revealed: -She did not know Resident #16 had two unracked oxygen tanks in his room. -If she knew, the oxygen tanks would have been placed in racks. -The personal care aides (PCAs) knew oxygen tanks should not be sitting on the floor because of training at the facility. -The 9-inch oxygen tank would be placed in a rack.	D 079		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required	D 238		

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in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:

(4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.

This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to assure medication orders were accurate and complete on the current FL2s for 1 of 7 sampled residents (#2).

The findings are:

Review of Resident #2's current FL-2 dated 01/08/19 revealed diagnoses included atrial fibrillation, weakness, reduced mobility, dementia without behavioral problems, cognitive communication deficit.

Review of Resident #2's Resident Register revealed the admission date to the facility was 03/01/16.

Review of Resident #2's rehabilitation discharge order summary report dated 01/01/19 revealed there was an order for Hydralazine HCl 50mg take one tablet three times daily. (Used to treat hypertension.)

Review of Resident #2's physician's orders revealed there was a prescription for Hydralazine HCl 50mg take one tablet three times daily dated 01/03/19.

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D 238	Continued From page 4 Review of Resident #2's hospital discharge summary dated 02/05/19 revealed there was a discontinue order for Hydralazine HCl 50mg take one tablet three times daily. Review of Resident #3's record revealed there was no documentation the physician was contacted for clarification of medication orders. Review of Resident #2's medication administration record (MAR) for January 2019 revealed: -There was an entry hand written for Hydralazine HCl 50mg take one tablet twice daily at 8:00am and 6:00pm. -There was documentation of administration for Hydralazine HCl 50mg at 8:00am and 6:00pm from 01/08/19 through 01/31/19. Review of Resident #2's medication administration record (MAR) for February 2019 revealed: -There was no entry for Hydralazine HCl 50mg take one tablet three times daily. -There was no documentation of administration for Hydralazine HCl 50mg from 02/01/19 through 02/15/19. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Interview with a medication aide (MA) on 02/21/18 at 6:55pm revealed the lead MA was responsible for checking the resident's medication orders and MAR's for accuracy. Telephone interview with Resident #2's Primary Care Provider (PCP) on 02/22/19 at 9:47am	D 238		

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revealed:
-He did not know the Hydralazine HCl 50mg was continued.
-Routinely, when a resident was seen for a hospital follow up he would reconcile the resident's medications from the discharge summary and reorder per discharge summary.
-Resident #2 was last seen by the PCP on 01/09/19.
-He did not continue the Hydralazine HCl 50mg according to his note on 01/09/19.
-If the Hydralazine HCl 50mg take one tablet three times daily was on the discharge summary then it should have been put on the current FL-2.
-He expected medication to be given as ordered.
-He expected the orders he provided to be followed.

Interview with a Pharmacist from the facility's contracted pharmacy on 02/21/19 at 5:49pm revealed the pharmacy did not have any record of ever filling Hydralazine HCl 50mg for Resident #2.

Interview with a Pharmacist from the facility's contracted back up pharmacy on 02/21/19 at 5:59pm revealed the pharmacy did not have any record of ever filling Hydralazine HCl 50mg for Resident #2.

Interview with the Director on 02/20/19 at 2:00pm revealed she was responsible for monitoring the MAs.

Interview with the Administrator on 02/19/19 at 3:00pm revealed the Director was responsible for training and monitoring the MAs for documenting administration of medications on the MAR.

Interview with the Administrator on 02/22/19 at

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D 238	Continued From page 6 8:05pm revealed: -She expected for all medications to be administered as ordered. -She expected all MARs to be accurate and documented according to policy. -The MAs were responsible for assuring accuracy of medication administrations and the documentation on the MARs.	D 238		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or	D 278		

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D 278	Continued From page 7 ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or	D 278		

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D 278	Continued From page 8 occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a Licensed Health Professional Support (LHPS) assessment was completed on 1 of 5 sampled residents (Resident #1) in the Special Care Unit (SCU) for the identified tasks of transferring a semi-ambulatory resident, ambulation using assistive device that requires physical assistance, and use of a physical restraint. The findings are: Review of Resident #1's current FL2 dated 12/20/18 revealed: -Diagnoses included unspecified dementia without behaviors, aftercare following a joint replacement, and gait abnormality. -There was an order for half bed rails nightly. Review of the Physician Restraint Order dated 12/13/18 revealed: -Half bed rails were to be used nightly. -A lap belt was to be used when Resident #1 was in the wheelchair. -The resident was to be checked every 30 minutes. -The restraints were to be loosened and removed every two hours.	D 278		

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D 278	Continued From page 9 Review of Resident #1's Resident Register revealed she was admitted to the facility on 11/01/17. Review of Resident #1's LHPS assessment dated 11/08/17 revealed LHPS task of assisting with ambulation. No other tasks were marked. Review of Resident #1's record revealed there was no documentation of a LHPS assessment completed since 11/08/17. Observation on 02/21/19 at 11:03am revealed Resident #1 was in her wheelchair, with a lap belt on, watching television in the community TV room. Based on observation, interviews, and record review, it was determined Resident #1 was not interviewable. Interview with a family member on 02/20/19 at 8:39am revealed that Resident #1 required assistance to transfer to her wheelchair and to the bathroom; and someone had to connect and disconnect her lap belt restraint. Interview with a personal care aide (PCA) on 02/21/19 at 10:10am revealed Resident #1 required assistance to transfer to and from the wheelchair and to the bathroom. Interview with the Special Care Unit (SCU) Resident Care Coordinator (RCC) on 02/21/19 at 1:08pm revealed: -The contracted pharmacy nurse was responsible for completing the LHPS reviews quarterly. -After the LHPS assessments were completed, she and the Director would review them.	D 278		

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D 278	Continued From page 10 -She did not know that Resident #1 was missing any LHPS assessments. Telephone interview with the contracted pharmacy nurse on 02/21/19 at 12:35pm was unsuccessful. Interview with the Director on 02/22/19 at 11:03am revealed: -The contracted pharmacy nurse was responsible for completing LHPS assessments. -She did not know Resident #1 was missing any LHPS assessments. -She was responsible for ensuring LHPS assessments were completed. -She expected them to be completed when due and to be computerized for auditing purposes.. Interview with the Administrator on 02/22/19 at 7:44pm revealed: -She did not know Resident #1's LHPS assessments were not up to date. -The facility Director was responsible for ensuring LHPS assessments were completed.	D 278		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were served nutritionally adequate and palatable	D 297		

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meals.

The findings are:

Interview with a family member on 02/19/19 at 10:35am revealed the food served at the facility tasted bland and did not smell appetizing.

Interview with a resident on 02/19/19 at 10:45am revealed the food had no taste or seasoning on it and sometimes it was not edible.

Interview with a second family member on 02/19/19 at 3:31pm revealed:
-She visited her family member daily and sometimes twice a day.
-The food was sometimes overcooked.
-Sandwiches were served several times a week.
-The sandwiches were hard and dried out sometimes.
-Earlier, in February 2019, the food was so hard it had to be thrown away. Staff then made peanut butter and jelly sandwiches for the residents.

Interview with a third family member on 02/20/19 at 8:39am revealed:
-She visited her family member daily and sometimes twice a day and helped feed her.
-The food was sometimes "as hard as a brick".
-The meats were cooked very tough and should be cooked so residents could eat them easier.
-The sandwiches were hard and dried out sometimes.
-Recently, on a few occasions, the food that was prepared using the menu had to be thrown away. Staff then made peanut butter and jelly sandwiches for the residents.

Review of the breakfast menu for 02/20/19 revealed juice, milk, oatmeal, scrambled eggs,

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sausage or bacon, and toast were to be served.

Observation of the breakfast meal service on 02/20/19 at 7:30am revealed:
-There were thirteen residents in the dining room for breakfast meal service.
-Oatmeal was served on the resident's plates. It was runny and covered one third of the plate.
-Scrambled eggs were served and covered one fourth of the resident's plates.
-Two strips of bacon, half an inch wide by 4 inches long, was served on the residents plates.
-Ground sausage was served to residents on a mechanical soft diet.
-A biscuit was offered to all residents.
-One resident did not like oatmeal and asked for cereal but the facility did not have any cereal she liked so she left the dining room.

Observations of the kitchen on 02/20/19 at 10:30am revealed:
-Baked pork chops were sitting on top the oven covered with foil.
-Lima beans were covered in a pot on the stove top.
-Macaroni noodles were cooking on the stove.

Review of the lunch menu for 02/20/19 revealed pork chops with gravy, macaroni and cheese, lima beans, rolls, and sherbet were to be served.

Observation of the lunch meal service on 02/20/19 at 11:30am revealed:
-There were fourteen residents in the dining room for the lunch meal service.
-Pork chops with gravy on top of them was served and covered one fourth of their plates.
-Ground pork chop with gravy was served to residents on a mechanical soft diet.
-Macaroni and cheese was served and covered

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one third of the resident's plates.
-Lima beans were served and covered one fourth of the resident's plates.
-A roll was offered to all residents.
-Two residents had difficulty cutting the pork chop into pieces so the personal care assistant cut it for them.
-Sherbet was served for dessert.

Interview with two residents on 02/22/19 at 10:05am revealed:
-The food at the facility was not good and had no taste.
-Just recently, their sandwiches had to be thrown out.

Interview with the dietary aide on 02/19/19 at 11:18am revealed:
-Currently, the facility did not have a Kitchen Manager (KM).
-There were complaints about the food when she was there.
-She was not the head cook. The head cook was off today.
-She followed the menu to prepare the meals.

Interview with the Cook on 02/20/19 at 12:15pm revealed:
-The facility did not have a Kitchen Manager (KM).
-When the previous KM was there, residents complained about the food.
-Some sandwiches had to be thrown out so staff made peanut butter and jelly sandwiches for the residents.
-She was the lead cook until a new KM was hired.
-She tried to use seasoning so the food would not be bland.
-She followed the menu to cook meals.

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D 297	Continued From page 14 Interview with the Special Care Unit (SCU) Resident Care Coordinator (RCC) on 02/22/19 at 10:19am revealed the residents did not complain about the food now. Interview with the Administrator on 02/22/19 at 7:44pm revealed: -She knew about the problems with the food. -The KM responsible for the poor quality food was no longer at the facility. -She expected the cooks to follow the approved dietician's menu. -She expected "the food to be nutritious and palatable".	D 297		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 8 ounces of milk was served to the residents twice daily in the Special Care Unit (SCU). The findings are:	D 299		

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D 299	Continued From page 15 Review of the resident Roster for the SCU revealed there were 16 residents in the SCU on 02/20/19. Review of the menu for 02/20/19 revealed 8 ounces of 2% milk was to be served for the breakfast and dinner meal. Observation of the refrigerator in the kitchen area of the SCU on 02/20/19 at 7:30am revealed there was one half gallon of 2% milk available to be served to the residents. (Two gallons would have been needed to serve 16 residents 2 eight ounce glasses of milk for one day.) Observation of the breakfast meal service in the SCU on 02/20/19 between 7:30am and 8:30am revealed: -There were 13 residents seated in the dining room. -The residents were not offered or served milk by staff. -There were four residents that had milk in their cereal. -The residents were served water and orange juice. -There was not a cup on the table for milk. Observation of the lunch meal services in the secured unit between 11:30am and 12:30pm revealed: -There were 14 residents seated in the dining room. -The residents were not offered or served milk by staff. -The residents were served water and tea. -There was not a cup on the table for milk. Interview with a personal care aide (PCA) on 02/20/19 at 12:05pm revealed:	D 299		

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-Milk was not offered or served to the residents for breakfast on 02/20/19.
-There was only one resident served milk with her meals.
-Milk was only given to residents for their cereal.
-She did not know milk was supposed to be served to residents two times a day with meals.
-Milk had not been served with any meals since she had been there (8 months) except to one resident served milk with every meal and residents who ate cereal for breakfast.

Interview with the second PCA on 02/20/19 at 12:10pm revealed:
-Milk was not offered or served to the residents for breakfast on 02/20/19.
-Milk was not served daily and it had been a while since it was served except to the one resident served milk with each meal and to residents when they ate cereal.
-She knew the residents were supposed to be served milk two times a day but did not answer if she was told not to serve milk.

Interview with the Director on 02/20/19 at 1:25pm revealed she did not know milk was supposed to be served to residents two times a day with meals and she had not reviewed the menus.

Interview with the Administrator on 02/20/19 at 12:26pm revealed:
-She knew milk was supposed to be served with two meals per day on the SCU.
-Milk was not offered or served in the SCU except to one resident served milk with each meal or when the resident ate cereal for breakfast.
-Milk was not served to the residents because it would be wasted.
-Most of the residents on the SCU did not like milk.

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D 299	Continued From page 17 - She "would not serve milk and let it be poured out". -She could substitute yogurt in place of milk so that the residents got their calcium. -The residents on the SCU liked yogurt.	D 299		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide feeding assistance in an unhurried manner to 1 of 1 resident (Resident #6) who needed assistance. The findings are: 1. Review of Resident #6's current FL2 dated 01/03/19 revealed: -Diagnoses included dementia, Diabetes Mellitus Type II, hypertension, and anxiety. -Resident #6 was intermittently disoriented. -Resident #6 was ambulatory. Review of Resident #6's care plan dated 01/04/19 revealed Resident #6 required limited assistance to eat. Observations on 02/20/19 from 7:30am to 8:30am of the breakfast meal service revealed:	D 312		

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D 312	Continued From page 18 -There were 13 residents in the dining room for breakfast. -After the breakfast meals were served to the residents a PCA was hurriedly going between 2 tables to feed 3 residents. -Resident #6 was sitting in her chair at the dining table, with her breakfast plate in front of her, but was not feeding herself. -A PCA went and stood beside Resident #6 and fed her a few bites and offered her orange juice and water to drink, then fed the resident next to her a few bites and remained standing. -The PCA then went to the next table and hurriedly gave a third resident a few bites before going back to Resident #6. -The PCA repeated this hurried process until Resident #6 did not want any more food. -The PCA did not sit beside any of the residents when assisting them to eat. She did not talk with them except to tell them to take another bite. Observations on 02/20/19 from 11:30am to 12:05pm revealed: -There were 14 residents in the dining room for lunch. -After the lunch meals were served to the residents a PCA was hurriedly going between 2 tables to feed 3 residents. -Resident #6 was again sitting in her chair at the dining table, with her lunch plate in front of her, but was not feeding herself. -A PCA went and stood beside Resident #6 and fed her a few bites and offered her tea and water to drink, then fed the resident next to her a few bites and remained standing. -The PCA then went to the next table and gave a third resident a few bites before going back to Resident #6. -The PCA repeated this process until Resident #6 did not want any more food.	D 312		

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D 312	Continued From page 19 -The PCA did not sit beside any of the residents when assisting them to eat. She did not talk with them except to tell them to take another bite. Based on observations, interviews and record review, Resident #6 was not interviewable. Interview with a PCA on 02/20/19 at 12:05pm revealed she knew that residents were supposed to be provided feeding assistance in an unhurried manner while sitting down with the resident. Interview with a second PCA on 02/20/19 at 12:10 pm revealed: -She knew that residents were supposed to be provided feeding assistance in an unhurried manner. -She had to ensure that all residents were fed their meal. Interview with the SCU RCC on 02/20/19 at 12:12pm revealed: -She helped out as often as she could. -She did not know residents were supposed to be provided feeding assistance in an unhurried manner. Interview with the Director on 02/20/19 at 12:25 pm revealed she did not know about the rule to provide feeding assistance in an unhurried manner. Interview with the Administrator on 02/20/19 at 12:26pm revealed: -She knew about the rule to provide feeding assistance in an unhurried manner. -She expected the PCA's to sit with the residents while assisting them to eat in an unhurried manner.	D 312		

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D 317	Continued From page 20	D 317		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a minimum of 14 hours of planned group activities for the residents residing in the Special Care Unit (SCU). The findings are: Review of February 2019 facility activity calendar in the SCU revealed blank calendar with no activities scheduled. Observations on 02/19/19 and 02/20/19 at various times throughout the day revealed there were no activities being conducted in the SCU and no activity supplies were sitting out for residents.	D 317		

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D 317	Continued From page 21 Interview with two residents on 02/22/19 at 10:05 am revealed there were no activities offered in the SCU and the only activities that were held was a group of 3-4 female residents playing with one of the residents' playing cards. Interview with Housekeeping Staff on 02/22/19 at 10:08am revealed: -She usually cleaned the SCU daily. -She had never seen any activities provided or conducted in the SCU. Interview with the SCU Resident Care Coordinator (RCC) on 02/22/19 at 10:19am revealed: -She held activities on 02/21/19 around 10:00 am for 15 minutes and then had residents to walk up and down the hall after lunch around 1:00 pm. -Some residents play cards in the evening with one of the residents' playing cards, but she played with them when she was available. -The group that played cards initiated the card game themselves. -The dining room was used for activities. -She had two sets of playing cards if the residents needed them. -Sometimes, the SCU staff would take the ambulatory residents to the front to join their activities. Interview with a medication aide (MA) on 02/22/19 at 10:43am revealed: -She used to be responsible for providing activities with the residents who resided on the assisted living (AL) unit. -She was assigned back on the medication cart. -She tried to provide some activities throughout the day. -It had been a couple of days since she had held activities in the SCU.	D 317		

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D 317	Continued From page 22 Interview with a resident's family member on 02/19/19 at 3:31pm revealed she visited daily and there were no activities conducted in the SCU. Interview with a second family member on 02/22/19 at 10:30am revealed she visited the SCU 1-2 times per day and the only activities she had seen was 3-4 female residents' playing with one of the residents' playing cards. Interview with the Director on 02/22/19 at 11:03am revealed: -She did not know there were no activities being held in the SCU. -She had been reworking schedules to be able to dedicate staff to conduct activities. -She knew there were supposed to be 14 hours of scheduled activities for the residents weekly. -She expected activities to be completed at least twice daily. Interview with the Administrator on 02/22/19 at 7:44pm revealed: -She expected staff to be appointed to activities. -She expected 14 hours of activities to be planned and carried out by staff.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

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D 358	Continued From page 23 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 4 residents (#8, #18, #19) observed during the medication passes including errors with medications related to an anti-psychotic (#8), potassium and fish oil supplements, a laxative and an antihistamine eye drop (#18), crushing and administering a medication that should not be crushed (#18), and not watching medications being administered (#19); and 1 of 7 sampled resident (#7) related to an anti-anxiety medication. The findings are: 1. The medication error rate was 18% as evidenced by the observation of 6 errors out of 32 opportunities during the 7:00am and 8:00am medication passes on 02/20/19. A. Review of Resident #18's current FL-2 dated 09/24/18 revealed diagnoses included dementia, dysphasia, symbolic dysfunction, depression, hip fracture, paranoid state, osteoarthritis and anxiety.	D 358		

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D 358	Continued From page 24 a. Review of Resident #18's current FL-2 dated 09/24/18 revealed a physician's order for Potassium Chloride (CL) 20meq 1 tablet daily, dissolve in four ounces of water for two minutes then stir for 30 seconds and drink. (Potassium is used to treat low potassium level. Potassium chloride should not be crushed.) Review of signed physician orders for January 2019 for Resident #18 revealed an order for potassium chloride 20meq 1 tablet daily, dissolve in four ounces of water for two minutes then stir for 30 seconds and drink. Observation of the morning medication pass on 02/20/19 at 8:00am to 8:10am revealed: -The medication aide (MA) crushed Resident #18's Potassium 20meq tablet, and administered it in apple sauce to the resident at 8:10am. (Potassium should not be crushed.) -The MA documented the medication as administered on the medical administration record (MAR). -The MA did not use a do not crush (DNC) list to determine which medications could be crushed. Review of Resident #18's February 2019 MAR revealed: -There was an entry for potassium 20meq (dissolve in four ounces of water for two minutes then stir for 30 seconds and drink.) every day at 8:00am. -Potassium 20meq was documented as administered on 02/20/19 at 8:00am. -There was no documentation on the MAR related to crushing the resident's potassium. Interview with the MA on 02/20/19 at 1:10pm revealed:	D 358		

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-She had noticed the directions on the label for the potassium 20meq 1 tablet daily, dissolve in four ounces of water for two minutes then stir for 30 seconds and drink.
-She had always crushed the potassium and put it in apple sauce.

Observation of Resident #18's medications on hand on 02/20/19 at 8:00am to 8:10am revealed:
-There was one container (cassette) of potassium 20meq tablets dispensed on 01/17/19 with 9 remaining.
-The pill container had directions that read "Dissolve in four ounces of water for two minutes then stir for 30 seconds and drink by mouth every morning".

Telephone interview with Resident #18's Primary Care Provider (PCP) on 02/22/19 at 9:47am revealed:
-He did not know the facility was crushing Resident #18's potassium 20meq.
-The potassium 20meq tablets should not be crushed, but dissolved.
-The potassium tablet form was on the do not crush list (DNC).

Telephone interview with the pharmacist from the contracted pharmacy on 02/21/19 at 4:03pm revealed:
-Resident #18 had an order for potassium 20meq tablets take one daily.(Dissolve in 4 oz of liquid for 2 minutes, stir and 30 seconds and drink).
-The potassium CL 20meq should not be crushed but could be dissolved.
-The potassium CL 20meq is on the DNC list.
-The potassium CL 20meq was dispensed, 14 tablets on 01/17/19, 01/31/19 and 02/14/19.

Refer to interview with the Director on 02/20/19 at

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D 358	Continued From page 26 2:00pm. Refer to interview with the Administrator on 02/19/19 at 3:00pm. Refer to interview with the Administrator on 02/22/19 at 8:05pm. b. Review of Resident #18's current FL-2 dated 09/24/18 revealed a physician's order for fish oil 1000mg 1 capsule every morning (fish oil is used as a supplement). Review of signed physician orders for January 2019 for Resident #18 revealed an order for fish oil 1000mg 1 capsule every morning. Observation of the morning medication pass on 02/20/19 at 8:00am to 8:10am revealed the MA administered one fish oil 500 mg capsule and documented on the MAR as administered. Review of Resident #18's February 2019 medication administration record (MAR) revealed: -There was an entry for fish oil 1000 mg capsule take one every morning at 8:00am. -Fish oil 1000mg was documented as administered at 8:10am on 02/20/19. Interview with the MA on 02/20/19 at 1:10pm revealed she always gave Resident #18 one fish oil capsule. Observation of Resident #18's medications on hand on 02/20/19 at 8:34am revealed: -There was one bottle of over the counter Fish oil 500 mg capsules available for administration. -Directions printed on the bottle was to take two capsules daily.	D 358		

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Telephone interview with Resident #18's PCP on 02/22/19 at 9:47am revealed:
-He did not know Resident #18 was given 500 mg of fish oil daily instead of 1000mg.
-He had ordered for Resident #18 to take 1000mg of fish oil daily.

Refer to interview with the Director on 02/20/19 at 2:00pm.

Refer to interview with the Administrator on 02/20/19 at 2:00pm.

Refer to interview with the Administrator on 02/22/19 at 8:05pm.

c. Review of Resident #18's current FL-2 dated 09/24/18 revealed a physician's order for polyethylene glycol 3350 powder mix one capful (17) gm with liquid and drink every day (used to treat constipation).

Review of signed physician orders for January 2019 for Resident #18 revealed an order for polyethylene glycol 3350 powder mix one capful (17) gm with liquid and drink every day.

Observation of the morning medication pass on 02/20/19 at 8:00am to 8:10am revealed:
-The MA administered polyethylene glycol 3350 powder mix one capful (17) gm with 4 ounces of water.
-The bottle of polyethylene glycol 3350 powder administered to Resident #18 had another resident's name on the printed prescription label from the pharmacy.
-The administration of the medication was documented on the MAR.

Review of Resident #18's February 2019

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medication administration record (MAR) revealed:
-There was an entry for polyethylene glycol 3350 powder mix one capful (17) gm with liquid and drink every day at 8:00am.
-Polyethylene glycol 3350 powder was documented as administered at 8:10am on 02/20/19.

Interview with the MA on 02/20/19 at 1:10pm revealed:
-The MA did not have to borrow the polyethylene glycol 3350 powder from another resident because Resident #18 had the medication on hand.
-Resident #18 did have polyethylene glycol 3350 powder on hand dispensed 07/26/18.

Observation of Resident #18's medications on hand on 02/20/19 at 8:34am revealed:
-There was a 527 gram bottle of polyethylene glycol 3350 powder labeled from the pharmacy for Resident #18.
-The bottle of polyethylene glycol 3350 powder had a hand written opened date of 09/15/18.
-The bottle of polyethylene glycol 3350 powder was stored in the wall cabinet in the medication room on the Special Care Unit (SCU).
-There was no polyethylene glycol 3350 powder on the SCU medication cart.

Refer to interview with the Director on 02/20/19 at 2:00pm.

Refer to interview with the Administrator on 02/19/19 at 3:00pm.

Refer to interview with the Administrator on 02/22/19 at 8:05pm.

d. Review of Resident #18's current FL-2 dated

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D 358	Continued From page 29 09/24/18 revealed a physician's order for Olopatadine 0.2% eye drops instill one drop into both eyes every morning (used to treat allergies of the eye). Review of signed physician orders for January 2019 for Resident #18 revealed an order for Olopatadine 0.2% eye drops instill one drop into both eyes every morning. Observation of the morning medication pass on 02/20/19 at 8:00am to 8:10am revealed Olopatadine 0.2% eye drops was not administered to Resident #18. Review of Resident #18's February 2019 medication administration record (MAR) revealed: -There was an entry for Olopatadine 0.2% eye drops instill one drop into both eyes every morning 8:00am. -Olopatadine 0.2% eye drops was documented as administered at 8:10am on 02/20/19. Interview with the MA on 02/20/19 at 1:10pm revealed: -She did not administer the Olopatadine 0.2% eye drops at the time of medication administration observation. -The Olopatadine 0.2% eye drops were administered after the time of medication administration observation. -She had forgotten to report the Olopatadine 0.2% eye drops would be administered at a later time. -The Olopatadine 0.2% eye drops had been reordered on 02/20/19. Observation of Resident #18's medications on hand on 02/20/19 at 1:11pm revealed: -There was an empty pill bottle with a pharmacy	D 358		

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label for Olopatadine 0.2% eye drops.
-The dispensing date was 10/04/18 for a quantity of 2.5 milliliters.
-The pill bottle did not contain the actual bottle of Olopatadine 0.2% eye drops.

Review of the facility's pharmacy requisition record dated 02/20/19 revealed the Olopatadine 0.2% eye drops had been reordered.

Based on observation, interview, and record review, it was determined Resident #18 was not interviewable.

Refer to interview with the Director on 02/20/19 at 2:00pm.

Refer to interview with the Administrator on 02/19/19 at 3:00pm.

Refer to interview with the Administrator on 02/22/19 at 8:05pm.

B. Review of Resident #8's current FL-2 dated 01/23/19 revealed:
-Diagnoses included history of temporal lobe seizure, schizophrenia, dementia, GERD, depression, anxiety, urinary tract infection (UTI), left knee bursitis, vitamin D deficiency, and temporal lobectomy.
-There was an order for Haldol concentrate 2mg/ml take 1 ml twice a day. (Used to treat schizophrenia.)

Observation of the morning medication pass on 02/20/19 at 7:25am to 7:32am revealed:
-The MA retrieved a monoject oral syringe with a small tan rubber cap with the only visible markings were 0.1, 0.2, 0.3 and 0.5.
-The MA used the monoject oral syringe to draw

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Haldol con 2mg/ml from the liquid medication bottle.
-The MA drew the Haldol 2mg/ml to the 0.5 mark on the monoject oral syringe.
-The MA dispensed the 0.5 of the Haldol 2mg/ml in to a cup containing two ounces of water.
-The water containing the Haldol was then administered to Resident #8.
-The MA documented the medication administration on the MAR.
-Resident #8 only received 0.5ml (1mg) of the Haldol 2mg/ml instead of the ordered dose of 1.0ml (2mg).

Review of Resident #8's February 2019 medication administration record (MAR) revealed:
-There was an entry for Haldol 2mg/mg take 1ml (2mg) twice daily, at 8:00am and 8:00pm.
-Haldol was documented as administered 8:00am on 02/22/19.

Observation of Resident #8's medications on hand on 02/20/19 at 7:35am revealed:
-There was one bottle of Haldol 2mg/mg.
-The dispensing date was 02/18/19 for a quantity of 60ml.

Interview with the medication aid (MA) on 02/20/19 at 7:35am revealed:
-She used the monoject oral syringe to draw the Haldol from the medication bottle.
-She was shown how to draw the medication from the medication bottle by the facility's pharmacist.
-She was shown to draw the Haldol to the 0.5 mark.
-She mixed the Haldol in the 2 ounces of water per Resident #8's request.
-There was no other oral syringe in the facility.

Telephone interview with the pharmacist from the

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contract pharmacy on 02/21/19 at 4:03pm revealed:
-Resident #8 had ordered Haldol 1 ml (2mg) take 1ml twice per day.
-Monoject oral syringes came in 1ml or 3ml dosage capacities.
-Haldol 1ml (2mg) was dispensed 60ml for each on 10/25/18, 11/16/18, 12/12/18, 01/04/19, 01/28/19 and 02/20/18.
-The 0.5ml mark would equal 1mg of the Haldol 1ml/2mg.

Telephone interview with a Certified Medical Assistant at for Resident #8's PCP office on 02/22/19 at 10:47am revealed:
-Resident #8 had an order for Haldol 2 mg twice per day.
-The last time the resident had been seen in the office was 03/24/16.

Interview with Resident #8 on 02/22/19 at 11:05am revealed:
-She did not think she was getting the correct dose of her Haldol.
-She did not think the MAs were measuring her Haldol correctly.
-She knew the Haldol was supposed to be measured with a syringe.
-The Haldol helps me "sleep and relax".

Interview with the Director on 02/20/19 at 2:00pm revealed:
-She did not know the MA was only drawing up 0.5ml of the Haldol instead of the 1ml as ordered.
-She had shown the MA how to properly draw up the 1.0ml of Haldol.
-She would order new syringes today.

Refer to interview with the Director on 02/20/19 at 2:00pm.

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D 358	Continued From page 33 Refer to interview with the Administrator on 02/19/19 at 3:00pm. Refer to interview with the Administrator on 02/22/19 at 8:05pm. C. Review of Resident #19's current FL-2 dated 11/09/18 revealed: - Diagnoses included arterial fibrillation, osteoarthritis, altered mental status, delirium, chronic kidney disease, emphysema and heart disease. -There was an order for Ferrous Sulfate 325mg take one daily. (Used as an iron supplement.) -There was an order for Lasix 40mg take one daily. (Used to treat fluid buildup.) -There was an order for Prilosec 20mg take one daily. (Used to treat acid reflux.) -There was an order for Miralax 17gm in 8 ounces of liquid daily. (Used to treat constipation.) -There was an order for Potassium 20meq take one daily. (Used to prevent and treat low potassium levels.) -There was an order for Quinapril 20mg take two daily. (Used to treat hypertension and congestive heart failure.) -There was an order for Seroquel 25 mg take twice daily. (Used to treat mental/mood conditions.) Observation of the morning medication pass on 02/20/19 at 7:38am to 7:40am revealed: -Ferrous Sulfate 325mg was prepared by the MA and placed in a medication cup for administration. -Lasix 40mg was prepared by the MA and placed in a medication cup for administration. -Prilosec 20mg was prepared by the MA and placed in a medication cup for administration. -Miralax 17gm was prepared by the MA and	D 358		

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placed in a medication cup for administration.
-Potassium 20meq was prepared by the MA and placed in a medication cup for administration.
-Quinapril 20mg was prepared by the MA and placed in a medication cup for administration.
-Seroquel 25 mg was prepared by the MA and placed in a medication cup for administration.
-The medication were left with Resident #19 which was sitting outside of the medication room on the assistant living unit of the facility.
-The MA left Resident #19 to return to the medication room to prepare another resident's medication.
-The MA did not watch Resident #19 take her the medications that were left with the resident.
-The MA did not return to ask Resident #19 if she had taken the medication.

Review of Resident #19's February 2019 medication administration record (MAR) revealed:
-There was an entry for Ferrous Sulfate 325mg take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Lasix 40mg take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Prilosec 20mg take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Miralax 17gm in 8 ounces of liquid daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Potassium 20meq take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Quinapril 20mg take two daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Seroquel 25 mg take twice daily at 8:00am and 8:00pm, and

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D 358	Continued From page 35 documented as administered on 02/20/19 at 8:00am. Interview with the MA on 02/20/19 at 7:50am revealed: -The resident did not have an order to self-administer. -She knew she was supposed to watch the residents take their medication before starting another residents' medications. Interview with Resident #19 on 02/20/19 at 4:50pm revealed: -The MAs always gave her the medication cup and water and the MAs did not watch her take her medications. -The MAs did not ask her if she had taken her medication. -The MAs knew she was going to take her medications. -She thought the MAs were supposed to watch her take her medications, but they do not. Interview with the Director on 02/20/19 at 2:00pm revealed: -The MAs were to watch the residents take their medications prior to documenting administration and prior to preparing another resident's medication. -MAs had been trained on proper medication administration multiple times in the past. -The MAs had been trained to actually watch the residents take their medications and document on the MARs after administration and before starting on another resident's medication. -The MAs should not leave the medications unattended. Refer to interview with the Director on 02/20/19 at 2:00pm.	D 358		

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D 358	Continued From page 36 Refer to interview with the Administrator on 02/19/19 at 3:00pm. Refer to interview with the Administrator on 02/22/19 at 8:05pm. D. Review of Resident #7's current FL2 dated 05/30/18 revealed: -Diagnoses included dementia Alzheimer type, memory loss, and anxiety. -There was an order for lorazepam 0.5 mg two times a day (used to treat anxiety). Review of Resident #7's December 2018, and January 2019 medication administration records (MARs) revealed: -There was an entry for lorazepam 0.5 mg two times a day scheduled for administration at 8:00am and 8:00pm daily. -Lorazepam 0.5 mg was documented as administered 2 times a day for December 2018 except for the evening dose not documented as administered from 12/23/18 to 12/28/19. (There was no reason documented for not administering the evening dose.) -Lorazepam 0.5 mg was documented as administered 2 times a day for January 2019 except for the 8:00pm dose on 01/26/19 with no reason documented for the missed dose. Review of Resident #7's physician's order dated 02/06/19 revealed lorazepam 0.5 mg was increased to 3 times a day for agitation. Review of Resident #7's February 2019 MAR revealed: -Lorazepam 0.5 mg two times a day was listed on the MAR, scheduled for administration at 8:00am and 8:00pm daily, and documented administered	D 358		

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as ordered from 02/01/19 to 02/05/19. The order was discontinued on 02/05/19.
-Lorazepam 0.5 mg three times a day was handwritten on the February 2019 MAR beginning on 02/06/19 and scheduled for administration at 8:00am, 3:00pm, and 8:00pm daily.

Review of Resident #7's controlled substance count sheet (CSCS) sent with lorazepam 0.5mg by the contracted pharmacy compared to the February 2019 MAR revealed:
-There was a CSCS sheet for 28 lorazepam 0.5 mg dispensed 01/31/19 and a CSCS for 27 lorazepam 0.5 mg sent on 02/06/19.
-There was an entry for lorazepam 0.5 mg two times a day scheduled for administration at 8:00am and 8:00pm daily, and documented as administered as ordered from 02/01/19 to 02/05/19. The order was discontinued on 02/05/19.
-There was an entry for lorazepam 0.5 mg three times a day handwritten on the February 2019 MAR beginning on 02/06/19 and scheduled for administration at 8:00am, 3:00pm, and 8:00pm daily, and documented as administered as ordered.
-On 02/06/19, lorazepam 0.5 mg was documented as administered on the MAR at 8:00am and 8:00pm, and only at 8:00pm on the CSCS.
-On 02/07/19, lorazepam was documented as administered on the MAR at 8:00am and 8:00pm, and at 8:00am and 8:00pm on the CSCS.
-On 02/08/19-02/15/19, lorazepam was documented as administered three times a day on the MAR at 8:00am, 3:00pm and 8:00pm, and on the CSCS 02/08/19, 02/09/19 and 02/10/19 at 8:00am, 3:00pm and 8:00pm correctly; but on the CSCS on 02/11/19 at 8:00am and 4:00pm; but on the CSCS on 02/12/19, 02/13/19, 02/14/19 and

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D 358	Continued From page 38 02/15/19 at 8:00am and 8:00pm. -On 02/16/19, lorazepam was documented as administered on the MAR at 8:00am and 8:00pm, and on the CSCS at 8:00am and 8:00pm. -On 02/17/19-02/20/19, lorazepam was documented as administered on the MAR at 8:00am, 3:00pm, and 8:00pm, and on the CSCS at 8:00am and 8:00pm on 02/17/19, 02/18/19, 02/20/19; on 02/19/19 documented at 8:00am only on the CSCS. On 02/21/19, lorazepam was documented as administered on the CSCS at 8:00am, 3:00pm, and 8:00pm. -On 02/22/19, lorazepam was documented as administered on the MAR and CSCS at 8:00am and 3:00pm. Based on review of the February 2019 MAR and Resident #7's CSCS for lorazepam 0.5 mg, Resident #7 was not administered 14 doses of lorazepam 0.5 mg from 02/06/19 to 02/22/19. Telephone interview with a representative of the contracted pharmacy on 02/22/19 at 11:15 am revealed: -Resident #7 was dispensed 28 tablets of lorazepam 0.5 mg tablets labeled for administration 2 times a day. -Resident #7 was dispensed 27 tablets of lorazepam 0.5 mg tablets labeled for administration 3 times a day. -The pharmacy sent CSCS sheets with the lorazepam 0.5 mg tablets to be used for tracking administration of the medication. Interview with the Special Care Unit Resident Care Coordinator (SCURCC) on 02/22/19 at 7:50pm revealed: -Medication aides were supposed to read the MAR and administer medications according to the orders on the MAR.	D 358		

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D 358	Continued From page 39 -She did not know why MAs had not been administering Resident #7's lorazepam 0.5 mg 3 times a day as ordered. -She was responsible for assuring resident in the SCU received medications as ordered. -She did not have a system in place to routinely audit residents' MAR compared to CSCS to assure medications were administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. Interview with the Administrator on 02/22/19 at 8:05pm revealed the MAs were responsible for assuring accuracy of medication administrations and the MARs and the Director or SCURCC were to monitor. Refer to interview with the Director on 02/20/19 at 2:00pm. Refer to interview with the Administrator on 02/19/19 at 3:00pm. Refer to interview with the Administrator on 02/22/19 at 8:05pm. _____ Interview with the Director on 02/20/19 at 2:00pm revealed: -She was responsible for monitoring the MA. -She expected all medications to be administered as ordered. -She expected for all medications to be administered properly by all MAs. Interview with the Administrator on 02/19/19 at 3:00pm revealed: -The Director was responsible for training and	D 358		

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D 358	Continued From page 40 monitoring the MAs. -The contract nurse came in after the Director had trained the MAs and would complete the competency validation checklist. Interview with the Administrator on 02/22/19 at 8:05pm revealed: -She expected for all medications to be administered as ordered. -She expected all MARs to be accurate and documented on according to policy. -She expected for medications to be on hand and available for administration. The facility failed to assure medications were administered as ordered to 3 residents (#8, #18, #19) observed during the medication passes including errors with medications related to an anti-psychotic, potassium and fish oil supplements, a laxative and an antihistamine eye drop (#8, #18), crushing and administering a medication that should not be crushed (#18) and not watching medications being administered (#19) and one resident (#7) related to an anti-anxiety medication. This failure of not receiving medications as ordered could result in failure to treat diseases properly and increased risk of exacerbations of clinical symptoms which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/22/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2019.	D 358		

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D 366	Continued From page 41	D 366		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff observed the resident actually taking the medications for 1 of 4 residents (#19) observed during medication passes on 02/20/19. The findings are: 1. Review of Resident #19's current FL2 dated 11/09/18 revealed: - Diagnoses included arterial fibrillation, osteoarthritis, altered mental status, delirium, chronic kidney disease, emphysema and heart disease. -There was an order for Ferrous Sulfate 325mg take one daily. (Used as an iron supplement.) -There was an order for Lasix 40mg take one daily. (Used to treat fluid buildup.) -There was an order for Prilosec 20mg take one daily. (Used to treat acid reflux.) -There was an order for Miralax 17gm in 8	D 366		

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ounces of liquid daily. (Used to treat constipation.)
-There was an order for Potassium 20meq take one daily. (Used to prevent and treat low potassium levels.)
-There was an order for Quinapril 20mg take two daily. (Used to treat hypertension and congestive heart failure.)
-There was an order for Seroquel 25 mg take twice daily. (Used to treat certain mental/mood conditions.)

Observation of the morning medication pass on 02/20/19 at 7:35am to 7:40am revealed:
-Ferrous Sulfate 325mg was prepared by the medication aide (MA) and placed in a medication cup for administration.
-Lasix 40mg was prepared by the medication aide (MA) and placed in a medication cup for administration.
-Prilosec 20mg was prepared by the MA and placed in a medication cup for administration.
-Miralax 17gm was prepared by the MA and placed in a medication cup for administration.
-Potassium 20meq was prepared by the MA and placed in a medication cup for administration.
-Quinapril 20mg was prepared by the MA and placed in a medication cup for administration.
-Seroquel 25 mg was prepared by the MA and placed in a medication cup for administration.
-The medications were handed to Resident #19 who was sitting outside of the medication room on the assistant living unit of the facility.
-The MA left Resident #19 to return to the medication room to prepare another resident's medications.
-The MA did not watch Resident #19 take her the medications that were left with the resident.
-The MA did not return to ask Resident #19 if she had taken the medication.

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Review of Resident #19's February 2019 medication administration record (MAR) revealed:
-There was an entry for Ferrous Sulfate 325mg take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Lasix 40mg take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Prilosec 20mg take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Miralax 17gm in 8 ounces of liquid daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Potassium 20meq take one daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Quinapril 20mg take two daily at 8:00am, and documented as administered on 02/20/19 at 8:00am.
-There was an entry for Seroquel 25 mg take twice daily at 8:00am and 8:00pm, and documented as administered on 02/20/19 at 8:00am.

Interview with the MA on 02/20/19 at 7:50am revealed she knew she was supposed to watch the residents take their medication before starting another resident's medications.

Interview with Resident #19 on 02/20/19 at 4:50pm revealed:
-The MAs always gave her the medication cup and water and the MAs did not watch her take her medications.
-The MAs did not ask her if she had taken her medication.
-The MAs knew she was going to take her medications.
-She thought the MAs were supposed to watch

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D 366	Continued From page 44 her take her medications, but they did not. Interview with the MA on 02/19/19 at 10:20am revealed: -She had completed the morning medication administrations for all the residents on the AL unit of the facility. -She was documenting on the MARs for all the medications administered to the all the residents on the AL unit of the facility. -Usually she documented the medications administration to residents as she administered the medication, but that morning she did not due to having to go to the special care unit (SCU) and help administer medications. Interview with the Director on 02/20/19 at 2:00pm revealed: -She was responsible for monitoring the MAs. -She expected all medications to be administered as ordered. -The MAs had been trained to actually watch the residents take their medications and document on the MARs after administration and before starting on another resident's medications. -MAs had been trained on proper medication administration multiple times in the past. Interview with the Administrator on 02/19/19 at 3:00pm revealed the Director was responsible for training and monitoring the MAs. Interview with the Administrator on 02/22/19 at 8:05pm revealed: -She expected for all medications to be administered as ordered. -She expected all MARs to be accurate and documented on according to policy.	D 366		

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D 367	Continued From page 45	D 367		
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 administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the medication administration records were accurate and complete for 3 of 7 sampled residents (#2, #4 and #7). The findings are:	D 367		

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D 367	Continued From page 46 1. Review of Resident #2's current FL-2 dated 01/08/19 revealed: -Diagnoses including atrial fibrillation, weakness, reduced mobility, dementia without behavioral problems, cognitive communication deficit. -There was an order for multi-vitamin take one daily. (Used to treat vitamin deficiency) Review of Resident #2's Resident Register revealed the admission date to the facility was 03/01/16. Review of Resident #2's medication administration record (MAR) for January 2019 revealed: -There was an entry for multi-vitamin one tablet daily, scheduled for 8:00am. -Multi-vitamin was documented as administered at 8:00 am daily from 01/08/19 through 01/31/19. Review of Resident #2's medication administration record (MAR) for February 2019 revealed: -There was an entry for multi-vitamin one tablet daily, scheduled for 8:00am. -Multi-vitamin was documented as administered at 8:00 am daily from 02/01/19 through 02/13/19 to 02/16/19 through 02/21/19. Observation of Resident #2's medication on hand on 02/21/19 revealed there was no bottle of multi-vitamin available for administration. Interview with the medication aide (MA) on 02/21/19 at 1:05pm revealed: -There was no multi-vitamin for Resident #2 in house. -Multi-vitamins for not a medication that the facility had as house stock.	D 367		

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-The residents' family was responsible for bring the Multi-vitamins.
-The MA would notify the residents' family when additional medication were needed.
-She would contact the family and have then bring some in.

Interview with the Director on 02/21/19 at 1:20pm revealed:
-Staff had been asked to document their contact with the residents' family down regarding residents needing medications.
-MAs were to call the residents family when the resident is down to seven doses of medication.
-The MA were to document the calls, how many medications are left and what was needed in the care notes in the medication rooms.

Observation of medication room over stock cabinet on the assisted living (AL) unit of the facility on 02/21/19 at 1:25pm revealed there was no house stock of multi-vitamin.

Interview with the Director on 02/21/19 at 1:25pm revealed:
-There was no house stock of multi-vitamin on the AL unit or the special care unit (SCU).
-She would try to find some.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Interview with Resident #2's responsible party on 02/21/19 at 3:45pm revealed:
-He comes to see the resident every week.
-He has never brought any medications to the facility for Resident #2.
-No one at the facility has ever asked him to provide any medication for Resident #2.

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D 367	Continued From page 48 Interview with a Pharmacist from the contracted pharmacy on 02/21/19 at 5:49pm revealed the pharmacy did not have any record of ever filling multi-vitamin for Resident #2. Interview with a Pharmacist from the back up contracted pharmacy on 02/21/19 at 5:59pm revealed the pharmacy did not have any record of ever filling multi-vitamin for Resident #2. Refer to interview with the Director on 02/20/19 at 2:00pm. Refer to interview with the Administrator on 02/19/19 at 3:00pm. Refer to interview with the Administrator on 02/22/19 at 8:05pm. 2. Review of Resident #7's current FL2 dated 05/30/18 revealed: -Diagnoses included dementia Alzheimer type, memory loss, and anxiety. -There was an order for lorazepam 0.5 mg two times a day (used to treat anxiety). Review of Resident #7's physician's order dated 02/06/19 revealed lorazepam 0.5 mg was increased to 3 times a day for agitation. Review of Resident #7's February 2019 MAR revealed there was an entry for lorazepam 0.5 mg three times a day handwritten on the February 2019 MAR beginning on 02/06/19 and scheduled for administration at 8:00am, 3:00pm, and 8:00pm daily. Review of Resident #7's February 2019 MAR compared to the controlled substance count	D 367		

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sheet (CSCS) sent with lorazepam 0.5mg by the contract pharmacy revealed:
-There was an entry for lorazepam 0.5 mg three times a day handwritten on the February 2019 MAR beginning on 02/06/19 and scheduled for administration at 8:00am, 3:00pm, and 8:00pm daily.
-On 02/06/19, lorazepam 0.5 mg was documented as administered on the MAR at 8:00am and 8:00pm, but at 8:00pm only on the CSCS.
-On 02/08/19-02/15/19, lorazepam was documented as administered three times a day on the MAR at 8:00am, 3:00pm and 8:00pm and on 02/08/19, 02/09/19 and 02/10/19 at 8:00am, 3:00pm and 8:00pm on the CSCS ; on 02/11/19, documented on the CSCS at 3:00pm and 8:00pm; on 02/12/19 documented on CSCS at 8:00am and 8:00pm; on 02/13/19, 02/14/19 and 02/15/19 at 8:00am and 8:00pm only on the CSCS .
-On 02/17/19-02/21/19, lorazepam was documented as administered on the MAR at 8:00am, 3:00pm, and 8:00pm, and on the CSCS at 8:00am and 8:00pm on 02/17/19, 02/18/19, 02/20/19 with 02/19/19 documented at 8:00am only on the CSCS.

Based on review of the February 2019 MAR and Resident #7's CSCS for lorazepam 0.5 mg, Resident #7 there were 14 doses of lorazepam 0.5 mg from 02/06/19 to 02/22/19 not administered and incorrectly listed on the MAR compared to the CSCS.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

Telephone interview with a representative of the

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contracted pharmacy on 02/22/19 at 11:15 am revealed:
-Resident #7 was dispensed 28 tablets of lorazepam 0.5 mg tablets labeled for administration 2 times a day.
-Resident #7 was dispensed 27 tablets of lorazepam 0.5 mg tablets labeled for administration 3 times a day.
-The pharmacy sent CSCS sheets with the lorazepam 0.5 mg tablets to be used for tracking administration of the medication.

Interview with the Special Care Unit Resident Care Coordinator (SCURCC) on 02/22/19 at 7:50pm revealed:
-Medication aides were supposed to read the MAR and administer medications according to the orders on the MAR.
-She did not know why MAs had not been administering Resident #7's lorazepam 0.5 mg 3 times a day as ordered.
-She was responsible for assuring resident in the SCU received medications as ordered.
-She did not have a system in place to routinely audit residents' MAR compared to CSCS to assure medications were administered as ordered.

Refer to interview with the Director on 02/20/19 at 2:00pm.

Refer to interview with the Administrator on 02/19/19 at 3:00pm.

Refer to interview with the Administrator on 02/22/19 at 8:05pm.

3. Review of Resident #4's current FL2 dated 01/01/19 revealed:
-Diagnoses included Alzheimer's disease, chronic

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obstructive pulmonary disease, and paranoid schizophrenia.
-There was an order for Norco 5/325 (a narcotic pain reliever used to treat moderate to severe pain) one tablet daily as needed for pain.

Review of Resident #4's record revealed a previous physician's order dated 11/07/18 for Norco 5/325 one tablet three times a day; and a subsequent physician's order dated 11/21/18 to decrease Norco 5/325 to as needed.

Observation of medication on hand for administration for Resident #4 on 02/22/19 revealed a prescription bottle from a local pharmacy labeled for Norco 5/325 quantity of ninety tablets dispensed on 11/08/18.

Review of Resident #4's facility generated controlled substance count sheet (CSCS) for Norco 5/325 revealed:
-There were 50 Norco 5/325 tablets documented administered and 4 tablets documented as wasted.
-The ending balance on 11/30/19 was thirty-six tablets.

Review of Resident #4's December 2018 medication administration record (MAR) revealed
-There was a handwritten entry for Norco (hydrocodone/acetaminophen) 5/325 one tablet as needed.
-There were 5 occasions when Norco was documented as administered on the December 2018 MAR.
-On 12/15/18, 12/16/18, 12/19/18, 12/20/18, and 12/21/18 there were doses of Norco documented as administered.

Review of Resident #4's facility generated

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controlled substance count sheet (CSCS) compared to the December 2018 MAR revealed:
-There were thirty-six tablets for the beginning balance for December 2018.
-There were 7 doses of Norco documented as administered on the CSCS.
-None of the days documented for administration on the MAR matched doses documented as administered on the CSCS.
-Doses documented as administered on the CSCS were on 12/04/18 at 6:00pm; on 12/07/18 at 8:00pm; on 12/10/18 at 8:00pm; on 12/11/18 at 4:00pm; on 12/12/18 at 8:00pm; on 12/13/18 at 8:00pm; and on 12/31/18 at 4:00pm.

Review of Resident #4's January 2019 MAR revealed:
-There was a handwritten entry for Norco (hydrocodone/acetaminophen) 5/325 one tablet as needed.
-There were 4 occasions when Norco 5/325 was documented as administered on the January 2019 MAR.
-One dose of Norco 5/325 was documented as administered on the January 2019 MAR on 01/03/19, 01/21/19, and 2 doses documented on 01/22/19.

Review of Resident #4's facility generated controlled substance count sheet revealed:
-There were twenty-nine tablets logged as the beginning balance on 01/01/19.
-There were 15 doses of Norco signed for administration on the CSCS.
-Three of the days documented for administration on the January 2019 MAR matched the doses documented as administered on the CSCS (01/03/19, 01/21/19, and 01/22/19 at 8:00pm).
-Examples of the eleven doses documented as administered on the CSCS that were not on the

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January 2019 MAR were: on 01/01/19 at 8:00pm; on 01/02/19 at 4:00pm and at 9:00pm; on 01/04/19 at 8:00am, 2:00pm, and 8:00pm; on 11/05/19 at 8:00am, 2:00pm, and 8:00pm; on 01/08/19 at 8:00am, and at 2:00pm.

Review of Resident #4's February 2019 MAR revealed:
-There was a handwritten entry for Norco (hydrocodone/acetaminophen) 5/325 one tablet as needed.
-There were 4 occasions when Norco was documented as administered on the February 2019 MAR.
-On 02/02/19, 02/03/19, 02/08/19 and on 02/19/19 there were doses of Norco documented as administered on the MAR.

Review of Resident #4's facility generated controlled substance count sheet (CSCS) revealed:
-There were fourteen tablets logged as the beginning balance on 02/01/19.
-There were four doses of Norco documented as administered on the CSCS.
-Two of the days documented for administration on the MAR matched the doses documented as administered on the CSCS (02/02/19 and 02/08/19).
-Two doses documented as administered on the CSCS for February 2019 were not on the February 2019 MAR; on 02/05/19 at 8:00am and 02/20/29 at 9:00am.

Observation of medication on hand for administration on 02/22/19 revealed Resident #4 had 10 Norco 5/325 on hand which matched the CSCS quantity.

Based on observations, interviews, and record

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GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(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 367	Continued From page 54 reviews it was determined Resident #4 was not interviewable. Interview with the Special Care Unit Resident Care Coordinator (SCURCC) on 02/22/19 at 9:00am revealed: -She did not know residents' CSCS documentation did not match the residents' MARs for controlled medications. -She did not currently have a system in place to audit residents MARs compared to CSCS for accuracy. -She was responsible for the accurate accounting of the residents' controlled substances in the Special Care Unit (SCU). Refer to interview with the Director on 02/20/19 at 2:00pm. Refer to interview with the Administrator on 02/19/19 at 3:00pm. Refer to interview with the Administrator on 02/22/19 at 8:05pm. Interview with the Director on 02/20/19 at 2:00pm revealed: -She was responsible for monitoring the medication aides (MAs) documenting of administration on the residents' MARs. -The MAs had been trained to document on the MARs after administration and before starting on another resident's medication. -She did not currently have a system in place to routinely audit residents' MARs for accuracy. -The MAs would have additional training provided. Interview with the Administrator on 02/19/19 at 3:00pm revealed the Director was responsible for	D 367		

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D 367	Continued From page 55 training and monitoring the medication aides for documenting administration of medications on the MAR. Interview with the Administrator on 02/22/19 at 8:05pm revealed: -She expected for all medications to be administered as ordered. -She expected all MARs to be accurate and documented according to policy. -The MAs were responsible for assuring accuracy of medication administrations and the documentation on the MARs. -The Director was to responsible to assure accuracy of the MARs.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 1 of 5 residents sampled (Resident #18) who was prescribed controlled substances. The findings are: Review of Resident #18 current FL2 dated 09/24/18 revealed:	D 392		

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D 392	Continued From page 56 -Diagnoses included dementia, depression, osteoarthritis and history of hip fracture. -The resident's recommended level of care was Special Care Unit (SCU). 1. Review of Resident #18's current FL2 dated 09/24/18 revealed an order for oxycodone -acetaminophen 10-325 mg (a narcotic pain reliever used to treat moderate to severe pain) one tablet 4 times daily. Review of Resident #18's record revealed a physician's order dated 10/05/18 to decrease oxycodone-acetaminophen 10-325 mg due to increased sedation (there was no definite number of times per day included). Review of Resident #18's record revealed a physician's order dated 02/06/19 to increase oxycodone-acetaminophen 10-325 mg to 4 times a day. Interview with the Special Care Unit Resident Care Coordinator (SCURCC) on 02/22/19 at 9:00 am revealed: -The medication aides (MAs) in the Special Care Unit (SCU) did not use all the CSCS provided by the facility's contracted pharmacy. -The pharmacy routinely sent control medications (Resident #18's oxycodone-acetaminophen 10-325) in cassettes of 15 tablets each. -The pharmacy sent a control sheet for the total number of tablets sent, but did not routinely send a CSCS with each cassette. -MAs documented on the front and back of the CSCS in 15 tablet blocks. -All medications were kept in a locked drawer on the medication cart. -The CSCS were kept in a book in the medication room.	D 392		

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D 392	Continued From page 57 -She was not aware of a facility policy for accounting for accounting, and storing for controlled substances. -She was in the process of developing a better system for managing controlled medications. -Medications were not always administered in the order they were received, making tracking of the receipt, administration, and disposition of a medication difficult. -The completed CSCS were not filed in a particular order. Telephone interview with a staff of the facility's contracted pharmacy on 02/22/19 at 11:20am revealed: -On 10/08/18, Resident #18 was dispensed 120 oxycodone-acetaminophen 10-325 mg. -On 11/13/18, Resident #18 was dispensed 120 oxycodone-acetaminophen 10-325 mg. -On 12/31/18, Resident #18 was dispensed 120 oxycodone-acetaminophen 10-325 mg . -On 01/31/19, Resident #18 was dispensed 120 oxycodone-acetaminophen 10-325 mg. -The pharmacy sent a control substance count sheet (CSCS) with the medications when dispensed. Review of Resident #18's December 2018 medication administration record (MAR) revealed: -Oxycodone-acetaminophen 10-325 mg one tablet 4 times daily was preprinted on the MAR and scheduled for 7:00am, 11:00am, 3:00pm and 7:00pm. -Oxycodone-acetaminophen 10-325 mg was documented as administered 114 times out of 120 opportunities for December 2018. Review of Resident #18's CSCS for oxycodone-acetaminophen 10-325 mg compared to the December 2018 MAR revealed:	D 392		

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D 392	Continued From page 58 -Oxycodone-acetaminophen 10-325 mg tablets dispensed on 11/13/18 (120 tablets) were documented on the CSCS for routine administration 3 times a day from 11/26/18 to 12/15/18 for a total of 75 tablets; from 01/15/19 at 3:00pm to 01/25/19 for a total of 30 tablets and four times a day from 02/17/19 at 3:00pm to 02/21/19 at 8:00am for a total of 15 tablets to equal 120 tablets. -There were no CSCS available for review for documentation of administration for oxycodone-acetaminophen 10-325 mg tablets from 12/25/18 to 12/31/18 for a total of 21 doses not accounted for. Review of Resident #18's January 2019 MAR revealed: -Oxycodone-acetaminophen 10-325 mg one tablet 3 times daily was transcribed on the MAR and scheduled for 8:00am, 2:00pm and 8:00pm. -Oxycodone-acetaminophen 10-325 mg was documented as administered 93 times out of 93 opportunities. Review of Resident #18's CSCS for oxycodone-acetaminophen 10-325 mg compared to the January 2019 MAR revealed there were 92 doses of oxycodone-acetaminophen 10-325 mg documented as administered one the MAR and 74 doses documented as administered on the CSCS and one dose documented as wasted for a total of 75 doses. There were 18 doses not accounted for. Review of Resident #18's February 2019 MAR revealed: --Oxycodone-acetaminophen 10-325 mg one tablet 4 times daily was preprinted on the MAR and scheduled for 7:00am, 11:00am, 3:00pm and 7:00pm.	D 392		

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D 392	Continued From page 59 -Oxycodone-acetaminophen 10-325 mg was documented as administered 68 times for February 2019 from 02/01/19 to 02/22/19 at 7:00am. Review of Resident #18's CSCS for oxycodone-acetaminophen 10-325 mg compared to the February 2019 MAR revealed: -Oxycodone-acetaminophen 10-325 mg tablets dispensed on 12/31/18 (120 tablets) were documented on the CSCS for administration for a total of 75 tablets. There were 45 doses not accounted for. Review of Resident #18's medication on hand for administration on 02/22/19 revealed oxycodone-acetaminophen 10-325 mg tablets dispensed on 01/31/18 (120 tablets) had 120 tablets on hand. Based on record review, interview, and observation there were 84 doses without an accounting from 360 tablets dispensed on 10/08/18, 11/13/18, 12/31/18 and 01/31/19. Based on observations, interviews, and record reviews it was determined Resident #18 was not interviewable. Refer to interview with a morning shift medication aide on 02/22/19 at 3:30pm. Refer to interview with the Director on 02/22/19 at 5:30pm. Refer to interview with the Administrator on 02/22/19 at 5:45pm. 2. Review of Resident #18's current FL2 dated 09/24/18 revealed an order for oxycodone 5mg (a	D 392		

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D 392	Continued From page 60 narcotic pain reliever used to treat moderate to severe pain) one daily. Review of Resident #18's record revealed signed physician's orders (no date) for January 2019 ordering oxycodone 5mg one daily. Telephone interview with a staff at the facility's contracted pharmacy on 02/22/19 at 11:20am revealed: -On 12/04/18, Resident #18 was dispensed 30 oxycodone 5 mg. -On 12/31/18, Resident #18 was dispensed 30 oxycodone 5 mg. -On 01/31/19, Resident #18 was dispensed 30 oxycodone 5 mg. -The pharmacy sent a control substance count sheet (CSCS) with the medications when dispensed. Interview with the Special Care Unit Resident Care Coordinator (SCURCC) on 02/22/19 at 9:00 am revealed: -The medication aides (MAs) in the Special Care Unit (SCU) did not use all the CSCS provided by the facility's contracted pharmacy. --The pharmacy routinely sent control medications (Resident #18's oxycodone 5 mg) in cassettes of 15 tablets each -The pharmacy sent a control sheet for the total number of tablets sent, but did not routinely send a CSCS with each cassette. -MAs documented on the front and back of the CSCS in 15 tablet blocks. -All medications were kept in a locked drawer on the medication cart. -The CSCS were kept in a book in the medication room. -She was not aware of a facility policy for accounting for accounting, and storing for	D 392		

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controlled substances.
-She was in the process of developing a better system for managing controlled medications.
-Medications were not always administered in the order they were received, making tracking of the receipt, administration, and disposition of a medication difficult.
-The completed CSCS were not filed in a particular order.

Review of Resident #18's December 2018 medication administration record (MAR) revealed:
-Oxycodone 5 mg one tablet daily was preprinted on the MAR and scheduled for 11:00pm.
-Oxycodone 5 mg was documented as administered 31 times out of 31 opportunities for December 2018.

Review of Resident #18's CSCS for oxycodone 5 mg dispensed compared to the December 2018 MAR revealed:
-Three tablets from thirty tablets dispensed on 11/05/18 were documented as administered in December 2018.
-Twenty six tablets were documented as administered from 30 tablets dispensed on 12/04/18 were documented as administered from 12/04/18 to 12/31/18 on the CSCS (one tablet each signed out by different staff on 12/07/19 at 11:00pm) and one tablet documented for dropped (wasted) on 12/08/19 at 11:00pm. No tablets were documented as administered on the CSCS from 12/25/18 to 12/28/18. There were four tablets not accounted for one the CSCS for 12/04/18 dispensing of 30 tablets.

Review of Resident #18's January 2019 MAR revealed:
-Oxycodone 5 mg one tablet daily was preprinted on the MAR and scheduled for 11:00pm.

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D 392	Continued From page 62 -Oxycodone 5 mg was documented as administered 31 times out of 31 opportunities for January 2019. Review of Resident #18's controlled drug count sheet (CSCS) for oxycodone 5 mg dispense on 12/31/18 for 30 tablets compared to the January 2018 MAR revealed: -Administration was documented from 01/01/19 to 01/16/19 and 01/19/19 to 01/31/19. -There were 2 occasions, 01/17/19 at 11:00pm and 01/18/19 at 11:00pm, when oxycodone 5 mg was documented as administered on the resident's MAR but not signed out on the CSCS. There were 2 doses not accounted for on the CSCS. Review of Resident #18's January 2019 MAR revealed: -Oxycodone 5 mg one tablet daily was preprinted on the MAR and scheduled for 11:00pm. -Oxycodone 5 mg was documented as administered 20 times out of 22 opportunities for February 2019 from 02/01/19 to 02/22/19. Review of Resident #18's February 2019 MAR compared to the CSCS for oxycodone dispensed on 01/31/19 for 30 tablets revealed: -There was one dose documented as administered on 02/01/19 from the CSCS sheet for dispense date of 12/31/18. -Administration was documented on the CSCS from 02/02/19 to 02/16/19 and 02/16/19 to 02/20/19. -On 02/01/19, one tablet was documented as administered on the CSCS at 11:00pm, but there was no documentation for administration of oxycodone 5 mg on the MAR (day was blank). -On 02/03/19, one tablet was documented as administered on the CSCS at 11:00pm, but there	D 392		

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was no documentation for administration of oxycodone 5 mg on the MAR (day was blank).
-On 02/21/19, the dose documented as administered on the MAR was not documented as administered on the CSCS.
-There was one dose not accounted for on the CSCS.

Observation of Resident #18's oxycodone 5 mg on hand for administration on 02/22/19 revealed 10 tablets remained matching the CSCS count that should be on hand.

Based on record review, interview, and observation there were 7 doses without an accounting from 90 tablets dispensed on 12/04/18, 12/31/18, and 01/31/19.

Based on observations, interviews, and record reviews it was determined Resident #18 was not interviewable.

Refer to interview with a morning shift medication aide on 02/22/19 at 3:30pm.

Refer to interview with the Director on 02/22/19 at 5:30pm.

Refer to interview with the Administrator on 02/22/19 at 5:45pm.

3. Review of Resident #18's current FL2 dated 09/24/18 revealed an order for alprazolam 0.5 mg (used to treat anxiety) one tablet three times daily.

Review of Resident #18's record revealed signed physician's orders signed (no date) for January 2019 ordering alprazolam 0.5 mg (used to treat anxiety) one tablet three times daily.

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D 392	Continued From page 64 Telephone interview with a staff at the contracted pharmacy on 02/22/19 at 11:20am revealed: -Resident #18 was dispensed 42 alprazolam 0.5 mg on 11/21/18. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 12/06/18. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 12/20/18. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 01/03/19. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 01/17/19. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 01/31/19. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 02/14/19. -The pharmacy sent a control substance count sheet (CSCS) with the medications when dispensed. Interview with the Special Care Unit Resident Care Coordinator (SCURCC) on 02/22/19 at 9:00 am revealed: -The MAs in the SCU did not use all the CSCS provided by the facility's contract pharmacy. -The pharmacy routinely sent control medications (Resident #18's alprazolam) in cassettes of 14 tablets each. -The pharmacy sent a control sheet for the total number of tablets sent, but did not routinely send a CSCS with each cassette. -MAs documented on the front and back of the CSCS in 15 tablet blocks. -All medications were kept in a locked drawer on the medication cart. -The CSCS were kept in a book in the medication room. -She was not aware of a facility policy for accounting for accounting, and storing for	D 392		

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controlled substances.
-She was in the process of developing a better system for managing controlled medications.
-Medications were not always administered in the order they were received, making tracking of the receipt, administration, and disposition of a medication difficult.
-The completed CSCS were not filed in a particular order.

Review of Resident #18's CSCS used to document administration of alprazolam 0.5 mg revealed:
-There were CSCS sheets for 14 tablets each generated by the facility that did not contain the date dispensed or an identifier that could be used to determine the date dispensed.
-The facility had no system in place to accurately track the receipt, administration or disposition of Resident #18's alprazolam.

Review of Resident #18's December 2018 MAR revealed:
-Alprazolam 0.5 mg one tablet three times a day was preprinted on the MAR and scheduled for 8:00 am, 2:00 pm, and 8:00pm.
-Alprazolam 0.5 mg was documented as administered 93 times out of 93 opportunities for December 2018.

Review of Resident #18's CSCS documenting administration for 12/01/18 to 12/31/18 compared to Resident #18's December 2018 MAR revealed:
-There were 6 occasions when alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS for alprazolam. (87 documented administration).
-On 12/20/18 at 8:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not

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D 392	Continued From page 66	D 392		

documented as administered on the CSCS.
-On 12/21/18 at 8:00am, 2:00pm, and at 8:00pm alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS.
-On 12/26/18 at 2:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS.
-On 12/28/18 at 2:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS.

Review of Resident #18's January 2019 MAR revealed:
-Alprazolam 0.5 mg one tablet three times a day was preprinted on the MAR and scheduled for 8:00 am, 2:00 pm, and 8:00pm.
-Alprazolam 0.5 mg was documented as administered 93 times out of 93 opportunities for January 2018.

Review of Resident #18's CSCS documenting administration from 01/01/19 to 01/31/19 compared to Resident #18's January 2019 MAR revealed:
-Alprazolam 0.5 mg was documented as administered 90 times on the CSCS.
-There were 3 occasions when alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS for alprazolam.
-On 01/10/19 at 2:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS.
-On 01/25/19 at 2:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS.
-On 01/26/19 at 8:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(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 392	Continued From page 67 Review of Resident #18's February 2019 MAR revealed: -Alprazolam 0.5 mg one tablet three times a day was preprinted on the MAR and scheduled for 8:00 am, 2:00 pm, and 8:00pm. -Alprazolam 0.5 mg was documented as administered 63 times out of 63 opportunities for February 2018 from 02/01/19 to 02/22/19. Review of Resident #18's CSCS documenting administration from 01/01/19 to 01/31/19 compared to Resident #18's February 2019 MAR revealed: -There were 4 occasions when alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS for alprazolam. -On 02/11/19 at 2:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS. -On 02/16/19 at 8:00am, and at 2:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS. -On 02/21/19 at 8:00pm, alprazolam 0.5 mg was documented as administered on the MAR but not documented as administered on the CSCS. Observation of Resident #18's alprazolam 0.5 mg on hand for administration revealed alprazolam 0.5 mg tablets as follows: -Resident #18 was dispensed 42 alprazolam 0.5 mg on 11/21/18, twenty-eight tablets remained. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 12/06/18, zero tablets remained. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 12/20/18, zero tablets remained. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 01/03/19, fourteen tablets remained.	D 392		

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D 392	Continued From page 68 -Resident #18 was dispensed 42 alprazolam 0.5 mg on 01/17/19, zero tablets remained. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 01/31/19, twenty-eight tablets remained. -Resident #18 was dispensed 42 alprazolam 0.5 mg on 02/14/19, twenty-eight tablets remained. Based on record reviews, interviews, and observations the number of doses of alprazolam 0.5 mg documented as administered and documented on the CSCS revealed there were 13 tablets not accounted for. It could not be determined if the quantity dispensed from the contracted pharmacy matched the quantity available for administration. Based on observations, interviews, and record reviews it was determined Resident #18 was not interviewable. Interview with a morning medication aide in the special care unit (SCU) on 02/22/19 at 3:30pm revealed: -She documented the residents' control medications on the MAR before she administered the medication. -She was very careful to document control medications on the CSCS only when she prepared the medication. -If she logged a control medication out on the CSCS, she administered the medication. -She sometimes overlooked correcting the residents MARs if the resident was not administered the medication because the resident refused the medication or the MA got very busy and did not administer. Interview with the Director on 02/22/19 at 5:30pm revealed: -She did not know the MAs in the SCU were not	D 392		

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D 392	Continued From page 69 using the CSCS sheets sent by the pharmacy to accurately tract the administration, receipt or disposition of controlled medications. -The SCURCC was responsible to assure controlled medications were monitored for accurate accounting of the controlled medications. -She did not currently have a system in place to routinely audit control medications compared to the CSCS sheets being used. -She did not know the CSCS were not in a readily retrievable order. -She did not know some of the CSCS were not able to be located. Interview with the Administrator on 02/22/19 at 6:00pm revealed: -She came to the facility every Wednesday and another alternating day of the week. -The Director and the SCURCC were responsible to assure controlled medications were properly tracked. -She did not know the controlled medications in the SCU were not being audited for the CSCS documentation compared to the residents' MARs. -She had implemented a system a couple of years ago for tracking the controlled medications at the facility. -Due to staff turnover, the system was not currently being used. -She would reinstate a full controlled substance tracking system immediately.	D 392		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a	D 454		

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D 454	Continued From page 70	D 454		

resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:
(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to notify the responsible party for 1 of 2 residents (Resident #5) who eloped.

The findings are:

Review of Resident #5's record revealed:
-Resident #5 was admitted to the facility on 01/02/19.
-Resident #5 resided in the Special Care Unit of the facility.

Review of Resident #5's current FL2 dated 01/02/19 revealed diagnosis included dementia and the resident was documented as a wanderer.

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D 454	Continued From page 71 Review of the facility's incident and accident reports revealed there was no report available for review regarding Resident #5 eloping from the Special Care Unit on 02/03/19. Telephone interview with the Responsible Party for Resident #5 on 02/21/19 a 11:30am revealed the Responsible Party had not been notified by anyone from the facility regarding an elopement of Resident #5 from the Special Care Unit. Interview with a Medication Aide (MA) in the Special Care Unit on 02/22/19 at 9:25am revealed: -The Medication Aide was working in the Special Care Unit of the facility on 02/03/19. -Resident #5 eloped from the Special Care Unit of the facility on 02/03/19 during the first of second shift. (Review of the staffing information revealed the SCU was staffed according to the requirements). -A staff member (the MA could not recall which staff member) from the Assisted Living side of the facility brought Resident #5 back to the Special Care Unit stating Resident #5 was found on the hallway outside of the Special Care Unit but still inside the building. -The MA did not know Resident #5 had eloped from the Special Care Unit. -The MA failed to contact the responsible party of Resident #5 regarding the elopement. -The MA failed to report the incident to the administration or notify the Responsible Party. Interview with the Director on 02/22/19 at 11:00am revealed no staff had reported the elopement of Resident #5 from the Special Care Unit on 02/03/19 to her.	D 454		

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D 454	Continued From page 72 Based on record review, and observation of Resident #5 on 02/22/19, it was determined the resident was not interviewable.	D 454		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) on the third shift for 10 of 11 third shifts sampled for 11 days from February 1, 2019 to February 20, 2019. The findings are: The facility was licensed by the Division of Health Service Regulation for a Special Care Unit with a capacity of 16 beds. Review of the facility resident census dated 02/01/19 revealed: -There was a SCU census of 14 residents, which required 11.2 staff hours on third shift. -Review of individual time cards dated 02/01/19	D 465		

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D 465	Continued From page 73	D 465		

revealed 8 staff hours were provided on third shift, leaving the shift short 3.2 hours.

Review of the facility resident census dated 02/02/19 revealed:
-There was a SCU census of 14 residents, which required 11.2 staff hours on third shift.
Review of individual time cards dated 02/02/19 revealed 8 staff hours were provided on third shift, leaving the shift short 3.2 staff hours.

Review of the facility resident census dated 02/03/19 revealed:
-There was a SCU census of 14 residents, which required 11.2 staff hours on third shift.
-Review of individual time cards dated 02/03/19 revealed 8 staff hours were provided on third shift, leaving the shift short by 3.2 staff hours.

Review of the facility resident census dated 02/04/19 revealed:
-There was a resident census of 14 residents, which required 11.2 staff hours ion third shift.
-Review of individual time cards dated 02/04/19 revealed 8 staff hours were provided on third shift, leaving the shift short by 3.2 staff hours.

Review of the facility resident census dated 02/09/19 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/09/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 02/10/19 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/10/19

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D 465	Continued From page 74	D 465		

revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 2/11/2019 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/11/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 02/18/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of individual time cards dated 02/18/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Review of the facility resident census dated 02/19/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of individual time cards dated 02/19/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Review of the facility resident census dated 02/20/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of the individual time cards dated 02/20/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Interview with a personal care aide (PCA) on 2/21/19 at 12:15am revealed:
-She started working on the Special Care Unit (SCU) about 4 months ago.
-Normally only one PCA worked on the SCU from

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D 465	Continued From page 75 11:00pm-7:00am. -She would call the PCA on the Assisted Living Unit (ALU) if she needed help. -On 3rd shift, the PCA from the ALU stayed on the SCU for an hour. -The PCA from the ALU would notify the RCC if the residents on the SCU required medication. Interview with a Medication Aide in the SCU on 02/22/19 at 9:25am revealed: -The facility Director is responsible for scheduling staff. -There were usually 2 aides scheduled for 3rd shift in the SCU. -If someone called out, the facility Director was notified and the Director and/or staff called to find other staff to come in to help. -Some staff worked double shifts to cover "call-outs". -Staff worked hard to meet the needs of the residents. Interview with the Director on 2/22/19 at 10:05am revealed: -The facility director was responsible for staff scheduling. -There had been several staff that quit since the first of the year. -She tried to schedule more staff than required so they would not be short if staff called out. -When staff informed her of a call out, she attempted to get other staff to come in to cover. -There were times when some staff worked double shifts. -She helped out on the floor if she is able to do so when they were short staffed.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train	D 468		

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D 468	Continued From page 76 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that 2 of 4 sampled staff (C and D) who provide care in the Special Care Unit had completed the 20 hours of training specific to the population served within six months of hire to	D 468		

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D 468	Continued From page 77	D 468		

work in the Special Care Unit (SCU).

The findings are:

1. Review of the personnel record for Staff C revealed:
-The hire date for Staff C was 04/17/18.
-Staff C worked as a Medication Aide.
-Staff C completed the required 6 hours of Special Care Unit (SCU) orientation on 04/20/18.
-Staff C had documentation of 15 of the 20 required hours required specific to the population served with 6 months of hire.

Staff C was no available for interview on 02/21/19 or 02/22/19.

Interview with the Administrator on 02/22/19 at 1:00pm revealed:
-A request was made for further documentation of SCU training for Staff C.
-No further documentation of the 20 hour training specific to the SCU for Staff C was provided by the end of the survey.

2. Review of the personnel record for Staff D revealed:
-Staff D was hired on 07/19/16.
-Staff D worked as a Medication Aide.
-Staff D completed the 6 hour Special Care Unit (SCU) orientation on 04/03/18 upon being assigned to work in the SCU.
-Staff D had documentation of 10 of 20 required hours of required training specific to the population being served within the first six months of assignment to the SCU.

Interview with the Administrator on 02/22/19 at 1:00pm revealed:
-A request was made for further documentation of

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D 468	Continued From page 78 SCU training for Staff D. -No further documentation of the 20 hour training specific to the SCU was provided by the end of the survey.	D 468		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep	D 482		

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a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure physical restraints were used only after an assessment, care and team planning, use of alternative were tried and documented, and a written order by a physician was obtained, for 2 of 6 sampled residents related to a resident (#3) who had a half bed rails attached to both sides of his bed; and 1 resident who had a lap belt used while sitting in the wheelchair (#17).

The findings are:

Review of the facility's restraint policy (no date) revealed:
-"A physician restraint order must be obtained prior to application of a restraint.
-Before physical restraints are applied, in addition to physician orders, consent must be obtained from the resident or resident's representative.

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-A restraint assessment and care plan should be completed."
-"The restraint assessment and care plan must be updated every 3 months".

1. Review of Resident #3's current FL2 dated 10/01/18 revealed:
-Diagnoses included acute kidney infection (AKI), Parkinson, hematemesis, aspiration pneumonia, dysphagia, fracture left femoral and hypertension.
-The resident was semi-ambulatory with the wheelchair.
-There was no physician's order for bed rails.

Review of Resident #3's Resident Register revealed an admission date of 03/08/18.

Review of Resident #3's assessment and care plan dated 03/23/18 revealed:
-The resident was always disoriented.
-The resident was totally dependent with ambulation, toileting, bathing, dressing and grooming.
-There was no documentation for the use of bed rails for Resident #3.

Review of Resident #3's Licensed Health Professional Support (LHPS) review dated 01/25/19 revealed there was no documentation for the use of bed rails for Resident #3.

Observation on 02/19/19 in Resident #3's bedroom in room #407 at 11:00am revealed:
-A hospital bed with half bed rails attached to both sides of his bed.
-The rail next to the wall was in an up position.

Interview with a personal care aide (PCA) on 02/20/19 at 6:35pm revealed:
-The side rails were pulled up when Resident #3

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went to bed.
-The rails were used to prevent Resident #3 from falling out of bed.

Observation on 02/21/19 at 8:30am revealed:
-A hospital bed with half bed rails attached to both sides in an up position.
-Resident #3 was in the bed.

Interview with a second PCA on 02/21/19 at 8:30am revealed:
-The side rails were pulled when Resident #3 was in the bed.
-Two staff members put Resident #3 in the bed, and they pulled up the bed rails to prevent resident from falling out of the bed.

Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 02/21/19 at 12:50pm revealed:
-She knew Resident #3 had side rails on his bed.
-The side rails were used to prevent resident from falling out of bed.

Telephone interview with the home health agency's nurse on 02/21/19 at 3:43pm revealed
-The half side rails were used to prevent Resident #3 from rolling out of the bed.
-The rails just came with the bed.
-The home health agency's physician had not been asked to write an order for bed rails for Resident #3
-The home health agency's physician could not write an order for bed rails because hospice was a restraint free agency.
-The primary care provider (PCP) for facility had to write the order for bed rails.

Interview with the Director on 02/21/19 at 6:45pm revealed:

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-She did not know a half side rail was consider a restraint.
-She would get an order for the restraint on 02/22/19.
-She did not know the staff pulled the half side rails up when Resident #3 was in bed.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

2. Review of Resident #17's FL-2 dated 01/03/18 revealed:
-Diagnoses included thyrotoxicosis, abnormal gait and tremor
-There was no documentation of ambulatory status.
-There was no physician's order for lap belt for Resident #17.

Review of Resident #17's Resident Register revealed an admission date of 01/03/18.

Review of Resident #17's assessment and care plan dated 01/03/18 revealed:
-The resident needed extensive assistance with ambulation, toileting, bathing, dressing and grooming.
-There was no documentation for the use of lap belt for Resident #17.

Review of Resident #17's Licensed Health Professional Support (LHPS) review dated 02/22/19 revealed there was no documentation for the use of lap belt for Resident #17.

Observation on 02/20/19 at 7:23am revealed Resident #17 was sitting in her wheel chair with a lap belt attached to the chair outside of the dining room.

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D 482	Continued From page 83 Interview with Resident #17 on 02/20/19 at 7:23am revealed; -She felt safe when the lap belt was attached to her wheelchair. -The staff attached the lap belt to the wheel chair. Telephone interview with Resident #17's family member on 02/22/19 at 2:29pm revealed: -She knew that Resident #17 had a lap belt on when sitting in the wheel chair. -The lap belt was used to prevent Resident #17 from sliding out of the wheel chair. -Resident #17 wanted to use the lap belt. -She thought there was an order for the lap belt. Observation on 02/21/19 at 11:30am revealed Resident #17 was sitting in her wheel chair with a lap belt attached to the chair outside of the dining room. Interview with the Resident Care Coordinator (RCC)/ medication aide (MA) on 02/21/19 at 3:30pm revealed: -A lap belt was used to prevent the resident from sliding out of the wheelchair. -The lap belt had been used for about 3 weeks. -She did not know if there was an order for the lap belt. Interview with a personal care aide (PCA) on 02/21/19 at 5:00pm revealed: - The lap belt was used to prevent Resident #17 from sliding in the floor. -She did not know if Resident #17 had an order for the lap belt. Interview with the Director on 02/21/19 at 6:45pm revealed: -She did not know that a lap belt was used to	D 482		

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D 482	Continued From page 84 prevent Resident #17 from sliding out of the wheelchair. -She just found out on 02/21/19. -She would get an order for the lap belt on 02/22/19. Telephone interview with the primary care physician (PCP) on 02/22/19 at 8:59am revealed: -He knew Resident #17 needed an order for a lap belt to prevent resident from sliding out of the wheelchair. -He did not remember when or who notified him that Resident #17 needed an order for a lap belt. -He gave the staff a verbal order for a lap belt. -He did not know the order required a medical need for the lap belt, the length of time the restraint should be used, and the time intervals the restraint was to be checked and released.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, 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	D912		

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D912	Continued From page 85 related to controlled substances, infection control prevention for sharing glucometers, medication administration and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 4 residents (#8, #18, #19) observed during the medication passes including errors with medications related to an anti-psychotic (#8), potassium and fish oil supplements, a laxative and an antihistamine eye drop (#18), crushing and administering a medication that should not be crushed (#18), and not watching medications being administered (#19); and 1 of 7 sampled resident (#7) related to an anti-anxiety medication. [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 6 diabetic residents sampled (Residents #20, #21, and #22) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. [Refer to Tag 0932 G.S.131D4.4A(b) Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection	D932		

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D932	Continued From page 86 Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, 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.	D932		

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

Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 6 diabetic residents sampled (Residents #20, #21, and #22) with orders for blood sugar monitoring resulting in sharing of glucometers between residents.

The findings are:

Interview with the facility Director on 02/20/19 revealed:
-Six residents had orders to check fingerstick blood sugar.
-No resident had a diagnosis of a blood borne pathogen disease.

Observation of a fingerstick blood sugar (FSBS) check on 02/20/19 at 8:45 am revealed:
-The medication aide (MA) wore gloves for the procedure.
-The MA retrieved a plastic bag labeled with a resident's name.

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D932	Continued From page 88 -The glucometer pouch inside the plastic bag was not labeled with the resident's name. -The glucometer inside the pouch was not labeled with a resident's name. -The MA obtained a fingerstick blood sugar check using a single use disposable lancing device and proper infection prevention techniques. -The MA disposed of the single use lancing device and the strip inside her glove and disposed of the items in the trash. Observation of medication carts on 02/20/19 at 12:45 pm revealed: -The facility had 2 medication carts containing 6 residents' glucometers and a house glucometer. -Each resident and the house glucometer had a clear plastic bag containing a glucometer and labeled with a resident's name or house glucometer. -The glucometer pouches were not labeled with either of the 5 residents' names (one resident had 2 plastic glucometer bags) and the house glucometer was not labeled for house glucometer. -The glucometer pouches contained glucometers (Brands A, B, C, D, E and F) which were not labeled with a resident's name. -Two glucometer pouches contained lancing device pens which were not labeled with residents' names. -There were no lancing device pens which contained used lancing needles. -There was a box of lancing needles for the lancing pens on one of the medication carts. -There were single use disposable lancing devices on both medication carts. Review of the Centers for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose	D932		

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monitoring devices (glucometers) should not be shared between 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 manufacturer's user manual of the Brand A glucometer revealed no disinfection procedures were recommended. Based on CDC guidelines, the glucometer should not be shared.

Review of the manufacturer's user manual of the Brand B glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended.

Review of the manufacturer's user manual of the Brand D glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended.

Review of the manufacturer's user manual of the Brand E glucometer revealed no disinfection procedures were recommended. Based on CDC guidelines, the glucometer should not be shared.

Interview with a medication aide (MA) on 02/20/19 at 12:30 pm revealed:
-The facility policy was for each resident to have a glucometer and staff should not share glucometers between residents.
-She routinely cleaned the glucometer after each use with an alcohol swab.
-She was not aware of a facility policy to routinely disinfect glucometers.
-She routinely used single use disposable lancing

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devices to stick residents' fingers when obtaining fingerstick blood sugars (FSBS).
-She did not recall ever using a lancing pen to check a resident's FSBS.
-She had never used the house glucometer or another residents' glucometer on another resident.

1. Review of Resident #20's current FL2 dated 09/01/18 revealed;
-Diagnoses included diabetes mellitus.
-There was an order to check fingerstick blood sugar (FSBS) as needed.

Review of Resident #20's physician orders revealed orders dated 01/01/19 and 02/01/19 to check FSBS daily before breakfast.

Observation of the glucometer identified for Resident #20 revealed:
-The plastic bag was labeled with Resident #20's name.
-The pouch was not labeled with Resident #20's name.
-The Brand C glucometer located in the pouch was not labeled with the resident's name.
-The date and time was not set correctly for the actual date and time.
-There was a lancing pen in the glucometer pouch but no lancing needle was in the lancing pen.

Review of the manufacturer's user manual of the Brand C glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended. Lancing pens should never be shared.

Review of Resident #20's Brand C glucometer's

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D932	Continued From page 91 history revealed: -FSBS readings recorded in the glucometer's history compared to FSBS values documented on Resident #20's February 2019 MAR were inconsistent for FSBS values documented on the MAR. -FSBS values documented on Resident #20's February 2019 MAR were not recorded in Resident #20's glucometer's history. -Resident #20 had the most recent FSBS reading of 120 recorded in the glucometer's history on 09/22/18 at 10:11 am that was documented on the February MAR for 7:00 am on 02/20/19. -There were no FSBS readings recorded in Resident #20's glucometer's history or the preceding 11 days that corresponded to FSBS values documented on the resident's February 2019 MAR. -There were days when multiple FSBS readings were recorded in the glucometer's history within a short period of time and none matched FSBS values documented on Resident #20's February 2019 MAR with examples as follows: -On 09/22/18 at 6:53 am, the FSBS reading was 172, and there was no corresponding FSBS value was recorded on the MAR. -On 09/22/18 at 6:25 am, the FSBS reading was 140, and there was no corresponding FSBS value was recorded on the MAR. -On 09/22/18 at 6:19 am, the FSBS reading was 91, and there was no corresponding FSBS value was recorded on the MAR. -On 09/19/18 at 4:27 pm, the FSBS reading was 210, and there was no corresponding FSBS value was recorded on the MAR. -On 09/19/18 at 4:25 pm, the FSBS reading was 97, and there was no corresponding FSBS value was recorded on the MAR. -On 09/14/18 at 4:31 pm, the FSBS reading was 103, and there was no corresponding FSBS value	D932		

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was recorded on the MAR.
-On 09/14/18 at 4:04 pm, the FSBS reading was 130, and there was no corresponding FSBS value was recorded on the MAR.
-On 09/14/18 at 10:28 am, the FSBS reading was 147, and did not correspond with a FSBS value of 127 was recorded on the MAR.
-On 09/14/18 at 10:22 am, the FSBS reading was 221, and there was no corresponding FSBS value was recorded on the MAR.
-On 09/14/18 at 7:26 am, the FSBS reading was 172, and there was no corresponding FSBS value was recorded on the MAR.
-On 09/14/18 at 6:46 am, the FSBS reading was 132, and there was no corresponding FSBS value was recorded on the MAR.

None of the values documented in the history of the glucometer used for Resident #20 matched values documented on the MARs of sampled residents (#20, #21, or #22).

Review of Resident #20's February 2019 Medication Administration Record (MAR) revealed:
-There was an entry to check FSBS daily scheduled for 7:00 am.
-FSBS values were documented daily for 20 occasions from 02/01/19 to 02/20/19 with a FSBS range from 100 to 150.

Interview with Resident #20 on 02/22/19 at 3:27 pm revealed:
-She did not know what brand of glucometer was used to check her FSBS.
-She did not know if staff used a different brand of glucometer to check her FSBS.

Refer to interview with the Director on 02/20/19 at 5:30 pm.

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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 93 Refer to interview with the Administrator on 02/20/19 at 5:45 pm. 2 Review of Resident #21's current FL2 dated 02/14/19 revealed: -Diagnoses included diabetes mellitus, and Alzheimer's dementia. -There was an order to check fingerstick blood sugars (FSBS) daily. Review of Resident #21's physician's orders revealed there were physician's orders signed (but not dated) for December 2018, January 2019 to check FSBS daily. Review of Resident #21's physician orders dated 01/01/19 and 02/01/19 revealed an order to check FSBS before breakfast. Observation of the glucometer identified for Resident #21 revealed: -The plastic bag was labeled with Resident #21's name. -The pouch was not labeled with Resident #21's name. -The Brand F glucometer located in the pouch was not labeled with the resident's name. -The date and time was set for one hour prior to the actual time. -On 02/20/19 at 1:12 pm the glucometer displayed the time and date of 02/20/19 at 12:23 pm. -There was a lancing pen in the glucometer pouch, but no lancing needle was in the lancing pen. Review of the manufacturer's user manual of the Brand F glucometer revealed no disinfection procedures were recommended. Based on CDC	D932		

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	HAL029010	A. BUILDING: _____ B. WING _____	C 02/22/2019

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D932	Continued From page 94 guidelines, the glucometer should not be shared. Review of Resident #21's Brand F glucometer's history revealed: -FSBS readings recorded in the glucometer's history compared to values documented on Resident #21's February 2019 MAR were inconsistent for FSBS values documented on the MAR. -FSBS values documented on Resident #21's February 2019 MAR were not recorded in Resident #21's glucometer's history. -Resident #21 had the most recent FSBS reading of 148 recorded in the glucometer's history on 08/22/18 at 5:51 am, but no FSBS documented on the February MAR for 7:00 am corresponded to the FSBS value. -There were no FSBS readings recorded in Resident #21's glucometer's history or the preceding 11 days that corresponded to FSBS values documented on the resident's February 2019 MAR. -There were days when multiple FSBS readings were recorded in the glucometer's history within a short period of time and none matched FSBS values documented on Resident #21's February 2019 MAR with examples as follows: -On 07/31/18 at 5:54 am, the FSBS reading was 134, and there was no corresponding FSBS value was recorded on the MAR. -On 07/31/18 at 5:48 am, the FSBS reading was 164, and there was no corresponding FSBS value was recorded on the MAR. -On 07/27/18 at 10:11 am, the FSBS reading was 229, and there was no corresponding FSBS value was recorded on the MAR. -On 07/27/18 at 10:08 am, the FSBS reading was 155, and there was no corresponding FSBS value was recorded on the MAR. -On 07/27/18 at 6:17 am, the FSBS reading was	D932		

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D932	Continued From page 95	D932		

151, and there was no corresponding FSBS value was recorded on the MAR.
-On 07/27/18 at 5:49 am, the FSBS reading was 113, and there was no corresponding FSBS value was recorded on the MAR.
-On 07/27/18 at 5:32 am, the FSBS reading was 127, and there was no corresponding FSBS value was recorded on the MAR.
-On 07/27/18 at 5:24 am, the FSBS reading was 149, and there was no corresponding FSBS value was recorded on the MAR.
-On 07/27/18 at 5:15 am, the FSBS reading was 102, and there was no corresponding FSBS value was recorded on the MAR.

Review of Resident #21's February 2019 Medication Administration Record (MAR) revealed:
-There was an entry to check FSBS daily scheduled for 8:00 am.
-FSBS values were documented daily for 20 occasions from 02/01/19 to 02/20/19 with a FSBS range from 162 to 190.

None of the values documented in the history of the glucometer used for Resident #21 matched values documented on the MARs of sampled residents (#20, #21, or #22).

Interview with the Special Care Unit Resident Care Coordinator (SCURCC) on 05/20/19 at 5:25 pm revealed:
-She did not have a system in place to routinely audit residents' glucometer history compared to FSBS values documented on the residents' MARs.
-She did not know MAs were sharing glucometers between residents.
-She knew the facility policy was each resident had a glucometer assigned to the resident and

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staff should use the assigned glucometer to check the resident's FSBS.
-Resident #21 received a new glucometer today because her current machine was not working.

Based on observations, interviews, and record review it was determined Resident #21 was not interviewable.

Refer to interview with the Director on 02/20/19 at 5:30 pm.

Refer to interview with the Administrator on 02/20/19 at 5:45 pm.

3. Review of Resident #22's current FL2 dated 04/04/18 revealed diagnoses included type 2 diabetes mellitus.

Review of Resident #22's physician's orders dated 02/01/19 revealed an order to check fingerstick blood sugar (FSBS) daily.

Observation of the glucometer identified for Resident #22 revealed:
-The plastic bag was labeled with Resident #22's name.
-The pouch was not labeled with Resident #22's name.
-The Brand B glucometer located in the pouch was not labeled with the resident's name.
-The date and time was set for one hour prior to actual time.
-On 02/20/19 at 12:58 pm the glucometer displayed the time and date of 02/20/19 at 1:58 pm.

Review of the manufacturer's user manual of the Brand B glucometer revealed the glucometer was recommended for use by a single person and

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should not be shared. No disinfection procedures were recommended.

Review of Resident #22's Brand B glucometer's history revealed:
-The current time and date did not display when the glucometer was turned on.
-There were only 2 FSBS readings recorded in the glucometer's history: on 08/16/18 at 11:50 am FSBS was 148 and on 07/31/18 at 8:15 pm FSBS was 223.

Review of Resident #22's February 2019 medication administration record (MAR) revealed:
-There was an entry to check FSBS daily scheduled for 8:00 am.
-FSBS values were documented daily for 20 occasions from 02/01/19 to 02/20/19 with a FSBS range from 122 to 158.

Review of Resident #22's Brand B glucometer's history compared to the MAR for February 2019 revealed twenty FSBS values documented on Resident #22's February 2019 MAR were not recorded in Resident #22's glucometer's history with examples as follows:
-On 02/20/19, a FSBS value of 138 was documented on the MAR with no corresponding FSBS reading in the glucometer's history.
-On 02/19/19, a FSBS value of 158 was documented on the MAR with no corresponding FSBS reading in the glucometer's history.
-On 02/18/19, a FSBS value of 155 was documented on the MAR with no corresponding FSBS reading in the glucometers history.
-On 02/17/19, a FSBS value of 151 was documented on the MAR with no corresponding FSBS reading in the glucometer's history.
-On 02/16/19, a FSBS value of 153 was documented on the MAR with no corresponding

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D932	Continued From page 98 FSBS reading in the glucometer's history. -On 02/15/19, a FSBS value of 122 was documented on the MAR with no corresponding FSBS reading in the glucometer's history. -On 02/08/19, a FSBS value of 130 was documented on the MAR with no corresponding FSBS reading in the glucometer's history. -On 02/01/19, a FSBS value of 138 was documented on the MAR with no corresponding FSBS reading in the glucometer's history. None of the values documented in the history of the glucometer used for Resident #22 matched values documented on the MARs of sampled residents (#20, #21, or #22). Interview on 02/22/19 at 4:30 pm with Resident #22 revealed: -Staff checked her FSBS daily. -She did not know the type of glucometer used to check her FSBS. -Staff told her the FSBS value after each FSBS check. -She did not know if staff used the same type of glucometer to check her FSBS each time. Refer to interview with the Director on 02/20/19 at 5:30 pm. Refer to interview with the Administrator on 02/20/19 at 5:45 pm. _____ Interview with the Director on 02/20/19 at 5:30 pm: -She did not know MAs were sharing glucometers between residents. -The facility policy was each resident had a glucometer assigned to the resident. FSBS checks should be done using the glucometer assigned to the resident.	D932		

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D932	Continued From page 99 -The MAs were trained by the Director, lead medication aides, or the Special Care Unit Resident Care Coordinator (SCURCC) to obtain FSBS checks using the residents' assigned glucometers. -The facility policy was to use single use disposable lancing devices to prick residents' fingers for FSBS testing. -She had never observed a MA using a lancing pen. -She did not know if any of the residents' glucometer pouches contained lancing pens. Interview with the Administrator on 02/20/19 at 5:45 pm revealed: -She did not know MAs were sharing glucometers between residents. -The facility MAs did not have a schedule to routinely clean and disinfect residents' glucometers. -The facility had an Environment Protection Agency (EPA) approved disinfecting wipe to clean and disinfect glucometers a long time ago, but not now. Staff should not be using a glucometer on any resident other than the assigned one, therefore disinfecting the glucometer was not required. -Staff were trained by her, the contracted pharmacy Nurse, or nurse completing the MA's medication aide competency skills validation for proper infection control regarding glucometers and no of sharing lancing pens between residents. -She would replace all glucometers for current residents prior to the next scheduled FSBS. The facility failed to implement infection control procedures consistent with CDC guidelines placing residents receiving finger stick blood sugar checks with glucometers at risk due to	D932		

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D932	Continued From page 100 possible exposure to blood borne pathogens diseases for Residents #20, #21, and #22. This failure is detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2019.	D932		