STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	R 07/15/2019

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 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 10-12, 2019 and exited via telephone on 7/15/19.	{D 000}		
{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 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 observations, interviews, and record reviews, the facility failed to assure residents' blood pressure (BP) orders had been clarified by the prescribing practitioner for 1 of 5 sampled (Resident #2). The findings are: Review of Resident #2's current FL2 dated 12/04/18 revealed: - The diagnoses included spinal stenosis, syncope, history of malignant neoplasm, pneumonia, hypertension, atrial fibrillation, and depression. -There was an order for weekly BP and an order	{D 238}	The Administrator shall ensure all medication orders are acurate and complete on the current FL2s. If the information on the FL2 is not clear or sufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. Upon admission, the facility Director will review the FL2 for the new resident to ensure it is accurate and complete. Upon return from the hospital or rehabilitation facility, the facility Director will review the discharge paperwork and/ or FL2 to ensure it is accurate and complete. The Administrator/DIrector will monitor new admission paperwork and when residents return from the hospital or rehab facilities to ensure the FL2 to ensure is accurate and complete. The Administrator/Director will monitor weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter.	8-15-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Garner | TITLE: ADMINISTRATOR | (X6) DATE: 08-21-2019

reviewed and accepted 10/3/19 Jo Scarlett, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 238}	Continued From page 1 for daily BP checks. -The BP order was not clarified. Review of subsequent physician's orders dated 05/01/19 revealed an order for daily BP checks. Review of Resident #2's May 2019 electronic Medication Administration Record (MAR) revealed: -There was an entry for BP/pulse check daily. -There was documentation of weekly BP for the month of May 2019. Review of Resident #2's June 2019 MAR revealed: -There was an entry for BP/pulse check daily. -There was documentation of weekly BP for the month of June 2019. Review of Resident #2's July 2019 MAR revealed: -There was an entry for BP/pulse check daily. -There was documentation of weekly BP for the month of July 2019. Review of the facility's vital sign book for May 2019 through July 2019 revealed: -Resident #2's BP range for May 2019 was 129-143/69-74. -Resident #2's BP range for June 2019 was 132-152/70-92. -Resident #2's BP for July 2019 was 136/63. Interview with the facility's contracted pharmacy on 07/11/19 at 10:25 am revealed: -The pharmacy managed the facility MARs. -The current BP order the pharmacy had on file for Resident #2 was for BP checks daily (original order from 12/12/17). -The pharmacy did not receive the FL2 dated 12/04/18 with the order for BP weekly.	{D 238}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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{D 238}	Continued From page 2 -The pharmacy had no record of the facility sending in a MAR corrections form for the BP order. Telephone interview with Resident #2's family member on 07/12/19 at 9:27 am revealed: -She visited Resident #2 at least every 2 weeks. -She knew the staff checked Resident #2's BP once monthly but was not sure of the BP schedule or readings. Interview with Resident #2's Primary Care Provider (PCP) on 07/12/19 12:56 pm revealed: -He expected the staff to check BP weekly. -Resident #2 had an order for BP checks weekly for hypertension. -The facility had not notified him to clarify the BP order. Interview with a first shift medication aide (MA), in the AL, on 07/15/19 at 11:05 am revealed: -She thought Resident #2 had orders for BP weekly. -MAs were responsible for obtaining BP's. -The facility also had contracted nurses that took BP once a month. -She did not know the FL2 dated 12/04/18 had conflicting BP orders. -The Director was responsible for completing the FL2 and order clarification when needed. Interview with the Executive Director on 07/12/19 at 11:45 am revealed: -MAs were responsible for checking BP. -She thought Resident #2 had orders for weekly BP's. -She was responsible for completing FL2's and clarification of the FL2. -She did not know Resident #2 had conflicting BP orders.	{D 238}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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{D 238}	Continued From page 3 -The BP daily order was an error but she did not catch the mistake. Interview with the Administrator on 07/15/19 at 2:11 pm revealed: -The Director was responsible for completing the FL2 and FL2 order clarification. -She expected staff to follow orders as prescribed. -She did not know Resident #2's FL2 had conflicting BP orders. -She would have expected the BP order to be clarified. Attempted interview with Resident #2 on 07/10/19 at 9:45 am was unsuccessful.	{D 238}	*** *** *** *** *** *** *** ***	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to notify the primary care providers for 1 of 3 sampled residents (Residents #2) regarding fingerstick blood sugars (FSBS) not obtained for 10 days. The findings are:	D 273	The Administrator/Director shall ensure healthcare referral and follow up is completed to meet the routine and acute health care needs of all residents. New policy was developed and implemented 8-1-19. Policy states all new orders are to be brought directly to the facility director for review. Director or her designee will fax orders to appropriate agency to ensure follow up and referrals are completed as ordered. Documentation of requests will be keep with original order. Director will follow up to ensure each order is completed by appropriate agency. The Administrator/DIrector will monitor referral and follow ups to ensure complete and accurate using a Healthcare follow up and referral monitoring form. The Administrator/Director will monitor weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter.	8-15-19

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D 273	Continued From page 4 Review of Resident #2's current FL2 dated 12/04/18 revealed: - The diagnoses included spinal stenosis, syncope, history of malignant neoplasm, pneumonia, hypertension, atrial fibrillation, and depression. -There was an order for FSBS every morning. Review of subsequent physician's orders on 05/01/19 revealed and order for FSBS every morning. Review of Resident #2's care plan dated 03/01/19 revealed FSBS daily. Review of Resident #2's licensed health professional support dated 04/27/19 revealed: -Staff monitored FSBS daily. -FSBS range documented was 123-246. Review of Resident #2's May 2019 electronic Medication Administration Record (MAR) revealed: -There was an entry for FSBS every morning scheduled at 8:00 am. -From 05/27/19 through 05/31/19 staff documented there were no glucometer strips available. -There was no documentation of FSBS from 05/27/19 through 05/31/19. Review of Resident #2's June 2019 MAR revealed: -There was an entry for FSBS every morning scheduled at 8:00 am. -From 06/01/19 through 06/05/19 staff documented there were no glucometer strips available. -There was no documentation of FSBS from	D 273	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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D 273	Continued From page 5 06/01/19 through 06/05/19. Interview with Resident #2's family member on 07/12/19 at 9:27 am revealed: -She visited Resident #2 at least every 2 weeks. -Staff monitored FSBS every morning. -Resident #2 notified her the staff were not checking her FSBS every morning. -When staff informed her of the cost of the strips she decided to get the strips through a mail order company for free. -She estimated Resident #2 was without strips at least a week. Interview with the medication aide (MA) on 07/12/19 at 12:00 pm revealed: -When Resident #2 ran out of glucometer strips on 05/26/19 she informed the Director. -She called Resident #2's primary care physician (PCP) for a new prescription for glucometer strips. -When staff called Resident #2's family member she did not want to pay for the strips and wanted to order through the mail instead. -The family member got a new order for a different glucometer so she could order strips for free. -The new glucometer strips did not arrive until 06/05/19. -She did not notify the PCP Resident #2's FSBS was not checked from 5/27/19 through 06/05/19. Interview with the Executive Director on 07/11/19 at 11:30 am revealed: -MAs were responsible for obtaining FSBS. -The facility purchased a new glucometer for Resident #2 in February 2019. -Resident #2's family member did not want to pay for strips and chose to purchase a new glucometer so the strips would be free.	D 273	*** PAGE INTENTIONALLY LEFT BLANK ***	

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D 273	Continued From page 6 -A MA notified her when Resident #2 ran out of glucometer strips on 05/26/19. -She instructed the MA to call the primary care physician (PCP) for a new order for strips. -She did not know if the MA informed the PCP of Resident #2 not obtaining FSBS from 05/25/19 through 06/05/19. -The facility had care notes but did not know where they were. Review of Resident #2's record revealed there were no care notes available for review. Interview with the Administrator on 07/15/19 at 2:11 pm revealed: -She knew Resident #2's family chose to purchase glucometer supplies through a mail order company. -She did not know Resident #2 did not have FSBS collected from 05/25/19 through 06/05/19. -She expected the staff to notify the PCP and obtain an order to hold FSBS until the new glucometer arrived. Interview with Resident #2's PCP on 07/12/19/19 at 12:56 pm revealed: -The PCP expected staff to monitor Resident #2's FSBS every morning as ordered. -The facility did not notify him that Resident #2 did not have strips available and staff were not checking FSBS from 05/25/19 through 06/05/19. -He expected staff to notify the office if they were unable to monitor FSBS as ordered.	D 273	*** PAGE INTENTIONALLY LEFT BLANK ***	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner	D 344		

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D 344	Continued From page 7 for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 5 sampled residents (Resident #5) regarding an order for an anticoagulant. The findings are: Review of Resident #5's current FL2 dated 11/09/18 revealed: -The diagnoses included atrial fibrillation, osteoarthritis, hypertension, altered mental status, delirium, chronic kidney disease, emphysema, and heart disease. -There was an order for Coumadin 3 mg everyday except Tuesday. -There was an order for Coumadin 3 mg, take 1.5 tablets (4.5 mg) Tuesdays only.	D 344	The Administrator/Director shall ensure the facility will contact the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; if orders are not clear or complete; or if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The Adminsitrator/Director shall ensure that this verification or clarification is documented in the resident's record. New policy was developed and implemented 8-1-19. Policy states all new orders are to be brought directly to the facility director for review. Director or her designee will review each order comparing to current orders. If a discrepancy is noted, Resident's physician or prescribing practitioner will be contacted to clarify order. The Administrator/DIrector will monitor orders and need for clarification or verification using a monitoring form designed by the Administrator. The Administrator/Director will monitor weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter.	8-15-19

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D 344	Continued From page 8 Review of Resident #5's subsequent physician's order dated 06/25/19 revealed: -There was an order to hold Coumadin on 06/25/19, start Coumadin 1.5 mg daily x 5 days, and Levaquin 500 mg everyday x 10 days. -There was also an order to hold Coumadin on 06/25/19 and then restart Coumadin 3 mg daily. -The orders were not clarified. Review of Resident #5's record revealed there was no documentation Resident #5's provider had been contacted to clarify the conflicting orders for Coumadin dated 06/25/19. Review of Resident #5's June 2019 MAR from 06/25/19 through 06/30/19 revealed: -The Coumadin was held on 06/25/19. -There was an entry for Coumadin 1.5 mg everyday for 5 days. Interview with a medication aide (MA) on 07/12/19 at 5:00 pm revealed: -On 06/25/19, she called the primary care physician's (PCP) office to clarify the order for Coumadin 1.5 mg everyday x 5 days. -She was instructed to disregard the previous order and hold Coumadin on 06/25/19 and resume 3 mg everyday. -She wrote the entry for Coumadin 3 mg everyday on the July 2019 MAR. Interview with the facility Director on 07/12/19 at 11:45 am revealed: -She completed MAR audits randomly each month. -She did not know when Resident #5's MAR was last audited. -She knew a MA had called to clarify the 06/25/19 Coumadin order for Resident #5 .	D 344	*** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** ***	

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D 344	Continued From page 9 Interview with the Administrator on 07/15/19 at 2:11 pm revealed: -The Administrator did not know there was any need for clarification of the Coumadin order. -She expected staff to clarify orders when needed. -She expected the Director to complete MAR audits monthly. Telephone interview with Resident #5's primary care physician (PCP) on 07/12/19 at 6:20 pm revealed: -On 06/25/19, Coumadin was decreased to 1.5 mg because Levaquin was ordered. -Levaquin could increase the INR levels. -The facility did not attempt to clarify both orders on 06/25/19. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 344	***	
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	{D 358}	*** SEE PAGE 11 FOR RESPONSE ***	

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{D 358}	Continued From page 10 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents (#1, #4, and #5) related to an antibiotic (#5), a diuretic (#1), and an anti-diabetic medication, anti-inflammatory medication, and anti-fungal medication (#4). The findings are: 1. Review of Resident #5's current FL2 dated 11/9/18 revealed diagnoses included atrial fibrillation, osteoarthritis, hypertension, altered mental status, delirium, chronic kidney disease, emphysema, and heart disease. Review of Resident #5's subsequent physician's orders dated 06/25/19 revealed an order for Levaquin (a medication used to treat infection) 500 mg daily x 10 days. Review of Resident #5's June 2019 Medication Administration Record (MAR) revealed there was no entry for Levaquin 500 mg daily x 10 days. Review of Resident #5's July 2019 MAR revealed there was no entry for Levaquin 500 mg daily x 10 days.	{D 358}	The Administrator/Director shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: orders by a licensed prescribing practitioner which are maintained in the resident's record; DHSR rules and the facility's policies. Training with Medication Aides/Supervisors on 7-15-19 including review of facility medication policy and procedures. Facility Pharmacy consultant completed additional training with all medication aides on 8-23-19 and 9-2-19 including additional in depth training of DHSR rules, facility policy and procedures, cart reviews, MAR reviews, and control substance count. Documentation of training will be kept at the facility for review. New Policy and Procedure was written and implemented on 8-1-19 to include family supplied medications and family provided transportation to physician appointments. The new policy and procedures parallel an amendment to the facility home policies. Family members were informed and have acknowledged new policies with documentation kept at the facility for review. The Administrator/Director will monitor medication pass periodically to ensure medications are being administered according to rule 10A NCAC 13F .1004(a). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	7-16-19

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{D 358}	Continued From page 11 Observation of Resident #5's medications on hand on 07/12/19 at 5:15 pm revealed there was no Levaquin 500 mg available. Telephone interview with a representative from the facility's contracted pharmacy on 07/11/19 at 10:25 am revealed: -The pharmacy never received an order for Levaquin 500 mg daily x 10 days. -The pharmacy did not dispense Levaquin. Interview with the Executive Director on 07/12/19 at 4:39 pm revealed: -She was responsible for providing oversight to the MAs. -She thought the Levaquin was administered but not documented. -The MA that received the order for Levaquin would be responsible for sending the order to the pharmacy and writing the new order on the MAR. -The Director, Supervisor, and MAs were responsible for making sure the medication was received and started. -When she compared the new month (July 2019) MARs with the previous month (June 2019) MARs she missed the Levaquin order because it was never added to the June MAR. -She did not know why the Levaquin was ordered. Interview with a medication aide (MA) on 07/12/19 at 5:00 pm revealed: -She worked as a MA in the evenings. -She remembered receiving the order for Levaquin from Resident #5's family member. -She called the primary care provider's (PCP) office to clarify the order (because it included a new Coumadin order also). -The office sent over a new order that did not include the Levaquin 500 mg daily x 10 days. -She thought since the new order did not include	{D 358}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 12 the Levaquin order it was no longer an order. -She did not send the Levaquin order to the pharmacy or call the PCP back to confirm the Levaquin should be administered. -She did not know why the Levaquin was ordered. Interview with the Administrator on 07/15/19 at 2:11 pm revealed: -She expected staff to administered medications as ordered. -She expected staff to clarify if Levaquin was to be administered. -The MA most likely did not know what the medication was used to treat. -She did not know the Levaquin was ordered and not administered. Telephone interview with Resident #3's primary care provider (PCP) on 07/19/19 at 9:45am revealed: -On 06/25/19 Resident #5 had a chest x ray and was diagnosed with pneumonia and was prescribed Levaquin 500 mg daily x 10 days. -Not receiving Levaquin could have caused Resident #5 to be hospitalized or caused death. Attempted interview with Resident #5's family member on 07/15/19 was unsuccessful. 2. Review of Resident #1's current FL2 dated 02/13/19 revealed: -Diagnoses included anemia, anxiety, arthritis, asthma, sleep apnea, B12 deficiency, stage 3 chronic kidney disease, coronary artery disease, and depression. -There was an order for Furosemide 20 mg daily. Review of Resident #1's subsequent physician's orders (located in Resident #1's record) dated 02/25/19 revealed an order for Furosemide 20	{D 358}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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	HAL029010	A. BUILDING: _____ B. WING _____	R 07/15/2019

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{D 358}	Continued From page 13 mg daily on odd days and 40 mg daily on even days. Review of Resident #1's subsequent physician's orders (located in Resident #1's record) dated 06/22/19 revealed an order for 40 mg daily x 7 days. Review of Resident #1's subsequent physician's orders (located in Resident #1's room) dated 06/25/19 revealed an order for 40 mg daily. Review of Resident #1's June 2019 Medication Administration Record (MAR) from 06/22/19 through 06/30/19 revealed: -On 06/22/19, there was an entry for Furosemide 40 mg daily x 7 days at 8:00 am. -Furosemide 40 mg was documented as administered from 06/22/19 through 06/28/19. -There was no entry for Furosemide 40 mg daily after the 06/22/19 order was completed on 06/28/19. -There was no entry for Furosemide 40 mg daily. Review of Resident #1's July 2019 MAR revealed: -There was an entry for Furosemide 20 mg daily on odd days scheduled at 8:00 am. -Furosemide 20 mg was documented as administered on 07/01/19, 07/03/19, 07/05/19, 07/07/19, and 07/09/19. -There was an entry for Furosemide 40 mg daily on even days scheduled at 8:00 am. -Furosemide 40 mg was documented as administered on 07/02/19, 07/06/19, 07/08/19, and 07/10/19. Observation of Resident #1's medications on hand on 07/10/19 at 4:00 pm revealed: -There was Furosemide 20 mg available for administration.	{D 358}	*** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 14 -There were 21 tablets of Furosemide dispensed on 07/03/19. Interview with Resident #1 on 07/10/19 at 2:20 pm revealed: -He knew he was prescribed Furosemide daily. -He knew Furosemide was to help decrease fluid. -He had chronic shortness of breath with minimal exertion. -He was not experiencing shortness of breath on 07/10/19. Telephone interview with a representative from the facility's contracted pharmacy on 07/10/19 at 3:19 pm revealed: -The order for Furosemide on file was 20 mg daily on odd days and 40 mg daily on even days. -The pharmacy did not have the most current order dated 06/25/19 for Furosemide 40 mg daily in their system. -There were 21 tablets of Furosemide 20 mg dispensed on 07/03/19. Interview with the Executive Director on 07/12/19 at 11:45 am revealed: -She did not know about the order dated 06/25/19 for Furosemide 40 mg daily. -She did not know Resident #1 had kept physician visit summaries in his room; which contained physician orders. Interview with a medication aide (MA) on 07/12/19 at 12:00 pm revealed: -She worked as a MA on day shift. -Resident #1 would go out with friends and go to appointments and not tell the staff. -She did not know Resident #1 had kept physician visit summaries in his room; which contained physician orders. -She thought the current order for Furosemide	{D 358}	*** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 15 was 20 mg daily on odd days and 40 mg daily on even days. Interview with the Administrator on 07/15/19 at 2:11 pm revealed: -She did not know Resident #1 had kept physician visit summaries in his room. -She did not know Resident #1 was currently ordered Furosemide 40 mg daily. -She expected staff to know when Resident #1 was at appointments but the resident scheduled his appointments. -Staff spoke with Resident #1 and told him he needed to alert the staff when he had appointments and provide any paperwork provided by the physician. -She called the physician's office on 07/15/19 and requested the office send all orders directly to the facility. Telephone interview with a representative from Resident #1's primary care provider's (PCP) office on 07/10/19 at 4:27 pm and 07/12/19 at 9:50 am revealed: -Weights from 03/25/19 through 06/25/19 were 161-169. -Resident #1 should be receiving Furosemide 40 mg daily. -Furosemide was increased to 40 mg daily to help decrease shortness of breath and decrease fluid overload. 3. Review of Resident #4's FL-2 dated 04/16/19 revealed: -Diagnoses included Alzheimer's dementia, diabetes mellitus, hypertension, congestive heart failure and gastroesophageal reflux disease. a. Review of Resident #4's FL-2 dated 04/16/19 revealed: -There was an order for metformin (used to treat	{D 358}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 16 high blood sugar) 500 mg daily. -There was an order for finger stick blood sugar (FSBS) checks daily. Review of Resident #4's May 2019 Medication Administration Records (MAR) revealed: -There was a computer-generated entry for metformin 500 mg daily scheduled at 5:00 pm. -There was documentation metformin was administered at 5:00 pm daily for 24 of 31 doses from 05/01/19 through 05/31/19. -There was no documentation metformin 500 mg was administered on 05/23/19, 05/24/19, 05/26/19, 05/28/19, 05/29/19, 05/30/19, and 05/31/19. -From 05/01/19 to 05/31/19 FSBS checks ranged from 104-279. Review of Resident #4's June 2019 MAR revealed: -There was a computer-generated entry for metformin 500 mg daily scheduled at 5:00 pm. -There was documentation metformin was administered at 5:00 pm daily for 9 of 30 doses from 06/01/19 through 06/30/19. -There was no documentation metformin 500 mg was given 05/03/19 - 05/14/19, 05/17/19 - 05/21/19, and 05/25/19 - 05/28/19. -From 06/01/19 - 06/28/19 FSBS checks ranged from 178-371. Observation of Resident #4's medications on hand on 07/12/19 at 10:15 am revealed: -There was a cassette which contained 10 metformin 500 mg tablets. -The label on the cassette was dated 6/06/19 and 14 tablets were dispensed. Telephone interview with the contracted Pharmacy Representative on 07/12/19 at 9:35 am	{D 358}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 358}	Continued From page 17 revealed: -The pharmacy was contracted to provide medications for Resident #4. -The pharmacy dispensed 14 tablets of metformin 500 mg on 05/23/19, 06/06/19, 06/20/19, and 07/03/19. -No metformin was returned to the pharmacy. -If Resident #4 did not take her metformin as ordered, then her finger stick blood sugars (FSBS's) could be higher than normal and could possibly lead to taking insulin. Interview with a medication aide (MA) on 07/12/19 at 10:30 am revealed: -She primarily worked day shift. -She had administered medications to Resident #4 during the past 3 months. -She had noticed there was an issue with some 5:00 pm medications not being given or documented. -She had verbally told the facility Director and the MA responsible for giving the 5:00 pm medications at least 3 times during June 2019 and weekly in July 2019 that some medications were not being given. -She addressed the issue in the communication book for medication aides on 07/05/19 because nothing had been done to correct the issue. -She had stayed late several times to ensure that residents received their 5:00 pm medications. -She was responsible for changing out the medication cassettes at the end of 14 day period. -When the medication cassettes were changed out, leftover medication, including metformin were discarded unless it was a full cassette. -The pharmacy did not accept returned medications or discard them unless it was a full cassette. Based on observations, interviews, and record	{D 358}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 358}	Continued From page 18 reviews it was determined Resident #4 was not interviewable. Interview with Resident #4's Primary Care Provider (PCP) on 07/12/19 at 11:23 am revealed: -He did not know Resident #4 had missed any doses of her metformin. -He did not know Resident #4's FSBS checks had been trending upward prior to her starting on a steroid. -Not taking her metformin as ordered could decrease control of her diabetes. -He did not know if not receiving her metformin caused her to have to start taking insulin injections because she started taking the steroid close to the same time. -He was very concerned for Resident #4's health and safety and expected her to receive medications as ordered. Interview with the Executive Director on 07/12/19 at 12:02 pm revealed: -She had passed morning medications to Resident #4 on 05/30/19 but had not noticed any missing documentation on the MARs. -She had been told there was 1 resident that medications had not been signed for in June 2019. -A MA did stay after 3:00 pm sometimes to pass medications so that the Resident Care Coordinator could complete her job. -She knew who had not signed the MAR by looking at the scheduled medication time. -MARs were glanced over with the monthly change over, looking for blanks, FSBS checks, and heart rates. -Random audits were completed weekly looking for blanks, new orders, check controlled count, and overall everything but Resident #4's chart	{D 358}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 19 and MAR had not been audited. -When medication carts are changed out, the only things removed were controlled substances and temporary medications such as antibiotics; everything else was sent back to the pharmacy. -She did not know what the pharmacy did to leftover medications. -Labels on the medication cassettes are not replaced with each 14-day refill. -She believed Resident #4 received her metformin, but the MA did not sign for it because it was the only medication on page 1 that was at a time other than 8:00 am. -She was informed that Resident #4's FSBS checks had started going up around the same time that the resident started taking steroids. -She did not want staff to "babysit" each other but did expect for them to make each other aware of blanks. -MA's needed to pay better attention to the MAR. -The biggest problem for the facility was the learning curve for new MA's, but that was "no excuse" for the errors. Interview with the Resident Care Coordinator (RCC) on 07/12/19 at 5:17 pm revealed: -She was a new MA and had passed medications, including metformin to Resident #4 in the past 3 months. -She knew she "had given every dose of metformin on the evenings she worked" even though she could not recall every single dose given. -She "may have made a mistake but would only take responsibility for not signing the MAR". -She did not know if medications were discarded at switch out every 2 weeks or if they were sent back to the pharmacy. -She had never assisted with the medication cart switch but knew to compare the old cassette with	{D 358}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 20 the new one. -She did not know Resident #4 FSBS checks were trending upward before she started on a steroid. Interview with the Administrator on 07/12/19 at 1:04 pm revealed: -She did not know about medications not being given to Resident #4 in May and June of 2019 or blanks on the MARs. -"The medications could have been given and the MAR not signed or there could have been some communication breakdown." -When a shift ends the oncoming MA is supposed to check for blanks and let the off going MA know if there is any. - Random MAR audits are completed by the facility Director and the Business Office Coordinator. -She expected medication to be given as ordered and per policy. b. Review of Resident #4's Physician's order dated 06/26/19 revealed: -There was an order for Prednisone (steroid used to treat inflammation caused by temporal arteritis) 10 mg 4 times a day for 2 days. -There was a consecutive order for Prednisone 10 mg 2 times a day for 2 weeks. -There was a consecutive order for Prednisone 10 mg daily indefinitely. Review of Resident #4's June 2019 MAR revealed: -There was an entry for Prednisone 10 mg 4 times a day for 2 days on 06/28/19 and 06/29/19 scheduled at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. -There was a consecutive entry for Prednisone 10 mg 2 times a day for 2 weeks to start on 06/30/19	{D 358}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 358}	Continued From page 21 scheduled for 8:00 am and 8:00 pm. -There was an entry for Prednisone 10 mg daily ongoing to start on 07/14/19 scheduled for 8:00 am. -There was no documentation that Prednisone had been given on 06/28/19 or 06/29/19. -There was documentation that Prednisone 10 mg was given as scheduled on 06/30/19. Review of Resident #4's July 2019 MAR revealed: -There was an entry for Prednisone 10 mg 2 times a day for 2 weeks to start on 06/30/19 scheduled for 8:00 am and 8:00 pm. -There was an entry for Prednisone 10 mg daily ongoing to start on 07/14/19 scheduled for 8:00 am. -There was documentation that Prednisone 10 mg was given as scheduled from 07/01/19 - 07/10/19. Observation of Resident #4's medications on hand on 07/12/19 at 10:15 am revealed: -The pharmacy had dispensed a cassette with 14 days of medication in it. -There were 3 bubble packs of Prednisone 10 mg each with 2 tablets in it. Based on observations, interviews, and record reviews it was determined Resident # 4 was not interviewable. Telephone interview with the contracted Pharmacy Representative on 07/12/19 at 9:35 am revealed: -Prednisone was initially dispensed on 06/27/19 and cycle fill was sent on 07/03/19. -If doses were missed the Resident temporal inflammation could worsen and she could have increased headaches.	{D 358}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 358}	Continued From page 22 Interview with a medication aide (MA) on 07/12/19 at 10:30 am revealed: -She primarily worked day shift. -She had administered medications to Resident #4 during the past 3 months. -She knew Resident #4 was taking Prednisone. -She made sure pharmacy sent the prescription over. -She recalled giving 2 doses of Prednisone 10 mg each day on 06/28/19 and 06/29/19 but had missed signing the MAR. -She did not believe Resident #4 received all her doses of Prednisone as there were extra pills on the cart. Interview with Resident #4's Primary Care Provider (PCP) on 07/12/19 at 11:23 am revealed: -He did not know Resident #4 had missed any doses of her Prednisone. -She started Prednisone to treat her symptoms of temporal arteritis. -Prednisone could cause Resident #4's fingerstick blood sugar (FSBS) checks to be high. -Resident #4 started on insulin injections earlier this month due to high FSBS checks. -Not receiving the Prednisone for temporal arteritis could cause blindness and increase inflammatory damage. -He was very concerned for Resident #4's health and safety and expected her to receive medications as ordered. Interview with the Executive Director on 07/12/19 at 12:02 pm revealed: -She did not know Resident #4 had missed any doses of Prednisone. -She believed Resident #4 most likely had received all her Prednisone and that the MARs were not signed off.	{D 358}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 358}	Continued From page 23 -She did not know why there would be extra Prednisone on the medication cart. -She knew Resident #4 had started on insulin around the same time that the resident started taking steroids. -MA's needed to pay better attention to the MAR. Interview with the Resident Care Coordinator (RCC) on 07/12/19 at 5:17 pm revealed: -She was a new MA and had passed medications, including Prednisone to Resident #4 in the past 3 months. -She knew she "had given every dose of Prednisone on the evenings she worked" even though she could not recall every single dose given. -She "may have made a mistake but would only take responsibility for not signing the MAR". -She would work harder to make sure the MARs are signed off. Interview with the Administrator on 07/12/19 at 1:04 pm revealed: -She did not know Resident #4 had missed any doses of Prednisone. -She felt as if Resident #4 received her Prednisone and the MAR was not signed. -She expected medication to be given as ordered and per policy. c. Review of Resident #4's Primary Care Physician's (PCP) order dated 06/19/19 revealed an order for nystatin powder (used to treat yeast infection) to groin and under breast for rash 2 times a day. Review of Resident #4's June 2019 MAR revealed: -There was an entry for nystatin powder to groin and under breast scheduled at 8:00 am and 8:00	{D 358}	*** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 24 pm. -There was no documentation nystatin powder was administered at 8:00 am on 06/28/19 and 06/29/19, and no documentation nystatin powder was administered at 8:00 pm from 06/20/19 - 06/28/19. Review of Resident #4's July 2019 MAR revealed: -There was an entry for nystatin powder to groin and under breast scheduled at 8:00 am and 8:00 pm. -There was no documentation nystatin powder was administered at 8:00 pm from 07/01/19 through 07/09/19. Observation of Resident #4's medications on hand on 07/12/19 at 10:15 am revealed 1 almost full bottle of nystatin powder was available for use. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Telephone interview with the contracted Pharmacy Representative on 07/12/19 at 9:35 am revealed: -Nystatin was dispensed on 06/19/19. -If doses were missed, Resident #4's rash could turn into a fungal infection. Interview with a medication aide (MA) on 07/12/19 at 10:30 am revealed: -She had applied nystatin powder under Resident #4's breast and in her groin on day shift. -She did not know if nystatin powder had been applied to Resident #4 at 8:00 pm. Interview with Resident #4's Primary Care Provider (PCP) on 07/12/19 at 11:23 am	{D 358}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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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 358}	Continued From page 25 revealed: -If Resident #4 missed doses of nystatin powder her rash could turn into a fungal infection. -He expected medications to be as ordered. Interview with the Executive Director on 07/12/19 at 12:02 pm revealed: -She believed Resident #4 received her nystatin powder, but the MA did not sign for it. -MA's needed to pay better attention to the MAR. Interview with the Resident Care Coordinator (RCC) on 07/12/19 at 5:17 pm revealed: -She was a new MA and had passed medications, including nystatin powder to Resident #4 in the past 2 months. -She "may have made a mistake but would only take responsibility for not signing the MAR". Interview with the Administrator on 07/12/19 at 1:04 pm revealed: -She did not know about medications not being given to Resident #4 in June and July 2019 or blanks on the MARs. -She believed Resident #4 received all her medications. _____ The facility failed to administer medications as ordered to three residents, including an antibiotic (#5) which could have led to hospitalization or caused death, a diuretic (#1) which could have increased shortness of breath and increase fluid overload, and an anti-diabetic medication which could lead to uncontrolled diabetes, anti-inflammatory medication which could lead to blindness and increased damage to other blood vessels, and anti-fungal medication (#4) which could lead to infection. This failure was detrimental to the health, safety and welfare of the residents; and constitutes an unabated Type	{D 358}	*** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** ***	

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{D 358}	Continued From page 26 B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/19 for this violation.	{D 358}	The Administrator/Director shall ensure The resident's medication administration record (MAR) shall be accurate and include the following: resident's name; name of the medication or treatment order; strength and dosage or quantity of medication administered; instructions for administering the medication or treatment; reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; date and time of administration; documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, name or initials of the person administering the medication or treatment. All MARs for every resident were reviewed for accuracy by facility Director on 7-30-19. Training with Medication Aides/Supervisors on 7-15-19 including review of facility medication policy and procedures. Facility Pharmacy consultant completed training on 8-23-19 and 9-2-19 including additional in depth training of DHSR rules, facility policy and procedures, cart reviews, MAR reviews, and control substance count. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor medication pass periodically to ensure medications are being administered according to rule 10A NCAC 13F .1004(j). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	
{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:	{D 367}		

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{D 367}	Continued From page 27 Based on observations, record reviews and interviews, the facility failed to assure the medication administration records (MARs) were accurate and complete for 1 of 7 sampled residents (Resident #5). The findings are: Review of Resident #5's current FL2 dated 11/9/18 revealed diagnoses included atrial fibrillation, osteoarthritis, hypertension, altered mental status, delirium, chronic kidney disease, emphysema, and heart disease. Review of Resident #5's subsequent physician order dated 06/12/19 revealed an order for Tylenol extra strength 500mg, take 2 tablets three times a day. Review of Resident #5's June 2019 from 06/12/19 through 06/30/19 Medication Administration Records (MAR) revealed: -There was an entry for Tylenol extra strength 500 mg, take 2 tablets three times a day scheduled at 8:00 am, 12:00 pm, and 8:00 pm. -Staff documented they administered Tylenol extra strength 38 of 57 opportunities from 06/12/19 through 06/30/19. -Staff did not provide a reason the Tylenol extra strength was not administered for 13 opportunities. Review of Resident #5's July 2019 Medication Administration Records (MAR) revealed there was no entry for Tylenol extra strength 500 mg, take 2 tablets three times a day. Observation of Resident #5's medications on hand on 07/12/19 at 5:15 pm revealed there was Tylenol extra strength 500 mg available to be	{D 367}	*** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** ***	

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{D 367}	Continued From page 28 administered. Telephone interview with a representative from the facility's contracted pharmacy on 07/11/19 at 10:25 am revealed the pharmacy did not receive the Tylenol order dated 06/12/19 and had never dispensed Tylenol extra strength for Resident #5. Interview with a medication aide (MA) on 07/15/19 at 11:05 am revealed: -She administered medications as instructed on the MAR. -She did administer Tylenol to Resident #5 but could not remember how often she administered the Tylenol. -Tylenol was ordered for generalized pain for Resident #5. -She did not know Tylenol was ordered to be administered three times a day. -She did not know there was missing documentation for the Tylenol in June 2019 and not listed on the MAR for July 2019. -The Director was responsible for MAR audits and compared the new month MARs to the previous month MARs. Interview with the Executive Director on 07/12/19 at 4:39 pm revealed: -She did not know Resident #5's June 2019 MAR had missing documentation and Tylenol was not transcribed on the July 2019 MAR. -She was responsible for MAR audits but did not know the last time a MAR audit was conducted for Resident #5. -She was responsible for comparing the new month MAR with the previous month MAR. -She must have overlooked the Tylenol on the June 2019 MAR as a standing order and did not add it to the July 2019 MAR.	{D 367}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 367}	Continued From page 29 Telephone interview with Resident #5's primary care physician (PCP) on 07/12/19 at 6:20 pm revealed: -Resident #5 was ordered Tylenol extra strength for generalized pain. -He expected staff to administer medications as ordered and notify him of any issues. -If Resident #5 did not receive Tylenol as ordered she could experience increased pain but he had not noticed increased pain with Resident #5. Attempted interview with Resident #5 on 07/12/19 at 6:30 pm was unsuccessful.	{D 367}	*** *** *** *** *** *** *** *** ***	
{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 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	{D 454}	The Administrator/Director shall ensure the notification of a 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: 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 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. Training with Medication Aides/ Supervisors on 7-15-19 including review of facility accident/incident policy and procedures and reporting of accident/incidents to responsible parties. The Administrator/Director will monitor accident/incident records periodically to ensure accurate documentation of accidents/incidents including notification of responsible party in the residents file in accordance to rule 10A NCAC 13F .1212(e). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	7-16-19

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{D 454}	Continued From page 30 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 Department of social Services (DSS) for 1 of 5 residents (Resident #1) who had a fall which required the resident to be sent to the emergency room. The findings are: Review of Resident #1's current FL2 dated 02/13/19 revealed: -Diagnoses included anemia, anxiety, arthritis, asthma, sleep apnea, B12 deficiency, stage 3 chronic kidney disease, coronary artery disease, and depression. Review of Resident #1's Resident Register on 07/10/19 revealed: -Resident #1 was admitted to the facility on 02/13/19. -Resident #1 was his own responsible party. Review of the facility's incident and accident reports revealed: -There was a report available for review regarding Resident #1's fall on 4/30/19. -The resident's family member and the facility Director were notified of Resident #1 falling on 04/30/19. Observations of Resident #1 on 07/10/19 at 9:05 am and 07/10/19 at 2:15 pm revealed the resident was alert and oriented. Interview with Resident #1 on 07/10/19 at 9:05	{D 454}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 454}	Continued From page 31 am and 2:15 pm revealed: -He fell a few weeks ago, beginning of May 2019, coming out of the bathroom. -Resident #1 was using his walker at the time of his fall. -He was sent to the emergency room and they did a scan of his head. -It took 6 weeks for his black eyes to go away. Interview with the Business Office Coordinator (BOC) on 07/11/19 at 9:05 am revealed she had completed an incident report but had misplaced it. Interview with the Business Office Coordinator (BOC) on 07/11/19 at 10:58 am revealed: -She had found the incident report on Resident #1 on 04/30/19. -The PCA had called her at around 1:30 am on 04/30/19 to let her know that Resident #1 had fell and hit his face. -Resident #1 had a severe nosebleed. -The PCA stayed with Resident #1 while she called the family. -The family agreed he should be sent to the emergency room. -She then called 911 and Resident #1 was sent out. -An Incident/Accident form is filled out for all incidents even if the resident is not sent to the emergency room. -She did not call the physician. Interview with a Representative with the County DSS on 07/11/19 at 3:48 pm revealed they had not received any incident reports for Resident #1. Interview with the Executive Director on 07/12/19 at 12:02 pm revealed: -She had recently let the medication aides (MAs) start faxing the incident reports to the physicians	{D 454}	*** *** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	

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{D 454}	Continued From page 32 and to the county DSS. -A list of numbers were posted above the fax machine, including DSS. -If DSS didn't receive the faxed incident report it must have been sent to the wrong number. -She highlighted the correct number so that DSS will receive all reports in the future. -She will resume faxing all incident reports herself. Interview with the Administrator on 07/12/19 at 1:10 pm revealed: -She believed the incident report had been faxed to DSS but not the correct department. -She expected all incident/accident reports to be faxed within 48 hours.	{D 454}	*** *** *** *** *** *** *** *** ***	
{D 468}	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 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.	{D 468}	The Administrator/Director shall ensure 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. 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. 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. 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. Administrator/Director reviewed training records of each SCU staff member to determine CEU hours needs for each staff member. The Administrator/Director will monitor SCU staff training records periodically to ensure accurate documentation of required CEU hours in accordance to rule 10A NCAC 13F .1309. Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/ Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	7-16-19

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{D 468}	Continued From page 33 (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 interviews and record review, the facility failed to assure that 1 of 5 sampled staff (F) who provide care in the Special Care Unit (SCU) had completed the 20 hours of training specific to the population served within six months of hire to work in the Special Care Unit (SCU). The findings are: Review of the personnel record for Staff F revealed: -The hire date for Staff C was 02/18/17. -Staff F worked as a Medication Aide (MA)and personal care aide (PCA) in the SCU. -Staff F completed the required 6 hours of Special Care Unit (SCU) orientation on 02/18/17. -Staff F had documentation of 15 of the 20 required hours required specific to the population served with 6 months of hire. Interview with Staff F on 07/12/19 at 6:24 pm revealed: -She had worked in the SCU almost 3 years. -She recalled completing the initial 6 hours of	{D 468}	*** PAGE INTENTIONALLY LEFT BLANK ***	

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{D 468}	Continued From page 34 SCU training but did not recall how many additional hours she had completed in her first 6 months of employment. Interview with the Director on 07/12/19 at 6:32 pm revealed: -She did not realize Staff F did not have all 20 hours of training specific to SCU within her first 6 months of employment. -Audits were completed periodically on personnel records to ensure all employee had completed their SCU training requirements. -Recent audits were started on July 8, 2019 and July 9, 2019 and were completed almost weekly. -It was her responsibility to ensure all employees whom work in the SCU had met their training requirements.	{D 468}	*** *** *** *** *** *** *** *** *** ***	
{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 related to medication administration.	{D912}	The Administrator/Director shall ensure every resident shall have the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as stated in G.S. 131D-21 Declaration of Residents Rights. See CAR pages 10 & 27, 87 for facility plan of correction for each deficiency related to residents receiving care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration.. Each specific corrected rule area has specific monitoring stated to ensure compliance with time frame to be corrected.	

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{D912}	Continued From page 35 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents (#1, #4, and #5) related to an antibiotic (#5), a diuretic (#1), and an anti-diabetic medication, anti-inflammatory medication, and anti-fungal medication (#4). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].	{D912}	*** *** *** *** *** *** *** *** PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** *** *** ***	