

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 an annual survey and complaint investigation on November 4-7, 2014.	D 000		
D 078	<p>10A NCAC 13F .0306(a)(5) Housekeeping And Furnishings</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interview, observation and record review, the facility failed to maintain a clean environment free of hazards related to a bedbug infestation in Room 204.</p> <p>The findings are:</p> <p>Interview with a Medication Aide on 11/4/14 at 3:30pm revealed: -The facility admitted a couple into Room 207 during the summer who brought in bedbugs. -"The couple was pretty much restricted to their room by the Administrator." -"Meals were brought to them in their room but they could go downstairs to smoke." -After they were discharged, "The facility steam cleaned the carpet and wiped down the room but it must not have worked because we still have</p>	D 078		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 1</p> <p>them." -Room 204 has had bedbugs for at least 2 weeks. -"I was driving home after work one night and happened to look down and saw a bedbug crawling on me." -"At a meeting last week (inservice on 10/30/14), the staff had been told bedbugs were in the headboard of Bed #1 (Resident #9's bed) in Room 204." -"The residents living in Room 204 (Residents #8 and #9) have not been restricted to their room like the previous residents in Room 207." -A staff member had found a bedbug in the Activity Room, "It had fallen off Resident #8 (the resident in Bed #2 in Room 204) who walks, and sits, all over the building." -"We know what they look like because we saw them in Room 207." -Families had not been notified about the bedbugs and staff were concerned the families who took home resident clothes to wash might be taking home bedbugs and didn't know it.</p> <p>Interview on 11/4/14 at 4:10pm with Resident #9 (Bed #1) revealed: -He found out about the bedbugs 2 or 3 weeks ago when a staff member "said something about there being bedbugs in the headboard of my bed." -Bedbugs had been found on his roommate's bed. -He had not had any bites that he was aware of. -The headboard of his bed had not been taken apart when it was vacuumed. -It had not been cleaned at all. -His bedside stand had not been emptied out and washed with the vinegar. -He used a walker and it had not been wiped off with vinegar.</p>	D 078		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 2</p> <p>-The Executive Director had told him "awhile back" they would have to get him a new headboard but he never said when it would be".</p> <p>Interview on 11/4/14 at 4:15pm with Resident #8 (Bed #2) revealed:</p> <p>-He had been in Room 204 for 3 to 4 months.</p> <p>-"All I know is when I moved in here, they were cleaning and how bedbugs got in here, I don't know."</p> <p>-He didn't see or feel any bites but stated, "I flap my sheet to keep them off of me and maybe that's why."</p> <p>-He had several open areas on his wrists and forearms that he had scratched and were open sores which he had for "awhile" (several months he thought).</p> <p>-"The housekeeper vacuums up the bedbugs every day."</p> <p>-"My bed was not taken apart when the headboard was vacuumed and washed with vinegar."</p> <p>-He had a CPAP (Continuous Positive Airway Pressure) machine on the bedside stand, that he used at night for sleep apnea and it, and the filter, had not been cleaned.</p> <p>-There was not enough room for his "stuff" so he left it on the floor.</p> <p>Observation of Bed #1 (along the right wall) in Room 204 on 11/4/14 at 4:20pm revealed:</p> <p>-Multiple specks of reddish-brown bedbug excrement on the back of the headboard and on the supports connecting it to the bed frame.</p> <p>-No bedbugs or eggs were seen on the headboard</p> <p>-No bedbugs, eggs or excrement were seen on the mattress and box spring.</p> <p>Observation of Bed #2 (headboard against the</p>	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 3</p> <p>left wall) in Room 204 on 11/4/14 at 4:25pm revealed:</p> <ul style="list-style-type: none"> -No bedbugs, eggs or excrement on the mattress and box spring. -Multiple specks of reddish-brown bedbug excrement on the back of the headboard and on the supports connecting it to the bed frame. - Multiple live, engorged adult bedbugs, multiple beige colored younger bedbugs and multiple eggs were in the spaces created where the back of both sides of the headboard attached to the bed frame. -An engorged adult bedbug caught on a cotton tipped applicator "popped" releasing reddish-orange fluid onto the applicator. <p>Interview on 11/4/14 at 4:30pm with the Executive Director revealed:</p> <ul style="list-style-type: none"> -A couple was admitted in June 2014 into Room 207 and brought in bedbugs. -An inservice was held on 6/27/14 to educate the staff. -In June/July 2014, after they were discharged, the entire 2nd floor was steam treated. -Maintenance and housekeeping discovered bedbugs last week on Wednesday (10/29/14). -In his absence, the Regional Director began the corporate Bedbug Protocol and inserviced the staff on 11/3/14. (Note: Documentation provided by the facility revealed the inservice occurred on 10/30/14). -The facility had not notified the families of residents living at the facility that there were bedbugs in the building. -He felt he and his staff had things under control, it wasn't a widespread problem and the pest control company was scheduled to treat the bugs. -He had been trained by the corporation not to move residents to other room because of cross contamination. 	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 4</p> <ul style="list-style-type: none"> - He stated, "The bedbugs would leave this room (204) and go looking for another food source if the residents were moved out of here." -He was uncomfortable being in Room 204 stating he did not want to take the bedbugs home. -He confirmed bedbug excrement on the back of bed #1's headboard. -He confirmed excrement, bedbug eggs, juveniles and engorged adults on the headboard of bed #2. -He confirmed a bug on a cotton tipped applicator removed from bed #2 was an engorged adult bedbug. -The Health Department had not been notified about the bedbugs. -At 4:45pm on 11/4/14, he notified the Health Department and an inspector would be out to inspect the facility the next morning (11/5/14). <p>Interview on 11/5/14 at 6:45am with a Medication Aide (MA)/Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> -One morning several weeks ago, Resident #8 was sitting downstairs from his room with other residents waiting for the dining room to open for breakfast. -A resident sitting next to Resident #8 stated, "Look, (Resident #8), you have a bug on you." -"I rushed over and saw a bedbug on Resident #8's white t-shirt but it disappeared before I could get it." -"I know it was a bedbug because I had looked them up online." -"I asked the resident sitting next to Resident #8 if the bug was on her but we couldn't see it." -When the residents in Room 207 had bedbugs, their clothes were taken to the laundromat and they had to stay in their room except to smoke. -We took their meals to their room. -"We (the employees) don't understand why the same things are not happening now." 	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 5</p> <ul style="list-style-type: none"> -The residents in Room 204 walk and sit all over the building, their laundry gets washed in the facility washing machine and they eat their meals in the dining room. Interview on 11/5/14 at 11:15am with a Health Department employee inspecting Room 204 revealed: <ul style="list-style-type: none"> -She had limited her inspection for bedbugs to Room 204. -An inspection of bed #1 revealed no live bedbugs or visible eggs. -Bedbug excrement was noted where the bed frame attached at the top back of the headboard of bed #1. -The metal bed frame (Bed #1), after the mattress and boxspring were lifted up, contained a large amount of what appeared to be dry skin, food crumbs and dust. -She placed clear packing tape along the metal frame, lifted it up which revealed possible bedbug shedding's and egg casings which she placed in a capped vial for further identification by the Department entomologists. -The cloth cover over the bottom of the boxspring was torn and hanging from the wooden frame and she stated it needed to be repaired. -There was a large yellowish stain on the side of the mattress near the head of the bed. -The Executive Director said he could not replace the mattress because he had no extra mattresses in the facility. -She stated the room was over cluttered and would be difficult to clean. -She stated the furniture in the room needed to be moved away from the walls. -Items should not be stored under the beds and needed to be removed to allow for better cleaning. -An inspection of bed #2 revealed bedbug eggs 	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 6</p> <p>and possible adult shedding's which she placed in a capped vial for further identification by the Department entomologists.</p> <p>-She was not familiar with vinegar water being used to treat for bedbugs.</p> <p>Review on 11/5/14 of the Corporation's Bed Bug Protocol, updated 5/20/14, to be followed to control and prevent spread of bedbug infestations revealed:</p> <p>-They were guidelines to follow until bedbugs were confirmed.</p> <p>-Visitors, residents and staff were not to spend time in the suspected area.</p> <p>-The resident and all their belongings were to be kept in the same room, not moved to another room.</p> <p>-The suspected room must be cleaned thoroughly: beds taken apart and all cracks and crevices vacuumed and cleaned with 1 cup of white vinegar to 1 gallon of warm water.</p> <p>-Clothing and linen needed to be bagged and taken to the laundry room, emptied into the dryer and run on high heat for at least 20 minutes.</p> <p>-Daily cleaning by housekeeping must include: thoroughly vacuuming and wiping down all surfaces to include baseboards, furniture (inside and out), beds, closets, pictures, personal items, cracks and crevices of beds, other furniture and walls.</p> <p>-Hallways that the resident frequents must be vacuumed thoroughly throughout the day.</p> <p>-Common areas that the resident sits in must be vacuumed and cleaned thoroughly each time the resident visits those areas to include crack and crevice cleaning and wipe down of all surfaces in the area with the vinegar solution.</p> <p>Observations of Resident #8 revealed:</p> <p>-On 11/4/14 from 9:15am until 10:00, 11/4/14 at</p>	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 7</p> <p>4:00pm until 4:30pm, 11/5/14 from 4:00pm until 4:45pm and 11/6/14 from 9:45am until 10:15am, he had been sitting in a cloth chair with several female residents in the upstairs hallway.</p> <ul style="list-style-type: none"> -The area was not vacuumed or cleaned per protocol after the resident left the area. -On 11/5/14 from 10:10am until 11:55am, the resident had fallen asleep in a cloth chair in the Activity Room. -The area was not cleaned or vacuumed per protocol after the resident left the area. -A resident visiting with her family sat in the same chair after lunch and was there for over an hour. <p>Interview on 11/5/14 at 8:50am with the resident living in Room 206 revealed:</p> <ul style="list-style-type: none"> -He knew there were bedbugs next door in room 204. -He had not seen any bedbugs in his room but he was watching for them. -His clothes were scattered over his floor because there wasn't enough room to put away his clean clothes. -Some of the clothes on the floor were dirty and he had no place to put them. -The staff took his laundry basket two weeks ago and had not brought it back. -He was unable to describe what a bedbug looked like. <p>Interview on 11/5/14 at 2:15pm with a Personal Care Attendant (PCA) revealed:</p> <ul style="list-style-type: none"> -During the summer, bedbugs had come into the facility with a couple who had been in Room 207. -The couple was "pretty much restricted to their room" except to go downstairs to smoke. -Their meals were brought to their room. -They moved out and the room was cleaned. -Now there were bedbugs in Room 204 but Resident #8 and Resident #9, who live in that 	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 8</p> <p>room, go wherever they want and they both eat in the dining room.</p> <p>-"The staff is afraid we will take them home and several staff have quit since we were told the bedbugs came back."</p> <p>Interview on 11/6/14 at 9:45am with the Maintenance Director revealed:</p> <p>-"For two and one half years, we haven't had any thing like this, not roaches or mice even."</p> <p>-Midsummer, a couple moved in and brought bedbugs with them."</p> <p>-An exterminator confirmed bedbugs with a specially trained dog.</p> <p>-Facility staff removed beds and headboards and disposed of them.</p> <p>-They steam cleaned the carpet and other furniture left in the room..."problem solved, had no other issue for months. They have reoccurred somehow."</p> <p>-"I found out a week and a half ago about the new problem by word of mouth and then from the front office."</p> <p>-"A pest control company was brought in, I know they have been here, but I don't know what the determination was."</p> <p>-This time, they were initially found when a bedbug was discovered crawling on Resident #8.</p> <p>-"It was hard for me to understand how they (the bedbugs) got from Room 207 to Room 204."</p> <p>-"I know the day before yesterday (11/4/14), staff put bags on their feet and were going in Room 204 to clean."</p> <p>Interview on 11/6/14 at 10:15am with a housekeeper revealed:</p> <p>-"Someone saw a bedbug on Resident #8 about 2 weeks ago."</p> <p>-"We had them before, in another room, Room 207."</p>	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 9</p> <p>- "The room was treated, and now they're back (in Room 204)."</p> <p>- "I was here when Room (207) was treated."</p> <p>- "They piped hoses in and treated Room 207, the Activity Room, maybe some of the hallway."</p> <p>"We weren't on the floor during the treatment but that was the rooms I heard they did."</p> <p>- For this outbreak, she was instructed to spray all cracks and crevices of the headboards, the bed frames, mattresses and box springs with vinegar water.</p> <p>- She was instructed to change the sheets every day, bag them and put them in the dryer .</p> <p>- She wiped down the bedside tables and dressers with vinegar water one time which "is supposed to kill the eggs."</p> <p>- Another housekeeper cleaned Room 204 yesterday and it took 3 hours.</p> <p>- She was instructed to vacuum the room thoroughly every day with a vacuum only used in that room.</p> <p>- "The vacuum is bag-less and is emptied after each use into a plastic bag and taken right to the dumpster."</p> <p>- Shoe covers and gowns have been worn to clean in Room 204.</p> <p>- "We couldn't find any gowns on Tuesday, hopefully they have some now."</p> <p>- Another housekeeper had seen bedbugs on the bed in Room 204.</p> <p>- "In the other room (207), they went up along the ceiling. They haven't done that in this room, we been watching."</p> <p>- "Evidence I saw this time was blood spots on the pillow cases and I showed them to the Regional Director of Operations. That was a week and a half ago."</p> <p>- Another housekeeper saw the bugs.</p> <p>- "(Named pest control company) has been called but won't be here until Monday (11/10/14). I wish</p>	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 10</p> <p>you could hurry them up."</p> <p>Review on 11/6/14 at 3:30pm of typed instructions dated 10/23/14 given to the housekeeper's after the bedbug was found in Room 204 stated:</p> <ul style="list-style-type: none"> -Bag all clothes and dry for 20 minutes. -Spray bottle -Vinegar up to bottom ring then fill water to top. -Spray walls and cracks, wipe down. -Vacuum good. -Spray mattress and wipe. -Check bed head board and frame for eggs. -Spray and wipe mattress for 14 days. <p>Review on 11/6/14 at 4:30pm of documents from a pest control company dated 6/25/14 revealed</p> <ul style="list-style-type: none"> -A "Service Ticket" that indicated the company had come to treat for ants and to inspect Room 207, using a specially trained dog, for bedbugs. -Bedbugs had been found in Room 207 on the headboards of both beds, on the walls of the room, in the closets, on picture frames. on the resident's laundry basket, on a cane and both beds. -Visible signs of bedbugs were found on the baseboards in the hallway near the room. -Chemicals applied: Zenprox, Demand and Gentrol. -Target pests for these three pesticides included ants and bedbugs. -"Application" area on the Service Ticket documented: Spray for ants. -Documentation on the Service Ticket also included, "All exterior doors, entry points and the Activity Room were treated for ants." -There was no information indicating treatment for bedbugs had been provided. <p>Review on 11/6/14 at 4:30pm of documents from the same pest control company dated 7/21/14</p>	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 11</p> <p>revealed:</p> <ul style="list-style-type: none"> -A "Service Ticket" that indicated they were there on a bedbug follow-up. -Chemical applied was pesticide Zenprox (target pests: ants and bedbugs). -Steam and vacuum cleaner were also utilized. -"Application" documented: Steam and spray. -Documentation that "Room 207 had been inspected for bedbugs and re-treated. Steam and Zenprox micro-spray utilized. Only dead bedbugs found". <p>Review on 11/6/14 at 4:30pm of documents from the same pest control company dated 10/28/14 revealed:</p> <ul style="list-style-type: none"> -A "ServiceTicket" that indicated they were there to spray for ants and a bedbug inspection. -Chemicals applied: pesticide Demand. A vacuum cleaner was also utilized. -Documentation of: "Perimeter spray of the facility for ants. Room 204 for bedbugs found on bed A (Bed 1/Resident #9) headboard. Treatment will be scheduled and contract sent". <p>Review on 11/6/14 at 4:45pm of "Service Agreement and Release for Treatment of Bedbugs" from the same pest control company revealed:</p> <ul style="list-style-type: none"> -The agreement had been entered into on 10/30/14. -It had been signed by the property manager. -This service does NOT provide for access to wall cavities in order to effect control of the bedbugs. - It did not indicate when the services would be provided. <p>Review on 11/6/14 of the report filed by the facility Medical Director on 11/6/14 revealed:</p> <ul style="list-style-type: none"> -The Medical Director was not Resident #8's physician. 	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	<p>Continued From page 12</p> <ul style="list-style-type: none"> -The Resident Care Coordinator and the Executive Director had requested he evaluate open sores on the wrists and forearms of Resident #8 "to determine if he had bedbugs". -He noted "several scattered small scabs and scratched areas on Resident #8's forearms consistent with old scrapes. -He noted "Resident #8 stated these had been present on and off for months." -Resident #8 told him "they were from bumping into things." -Resident #8 denied any itching or rash anywhere else. -His assessment: "Skin lesions, consistent with minor trauma and not suspicious for parasitic attack." -He added: "However, if the bugs found turn out to be bedbugs, it is necessary to be extremely vigilant about searching for them and any potential hiding spots, reporting them promptly, and eliminating them with any means necessary before they become a problematic infestation. Please keep me posted on the progress of any future appearances of these potential parasites". <p>_____</p> <p>A Plan of Protection was received from the facility on November 5, 2014 and included the following:</p> <ul style="list-style-type: none"> -Remove headboards and dispose of in dumpster. -Wipe down bed rails and legs with alcohol or vinegar water. -Put cups on all four legs of each bed. -Encase boxsprings and mattresses with plastic coverings and seal (zipper) with adhesive (duct) tape. -Monday (November 10, 2014), pest control services will come and service all suspected infected areas. 	D 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 078	Continued From page 13 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 22, 2014.	D 078		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to assure referral and follow-up to meet the acute care needs of 1 of 3 sampled residents (#3) related to falls and 1 of 7 sampled residents (#5) for medication administration.</p> <p>The findings are:</p> <p>A. Review of Resident #3's current FL2 dated 7/30/14 revealed diagnoses included: -Dementia. -Psychosis. -Depressive Disorder. -Anxiety. -Insomnia. -Osteoarthritis. -Diabetes.</p> <p>Continued review of Resident #3's current FL2 revealed medications included: -Divalproex (Depakote Sprinkles) 125mg capsule, 1 twice a day (to treat psychosis).</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 14</p> <ul style="list-style-type: none"> -Divalproex ER (Depakote Extended Release) 250mg tablet, 1 three times a day. -Melatonin 3mg tablets take 2 daily at dinner (a herbal sleep aid). -Quetiapine (Seroquel) 100mg tablets, take 5 (500mg) qhs (at bedtime). to treat psychosis and depression. <p>Continued review of Resident #1's current FL2 dated 7/30/14 revealed:</p> <ul style="list-style-type: none"> -The resident was semi-ambulatory with a walker. -She was continent of bowel and bladder. -She was constantly disoriented. -She was not identified as a falls risk. <p>Review of Resident #3's signed Physician's Orders form dated 7/30/14 revealed</p> <ul style="list-style-type: none"> -Quetiapine (Seroquel) 100mg tablets, 5 tablets (500mg) every night at bedtime. -Melatonin 6mg scheduled daily at dinner. -Divalproex 125mg twice a day. -Divalproex 250mg ER, three times a day. <p>Review on 11/5/14 of Resident #3's Record revealed:</p> <ul style="list-style-type: none"> -On 4/7/14 at 7:00pm, she was found on the floor by her bed, bruising noted of upper left wrist. -On 5/3/14 at 2:00am, she was found on her bathroom floor, scraped back. -On 5/22/14 at 10:50pm, she was found on her bedroom floor, complaining of left sided chest pain and skin tears to left forearm and left lower leg. To Emergency Room with no further injury noted. -On 8/3/14 at 9:30pm, she was found on her bedroom floor, skin tears to both arms. -On 8/23/14 on 3:00pm to 11:00pm shift, she was found sitting on the floor of her room, no apparent injury. -On 8/27/14 at 2:30pm, found sitting on floor by 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 15</p> <p>her bed, no apparent injury.</p> <p>-On 9/15/14 at 2:30pm, found on her floor by her dresser, facility staff noted no injury.</p> <p>-On 9/15/14 at 4:30pm, Home Health nurse noted left hip swelling and the resident was complaining of hip pain, she was sent to the Emergency Room. Diagnosis: left hip contusion.</p> <p>Continued review on 11/5/14 of Resident #3's Record related to post-fall interventions revealed:</p> <p>-4/7/14: Physician requested daily vital signs for 3 days. Vital signs post fall were 138/78 (blood pressure), 98.6 (temperature), 84 (pulse) and 20 (respirations). No additional vital signs were located in the resident's record related to this fall. No documented falls prevention interventions were documented by the facility.</p> <p>-5/3/14: No documented interventions by the facility</p> <p>-5/22/14: Facility noted 30 minute checks of the resident for 72 hours. A Safety Measures for Falls Reduction sheet was completed on the resident.</p> <p>-8/3/14: No documented intervention(s) by the facility.</p> <p>-8/23/14 : No documented intervention(s) by the facility.</p> <p>-8/25/14: Physician's order received for PT (Physical Therapy) evaluation and treatment. Diagnosis: Unsteady gait.</p> <p>-8/27/14: No documentation of intervention(s) by the facility.</p> <p>-9/11/14: Physician follow-up of resident's falls and somnolence (excessive sleepiness) - Medication and dementia related. Continue same medications with out changes. Return to office in 2-3 months (12/3/14).</p> <p>-9/15/14: Staff placed resident on 30 minute checks for 72 hours and would make sure she used her walker.</p> <p>-9/15/14: A Safety Measures For Falls Reduction</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 16</p> <p>sheet was completed for the resident.</p> <p>Review on 11/5/14 of Safety Measures for Falls Reduction sheet dated 5/22/14 for Resident #3 revealed:</p> <ul style="list-style-type: none"> -The resident had a history of falls. -The facility was not concerned the resident was a falls risk after observation of her ambulation/transfers. -Resident was referred to her physician for fall evaluation. -Physical therapy evaluation had been ordered and completed. -Mandatory meeting was held with resident's responsible party to educate him regarding her frequent falls and falls prevention, interventions and that all falls can not be prevented. -Safety awareness emblem placed by resident's door to alert staff that the resident needs safety measures. -Other interventions employed as recommended: The facility will check on resident "72 hours for three days". <p>Review on 11/5/14 of Safety Measures for Falls Reduction sheet dated 9/15/14 for Resident #3 revealed:</p> <ul style="list-style-type: none"> -It contained the same information as the form dated 5/22/14 except the staff was to be sure the resident was wearing shoes. <p>Review on 11/5/14 of the Physical Therapy notes in Resident #3's record revealed:</p> <ul style="list-style-type: none"> -The resident was first seen on 8/28/14. -Goals of therapy: to decrease falls, increase overall strength and decrease lower extremity and back pain. -Progress note on 10/20/14 stated the resident had made progress in gait tolerance and pain. -The resident was discharged from therapy on 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 17</p> <p>10/23/14 secondary to plateau in overall progress. -On 10/23/14, the resident was noted to remain confused and disoriented.</p> <p>Observation on 11/4/14 at 8:35am of Resident #3 revealed: -The resident was lying on her bed. -She had a purplish red bruise on her left forehead about the size of a quarter. -She had a one inch cut across the top of her left eye. -There were five dime sized areas of bruising on her right forearm. -There was a two inch by two inch sized area of bruising on the back of the resident's right hand.</p> <p>Interview on 11/4/14 at 8:35am with Resident #3's roommate revealed: -"She's been falling a lot for a year." -"She gets weak when she gets up and and falls." -"She can't remember anything". -"She fell just a few minutes ago, fell and hit (pointed to Resident #3's bedside table) that table." -"Says her back hurts all the time and she can't walk."</p> <p>Observation on 11/4/14 at 4:05pm of Resident #3 revealed: -Resident ambulated without her walker to the bathroom. -She was unsteady on her feet. -She returned from the bathroom and stated she was tired and needed to go bed.</p> <p>Interview on 11/4/14 at 4:10pm with Resident #3 revealed: -Her speech was garbled and slurred. -She was confused and disoriented as to place</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 18</p> <p>and time. -She did not remember if she had any falls. -She did not remember if she had eaten breakfast or lunch that day.</p> <p>Interview on 11/4/14 at 4:15pm with Resident #3's roommate revealed: -Resident #3 was tired all the time but it was worse in the evening. -Resident #3 missed meals, not just dinner, because she was too tired to go to the dining room. -Resident #3 was forgetful and would walk without her walker. -Resident #3's family was concerned she was not getting to meals. -Resident #3 had fallen multiple times and gone to the hospital once or twice. -She felt it was just a matter of time before Resident #3 fell and broke a hip.</p> <p>Interview on 11/6/14 at 4:30pm with the Resident Care Coordinator revealed: -The bedtime medications on the first floor, where Resident #3's room was located, were scheduled for 8:00pm. -The bedtime medication administration time for some of the residents had been changed, with their doctor's permission, to 5:00pm. -The time change was made because those resident's went to bed earlier and it was easier to give them their medications at dinner, while they were in on place. -The facility had faxed Resident #3's physician requesting her bedtime medications be changed to 5:00pm and the physician had signed it on 12/11/13. -She was aware Resident #3 had fallen multiple times and had been sent to the Emergency Room after several of the falls.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 19</p> <ul style="list-style-type: none"> -She was not aware Resident #3 had fallen 7 times since 4/7/14. -She was not aware the 7 falls occurred between 2:30pm and 2:00am. -The facility had not considered a toileting program for Resident #3 who was noted to have become occasionally incontinent of bladder. -She was aware Resident #3 sometimes missed meals because she wanted to sleep or was lethargic. -The facility had notified the physician of the resident falls. -No on-going interventions had been put into place as a result of Resident #3's numerous falls. <p>Review on 11/6/14 at 10:10am of the most current Assessment and Care Plan for Resident #3 provided by the Resident Care Coordinator revealed:</p> <ul style="list-style-type: none"> -It had not been dated or signed by a facility representative or by the resident's physician. -It indicated it was an assessment completed due to a significant change in the resident. -It did not identify the significant change. -The resident was always disoriented and needed reminders due to forgetfulness. -Under "Risk Management", Safety Measures To Implement and Assistive Device Requirements were both blank. -The Mobility section indicated the resident was independent with transfers and ambulation. -The Toileting section indicated the resident required supervision. -The resident was not identified as a falls risk. <p>Review of the Licensed Health Professional Support sheet dated 9/12/14 for Resident #3 revealed:</p> <ul style="list-style-type: none"> -She ambulated with an assistive device that required physical assistance. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 20</p> <p>-She had not been identified as a falls risk</p> <p>Interviews on 11/6/14 at 8:00am and 10:21am with the office assistant for Resident #3's physician revealed:</p> <p>-The physician was not aware the Quetiapine 500mg had been re-scheduled for 5:00pm.</p> <p>-The physician had specifically ordered it "at bedtime" because it was a high dose and would make the resident sleepy.</p> <p>-She was not concerned about the timing of the Divalproex 125mg, Divalproex 250 ER and the Melatonin.</p> <p>-She was concerned the Quetiapine 500mg was not being given "at bedtime" as ordered.</p> <p>-The physician was going to discontinue the resident's Melatonin.</p> <p>Interview on 11/6/14 at 3:05pm with a family member of Resident #3 revealed:</p> <p>-He visited every other day and had noticed a cognitive decline.</p> <p>-He wondered if the decline was due to her medication.</p> <p>-The resident was often laying in the bed when he came to visit.</p> <p>-He knew she missed meals because of being sleepy.</p> <p>-He stated he didn't think she had lost weight.</p> <p>-He wondered if there was a way the facility could keep track of what, and if, she ate.</p> <p>-There were snacks in her drawer if she got hungry.</p> <p>-"Honestly, she is loopy after her medications at 5:00pm".</p> <p>-She tries to get to the bathroom by herself and I help her because she needs the help".</p> <p>-"She becomes really unsteady on her feet, some days are worse than others".</p> <p>-She had fallen a few times and went by EMS to</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 21</p> <p>the hospital twice.</p> <ul style="list-style-type: none"> -The facility called him when she fell. -Post-fall and fall prevention interventions had not been discussed with him by the facility. -He had not seen any changes made that might prevent her from falling. -"With what all is going on, I think it's time for me to talk with her doctor". -He felt for her her safety, the 5:00pm medication needed to be reviewed by the physician as soon as possible. <p>B. Review of Resident #5's current FL2 dated 10/7/14 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included bipolar with depression and seizure disorder. -Pristiq (used to treat depression) 200mg daily at bedtime. <p>Interview with Resident #5 on 11/4/14 at 9:47am revealed:</p> <ul style="list-style-type: none"> -"I'm out of my antidepressant now." -The resident had been out "5 or 6 days." -The resident stated Pristiq was a medication "...you don't stop abruptly." <p>Observation of Resident #5's medications on hand on 11/5/14 at 11:15am revealed there was no Pristiq on the medication cart.</p> <p>Review of Resident #5's October 2014 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> -An entry for Pristiq 100mg take two tablets every night at 7pm or 8pm. -Pristiq was documented as administered at 8pm on 10/8/14 and 10/9/14 for 2 occurrences out of 2 opportunities. -Pristiq was documented as administered at 7pm from 10/10/14 to 10/27/14 for 18 occurrences out 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 22</p> <p>of 18 opportunities.</p> <p>-On 10/28/14 to 10/31/14 Pristiq was documented as "resident refused."</p> <p>Review of Resident #5's November 2014 MAR revealed:</p> <p>-An entry for Pristiq 100mg take two tablets every night at 7pm.</p> <p>-Pristiq was documented a "resident refused" for 11/2/14 to 11/4/14 for 4 occurrences out of 4 opportunities.</p> <p>-A pass note dated 11/1/14 revealed the Pristiq "med not here."</p> <p>-A pass note dated 11/3/14 revealed the Pristiq "waiting on a prior approval from insurance."</p> <p>Interview with Resident #5 on 11/5/14 at 4:15pm revealed:</p> <p>-"I have never refused my bipolar meds."</p> <p>-The medication aides had brought it every night and she had taken the Pristiq "when I had a supply."</p> <p>-She stated she hadn't had the Pristiq since 10/28/14 and "I feel better" and she wanted the medication discontinued by her physician.</p> <p>-She stated she had asked staff multiple times about getting the medication.</p> <p>-She spoke with the Supervisor on 10/29/14 before her follow-up appointment with the physician who had ordered the Pristiq and asked should she ask her physician for a substitute.</p> <p>-The Supervisor had said "what I'm asking you is do you want your meds to come from [facility pharmacy name]."</p> <p>-Resident #5 had her physician write her another prescription on 10/29/14 for Pristiq and the facility staff faxed it to the facility pharmacy to get it filled.</p> <p>Interview with the Supervisor on 11/5/14 at 12:15pm revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 23</p> <ul style="list-style-type: none"> -Resident #7 had a current order for Pristiq. -The insurance was denying payment on the medication. -The Supervisor had called Resident #5's physician and "couldn't get a response." -The insurance company had to send a rejection to the physician and then the physician would have to change the medication to something that was covered by insurance. -"That's when I knew we were going to have to get the medication from [back up pharmacy's name]." -The Pristiq "is actually being picked up from [back up pharmacy's name] today." -The resident will have to pay "out of pocket" for the prescription. <p>Observation of Resident #5's medications on hand on 11/6/14 at 8:15am revealed there was a bottle of Pristiq 30 tablets on the medication cart that were dispensed according to the label on 11/5/14.</p> <p>Telephone interview with the facility pharmacy on 11/6/14 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -14 tablets (7 day supply) of Pristiq had been sent out to Resident #5 on 10/20/14. -The facility would have received the medication on 10/21/14 to allow medication to be given at bedtime on 10/21/14. -The Pristiq was included in the resident's multi-dose packet. <p>Interview with Resident #5 on 11/6/14 at 2:40pm revealed:</p> <ul style="list-style-type: none"> -She received her Pristiq dose of 200mg at bedtime on 11/5/14. -She "slept better last night." -"I feel good today." 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 24</p> <p>Telephone interview with Resident #5's physician's nurse on 11/6/14 at 3:25pm revealed:</p> <ul style="list-style-type: none"> -Resident #5's physician had not been notified until Monday 11/3/14 that they couldn't get Resident #5's Pristiq filled. -The pharmacy just needed prior authorization from Resident #5's insurance company. -"If she's been off the dose that long she shouldn't be started back on that dose." -"Even the physician on call could have done the authorization." -"She needs to be at 50mg" to restart the medication and the facility should work with their pharmacy as to titrating the dose back up to the 200mg per day the resident had been taking. -"This was a medication he had samples of and could have given the resident a 2 week supply." -"No one said anything while she was seeing him on 10/29/14." -The only side effects of restarting the Pristiq at the 200mg dose without titrating up, the resident might experience headaches and nausea. <hr/> <p>The facility provided a plan of protection on 11/18/14 which included the following:</p> <ul style="list-style-type: none"> -Residents will be assessed after every fall for intervention and follow up. -Physicians will be notified to re-evaluate for possible increase in level of care. -Care plan meetings will be conducted with the family to discuss alternate interventions and strategies to reduce possibility of future falls. <p>Any resident identified as a fall risk will be re-evaluated by the Executive Director and RCM for increased supervision and additional safety measures based on individual need.</p> <p>CORRECTION DATE FOR FOR THE TYPE B</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 25 VIOLATION SHALL NOT EXCEED DECEMBER 22, 2014.	D 273		
D 287	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes:</p> <p>(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure non-disposable place settings were used for residents residing in the facility.</p> <p>The findings are:</p> <p>Observation in the dining room on 11/4/14 at 12:10pm revealed one table where three residents had eaten lunch, there were three used styrofoam dessert sized bowls on the table.</p> <p>Observation in the dining room on 11/4/14 at 12:11pm revealed:</p> <ul style="list-style-type: none"> -A second table where three residents were still eating their lunch. -One of the three residents was eating a peanut butter and jelly sandwich and plain chips off a styrofoam plate. -All three residents had a styrofoam bowl that fruit had been served in. 	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 287	<p>Continued From page 26</p> <p>Interview on 11/5/14 at 12:40 pm with the Dietary Manager revealed:</p> <ul style="list-style-type: none"> -There were no desert bowls because she dropped a tray and broke them. -She had placed an order on 11/3/14 to replace the broken bowls. -She did not know why the staff were using paper plates. -She had not told the kitchen staff to use Styrofoam plates for sandwiches. -Styrofoam cups were used because residents prefer them so they can take them back to their room. -Styrofoam is used sometimes because of hot water issues in the kitchen. <p>A confidential interview with a staff member revealed:</p> <ul style="list-style-type: none"> -Styrofoam was used 2 to 3 times per week. -Staff feel that it is was not appropriate for Styrofoam to be used for the residents. <p>Interview on 11/5/14 at 3:00 pm with the Executive Director revealed:</p> <ul style="list-style-type: none"> -He had told the Dietary Manager to order the dessert dishes. -They should not be using Styrofoam unless there is an emergency. -He did not know if the Dietary Manager had placed the order for the dishes. <p>Observation on 11/6/14 at 2:30 pm of glassware in the kitchen revealed:</p> <ul style="list-style-type: none"> -49 eight inch dinner plates, 44 four inch desert / bread plates, 17 soup bowls, 13 small desert bowls, and 29 coffee cups. <p>A common interview with two kitchen staff on 11/6/14 at 3:25 pm revealed:</p> <ul style="list-style-type: none"> -They had been told to serve sandwiches on 	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 287	<p>Continued From page 27</p> <p>Styrofoam plates.</p> <ul style="list-style-type: none"> -They always served soups, chili, and deserts in Styrofoam bowls because they did not have enough glass bowls. -They always used real silverware, and they would boil water to sterilize if there was a need because of lack of hot water. -They were not aware of, many, times there was no hot water for dishes to be washed. -There were additional plates and coffee cups on the storage shelves. <p>Observation on 11/6/14 at 3:30 pm revealed:</p> <ul style="list-style-type: none"> -Kitchen staff looking on the storage shelves and locating 11 additional 8 inch dinner plates, and 22 additional coffee cups. <p>Confidential interview with second staff member revealed:</p> <ul style="list-style-type: none"> -The residents were fed on Styrofoam plates and cups on a regular bases 2 to 3 times per week. -The residents always had silverware to eat with. -It seemed that every meal had something that was Styrofoam. -The residents deserved better than to be served food on Styrofoam plates. <p>Interviews with three residents in the dining room on 11/4/14 revealed the following comments:</p> <ul style="list-style-type: none"> -"I don't pay attention to what they serve in." -"They sometimes use styrofoam cups. My fruit was in a styrofoam bowl today." -"Last night all the dishes were styrofoam. A lot of times they use styrofoam." <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> -They had just started using Styrofoam plates. -It did not bother them, they liked the Styrofoam cups because they could take the coffee out of the dining room. 	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 287	<p>Continued From page 28</p> <p>A second confidential interview with a resident revealed: -They just started using Styrofoam plates because of hot water issues. -It did not bother them to eat off of Styrofoam plates.</p> <p>A third confidential interview with a resident revealed: -The facility needs more plates. -They were fine with eating off of Styrofoam. -It had been about a month or two since the facility started using Styrofoam.</p> <p>Observation on 11/6/14 at 4:10 pm revealed: -Business Office Manager presented an order sheet dated 11/6/14 from their corporate office for 60 desert bowls, and 40 soup bowls.</p>	D 287		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, failed to assure Pristiq was administered as prescribed to 1 of 7 sampled residents (Resident #5).</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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	<p>Continued From page 29</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated 10/7/14 revealed: -Diagnoses included bipolar with depression and seizure disorder. -Pristiq (used to treat depression) 200mg daily at bedtime.</p> <p>Interview with Resident #5 on 11/4/14 at 9:47am revealed: -"I'm out of my antidepressant now." -The resident had been out "5 or 6 days." -The resident stated Pristiq was a medication "...you don't stop abruptly."</p> <p>Observation of Resident #5's medications on hand on 11/5/14 at 11:15am revealed there was no Pristiq on the medication cart.</p> <p>Review of Resident #5's October 2014 Medication Administration Record (MAR) revealed: -An entry for Pristiq 100mg take two tablets every night at 7pm or 8pm. -Pristiq was documented as administered at 8pm on 10/8/14 and 10/9/14 for 2 occurrences out of 2 opportunities. -Pristiq was documented as administered at 7pm from 10/10/14 to 10/27/14 for 18 occurrences out of 18 opportunities. -On 10/28/14 to 10/31/14 Pristiq was documented as "resident refused."</p> <p>Review of Resident #5's November 2014 MAR revealed: -An entry for Pristiq 100mg take two tablets every night at 7pm. -Pristiq was documented a "resident refused" for 11/2/14 to 11/4/14 for 4 occurrences out of 4</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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	<p>Continued From page 30</p> <p>opportunities.</p> <p>-A pass note dated 11/1/14 revealed the Pristiq "med not here."</p> <p>-A pass note dated 11/3/14 revealed the Pristiq "waiting on a prior approval from insurance."</p> <p>Interview with Resident #5 on 11/5/14 at 4:15pm revealed:</p> <p>- "I have never refused my bipolar meds."</p> <p>- The medication aides had brought it every night and she had taken the Pristiq "when I had a supply."</p> <p>- She stated she hadn't had the Pristiq since 10/28/14 and "I feel better" and she wanted the medication discontinued by her physician.</p> <p>- She stated she had asked staff multiple times about getting the medication.</p> <p>- She spoke with the Supervisor on 10/29/14 before her follow-up appointment with the physician who had ordered the Pristiq and asked should she ask her physician for a substitute.</p> <p>- The Supervisor had said "what I'm asking you is do you want your meds to come from [facility pharmacy name]."</p> <p>- Resident #5 had her physician write her another prescription on 10/29/14 for Pristiq and the facility staff faxed it to the facility pharmacy to get it filled.</p> <p>Interview with the Supervisor on 11/5/14 at 12:15pm revealed:</p> <p>- Resident #7 had a current order for Pristiq.</p> <p>- The insurance was denying payment on the medication.</p> <p>- The Supervisor had called Resident #5's physician and "couldn't get a response."</p> <p>- The insurance company had to send a rejection to the physician and then the physician would have to change the medication to something that was covered by insurance.</p> <p>- "That's when I knew we were going to have to</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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	<p>Continued From page 31</p> <p>get the medication from [back up pharmacy's name]."</p> <p>-The Pristiq "is actually being picked up from [back up pharmacy's name] today."</p> <p>-The resident will have to pay "out of pocket" for the prescription.</p> <p>Observation of Resident #5's medications on hand on 11/6/14 at 8:15am revealed there was a bottle of Pristiq 30 tablets on the medication cart that were dispensed according to the label on 11/5/14.</p> <p>Telephone interview with the facility pharmacy on 11/6/14 at 2:10pm revealed:</p> <p>-14 tablets (7 day supply) of Pristiq had been sent out to Resident #5 on 10/20/14.</p> <p>-The facility would have received the medication on 10/21/14 to allow medication to be given at bedtime on 10/21/14.</p> <p>-The Pristiq was included in the resident's multi-dose packet.</p> <p>Interview with Resident #5 on 11/6/14 at 2:40pm revealed:</p> <p>-She received her Pristiq dose of 200mg at bedtime on 11/5/14.</p> <p>-She "slept better last night."</p> <p>-"I feel good today."</p> <p>Telephone interview with Resident #5's physician's nurse on 11/6/14 at 3:25pm revealed:</p> <p>-Resident #5's physician had not been notified until Monday 11/3/14 that they couldn't get Resident #5's Pristiq filled.</p> <p>-The pharmacy just needed prior authorization from Resident #5's insurance company.</p> <p>-"If she's been off the dose that long she shouldn't be started back on that dose."</p> <p>-"Even the physician on call could have done the</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 32 authorization." -"She needs to be at 50mg" to restart the medication and the facility should work with their pharmacy as to titrating the dose back up to the 200mg per day the resident had been taking. -"This was a medication he had samples of and could have given the resident a 2 week supply." -"No one said anything while she was seeing him on 10/29/14." -The only side effects of restarting the Pristiq at the 200mg dose without titrating up, the resident might experience headaches and nausea.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered to residents within one hour before or one hour after for scheduled multi-dose time sensitive medications for 4 of 7 sampled residents (Residents #1, #3, #4, and #7). The findings are: A. Review of Resident #4's current FL2 dated 4/2/14 revealed: -Diagnoses included Parkinsons Disease and gait disturbance. -Carbidopa/Levodopa (used to reduce the	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 33</p> <p>symptoms of Parkinson's Disease) 25-100mg 2 tablets three times a day.</p> <p>-Ropinirole (used to reduce the symptoms of Parkinson's Disease) 5mg 1 tablet three times a day.</p> <p>1. Review of Resident #4's physician order form dated 7/8/14 revealed Carbidopa/Levodopa 25-100mg 2 tablets three times a day at 6am, 12pm, and 6pm.</p> <p>Interview with Resident #4 on 11/4/14 at 9:05am revealed:</p> <p>-The resident routinely received medications throughout the day to control her Parkinson's symptoms.</p> <p>-"I have [some Parkinson's medication] scheduled at 6am and [the medication aides] can't get around to everybody so it's overdue about 30 minutes or longer sometimes."</p> <p>-"See Parkinsons medication can get out of your system and it causes my symptoms to be worse."</p> <p>-"I shake a lot, but I can't help it."</p> <p>-"Of a mornings, I can't hardly go if I don't get my medicine."</p> <p>Review of Resident #4's October 2014 electronic Medication Administration Record (e-MAR) revealed:</p> <p>-An entry for Carbodopa/Levodopa 25-100mg two tablets three times a day (blister pack) at 6am, 12pm, and 6pm.</p> <p>-The medication was documented as administered 10/1/14 to 10/31/14 for 93 occurrences out of 93 opportunities.</p> <p>Review of Resident #4's November 2014 e-MAR revealed:</p> <p>-An entry for Carbodopa/Levodopa 25-100mg two tablets three times a day (blister pack) at 6am,</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 34</p> <p>12pm, and 6pm. -The medication was documented as administered 11/1/14 to 11/6/14 for 16 occurrences out of 16 opportunities.</p> <p>Review of Resident #4's medication administration history for the Carbodopa/Levodopa 25-100mg from 10/5/14 6am until 11/4/14 12pm revealed: -The medication was administered outside of the one hour before/after time frame for 19 occurrences out of 92 opportunities. The following are examples: -On 10/9/14 6pm documented as administered at 4:32pm. -On 10/12/14 6pm documented as administered at 4:29pm. -On 10/16/14 12pm documented as administered at 1:46pm. -On 10/24/14 6am documented as administered at 7:26am. -On 10/27/14 6pm documented as administered at 4:26pm. -On 10/28/14 6pm documented as administered at 4:09pm. -On 10/31/14 6am documented as administered at 7:28am.</p> <p>Observation on 11/5/14 at 7:46am revealed there were 26 doses of Carbodopa/Levodopa 25-100mg tablets in a bubble pack locked up inside the medication cart for Resident #4.</p> <p>Attempted telephone interview with Resident #4's physician on 11/6/14 at 11:45am was unsuccessful.</p> <p>Refer to interview with a medication aide on 11/4/14 at 3:30pm.</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 35</p> <p>Refer to interview with a second medication aide on 11/5/14 at 7:15am.</p> <p>Refer to interview with the Resident Care Coordinator on 11/5/14 at 12:30pm.</p> <p>Refer to telephone interview with the facility's pharmacy on 11/7/14 at 10:30am.</p> <p>2. Review of Resident #4's physician order form dated 7/8/14 revealed Ropinirole 5mg 1 tablet three times a day for Parkinson's Disease at 9am, 3pm, and 8pm.</p> <p>Interview with Resident #4 on 11/4/14 at 9:05am revealed: -The resident routinely received medications throughout the day to control her Parkinson's symptoms. -"I have [some Parkinson's medication] scheduled at 6am and [the medication aides] can't get around to everybody so it's overdue about 30 minutes or longer sometimes." -"See Parkinsons medication can get out of your system and it causes my symptoms to be worse." -"I shake a lot, but I can't help it." -"Of a mornings, I can't hardly go if I don't get my medicine."</p> <p>Review of Resident #4's October 2014 e-MAR revealed: -An entry for Ropinirole 5mg one tablet three times a day (blister pack) at 9am, 3pm, and 8pm. -The medication was documented as administered 10/1/14 to 10/31/14 for 93 occurrences out of 93 opportunities.</p> <p>Review of Resident #4's November 2014 e-MAR revealed: -An entry for Ropinirole 5mg one tablet three</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 36</p> <p>times a day (blister pack) at 9am, 3pm, and 8pm. -The medication was documented as administered 11/1/14 to 11/6/14 for 16 occurrences out of 16 opportunities.</p> <p>Review of Resident #4's medication administration history for the Ropinirole 5mg from 10/5/14 9am until 11/4/14 3pm revealed: -The medication was administered outside of the one hour before/after time frame for 62 occurrences out of 92 opportunities. The following are examples: -On 10/9/14 8pm documented as administered at 6:20pm. -On 10/18/14 9am documented as administered at 7:12am. -On 10/24/14 3pm documented as administered at 12:18pm. -On 10/27/14 9am documented as administered at 7:07am. -On 10/29/14 9am documented as administered at 7:19am. -On 10/31/14 9am documented as administered at 7:28am. -On 11/1/14 9am documented as administered at 7:16am.</p> <p>Observation on 11/5/14 at 7:46am revealed there were 12 doses of Ropinirole tablets in a bubble pack locked up inside the medication cart for Resident #4.</p> <p>Observation on 11/5/14 at 10:41am during the morning medication pass revealed Resident #4 received her 9am dose of Ropinirole at 10:41am.</p> <p>Attempted telephone interview with Resident #4's physician on 11/6/14 at 11:45am was unsuccessful by exit.</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 37</p> <p>Refer to interview with a medication aide on 11/4/14 at 3:30pm.</p> <p>Refer to interview with a second medication aide on 11/5/14 at 7:15am.</p> <p>Refer to interview with the Resident Care Coordinator on 11/5/14 at 12:30pm.</p> <p>Refer to telephone interview with the facility's pharmacy on 11/7/14 at 10:30am.</p> <p>B. Review of Resident #7's current FL2 dated 3/17/14 revealed: -Diagnoses included Parkinson's Disease and debility. -Carbidopa/Levodopa 25-100mg 1 tablet five times a day.</p> <p>Review of Resident #7's physician order form dated 4/21/14 revealed Carbidopa/Levodopa 25-100mg 1 tablet five times a day at 6am, 10am, 2pm, 6pm, and 10pm.</p> <p>Observation on 11/5/14 at 10:46am during the morning medication pass revealed Resident #7 received her 10am dose of Ropinirole at 10:46am.</p> <p>Review of Resident #7's October 2014 e-MAR revealed: -An entry for Carbodopa/Lovadopa 25-100mg two tablets five times a day (blister pack) at 6am, 10am, 2pm, 6pm, and 8pm. -The medication was documented as administered 10/1/14 to 10/31/14 for 155 occurrences out of 155 opportunities.</p> <p>Review of Resident #7's November 2014 e-MAR revealed:</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 38</p> <p>-An entry for Carbodopa/Lovadopa 25-100mg two tablets five times a day (blister pack) at 6am, 10am, 2pm, 6pm, and 8pm.</p> <p>-The medication was documented as administered 11/1/14 to 11/5/14 for 22 occurrences out of 22 opportunities.</p> <p>Review of Resident #7's medication administration history for the Carbodopa/Lovadopa from 10/1/14 6am until 11/5/14 10am revealed:</p> <p>-The medication was administered outside of the one hour before/after time frame for 43 occurrences out of 177 opportunities. The following are examples:</p> <p>-On 10/7/14 2pm documented as administered at 5:12pm.</p> <p>-On 10/17/14 10am documented as administered at 6:58am.</p> <p>-On 10/24/14 6am documented as administered at 7:46am.</p> <p>-On 10/30/14 10am documented as administered at 1:13pm.</p> <p>-On 10/31/14 6am documented as administered at 7:37am.</p> <p>-On 11/2/14 10pm documented as administered at 6:49pm.</p> <p>-On 11/4/14 10am documented as administered at 11:28am.</p> <p>Interview with Resident #7 on 11/6/14 at 3:20pm revealed:</p> <p>-She "pretty much" received her medications on time.</p> <p>-"I think [staff] are rushed giving meds."</p> <p>Refer to interview with a medication aide on 11/4/14 at 3:30pm.</p> <p>Refer to interview with a medication aide on</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 39</p> <p>11/5/14 at 7:15am.</p> <p>Refer to interview with the Resident Care Coordinator on 11/5/14 at 12:30pm.</p> <p>Refer to telephone interview with the facility's pharmacy on 11/7/14 at 10:30am.</p> <p>C. Review of Resident #3's current FL2 dated 7/30/14 revealed diagnoses included: -Dementia. -Psychosis. -Depressive Disorder. -Anxiety. -Insomnia.</p> <p>Continued review of Resident #3's current FL2 revealed medications included: -Divalproex (Depakote Sprinkles) 125mg capsule, 1 twice a day (used to treat psychosis). -Divalproex ER (Depakote Extended Release) 250mg tablet, 1 three times a day. -Melatonin 3mg tablets take 2 daily at dinner (an herbal sleep aid). -Quetiapine (Seroquel) 100mg tablets, take 5 (500mg) qhs (at bedtime). Used to treat psychosis and depression.</p> <p>Review of Resident #3's signed Physician's Orders form dated 7/30/14 revealed: -Quetiapine (Seroquel) 100mg tablets, 5 tablets (500mg) every night at bedtime scheduled daily for 5:00pm. -Melatonin 6mg daily at dinner (5:00pm). -Divalproex 125mg twice a day scheduled for 7:00am and 5:00pm. -Divalproex 250mg ER, three times a day scheduled for 6:00am, 12:00 and 5:00pm.</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 40</p> <p>Observation of Resident #3 on 11/5/14 at 8:45pm revealed the resident was not interviewable.</p> <p>Interview on 11/6/14 at 4:30pm with the Resident Care Coordinator revealed:</p> <ul style="list-style-type: none"> -The bedtime medications on the first floor where Resident #3's room was located, were scheduled for 8:00pm. -The bedtime medications on the second floor of the facility were scheduled for 9:00pm. -Bedtime medication time for some of the residents had been changed, with their doctor's permission, to 5:00pm. -The time change was made because those residents went to bed early and it was easier to give them their medications at dinner, while they were all in on place. -The facility had faxed a request to Resident #3's physician requesting her bedtime medication time be changed to 5:00pm which the physician signed on 12/11/13. -She was aware Resident #3 had fallen multiple times and sent to the Emergency Room after several of the falls. -She was not aware Resident #3 had fallen 7 times since 4/7/14. -She was not aware the 7 falls occurred between 2:30pm and 2:00am. -She was aware Resident #3 sometimes missed meals because she wanted to sleep or was lethargic. <p>Review of Resident #3's September, October and November 2014 electronic Medication Administration Records (e-MAR) revealed:</p> <ul style="list-style-type: none"> -An entry for Quetiapine 100mg, take 5 tablets every night at bedtime. (Scheduled for 5:00pm). -The medication was documented as administered 9/1/14 to 11/4/14 for 65 occurrences out of 65 opportunities. 	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 41</p> <p>Review of Resident #3's medication administration history for the Quetiapine 500mg from 9/1/14 to 11/4/14 included the following examples:</p> <ul style="list-style-type: none"> -The medication was administered outside of the one hour before time frame for 4 occurrences out of 65 opportunities. -On 9/1/14 documented as administered at 3:19pm. -On 9/6/14 documented as administered at 3:11pm. -On 9/12/14 documented as administered at 3:47pm. -On 9/24/14 documented as administered at 3:18pm. <p>Interviews on 11/6/14 at 8:00am and 10:21am with the office assistant for Resident #3's physician revealed:</p> <ul style="list-style-type: none"> -The physician was not aware the Quetiapine 500mg had been re-scheduled for 5:00pm. -The physician had specifically ordered it "at bedtime" because it was a high dose and would make the her sleepy. -She was not concerned about the timing of the Divalproex 125mg, Divalproex 250 ER and the Melatonin. -She was concerned the Quetiapine 500mg was not being given "at bedtime" as ordered. -The physician was going to discontinue the resident's Melatonin. <p>Interview on 11/6/14 at 3:05pm with a family member of Resident #3 revealed:</p> <ul style="list-style-type: none"> -He visited every other day and noticed a cognitive decline. -He wondered if the decline was due to her medication. -The resident was often laying in the bed when he 	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 22</p> <p>came to visit.</p> <ul style="list-style-type: none"> -He knew she missed meals because of being sleepy. -He stated he didn't think she had lost weight. -He wondered if there was a way the facility could keep track of what, and if, she ate. -There were snacks in her drawer if she got hungry. -"Honestly, she is loopy after her medications at 5:00pm". -She tries to get to the bathroom by herself and I help her because she needs the help". -"She becomes really unsteady on her feet, some days are worse than others". -She had fallen a few times and went by EMS to the hospital twice. -The facility called him when she fell. -Post-fall and fall prevention interventions had not been discussed with him by the facility. -He had not seen any changes made that might prevent her from falling. -"With what all is going on, I think it's time for me to talk with her doctor". -He felt for her safety, the 5:00pm medication needed to be reviewed by the physician as soon as possible. <p>Refer to interview with a medication aide on 11/4/14 at 3:30pm.</p> <p>Refer to interview with a second medication aide on 11/5/14 at 7:15am.</p> <p>Refer to interview with the Resident Care Coordinator on 11/5/14 at 12:30pm.</p> <p>Refer to telephone interview with the facility's pharmacy on 11/7/14 at 10:30am.</p> <p>D. Review of Resident #1's current FL2 dated</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 43</p> <p>7/22/14 revealed diagnoses included: -Atypical chest pain. -Coronary Artery Disease). -Ventricular Fibrillation. -Cerebral Aneurysm (ruptured and treated in 1986). -Cardio-Vascular Accident. -Hypertension.</p> <p>Continued review of Resident #1's current FL2 dated 7/22/14 revealed medication included: -Carvedilol 25mg twice a day (decreases blood pressure). -Furosemide 20mg every morning (decreases edema and blood pressure). -Losartan Potassium 50mg daily (decreases blood pressure).</p> <p>1. Review of Resident #1's physician order form dated 5/28/14 revealed: -Furosemide 20mg every morning at 9:00am. -An order to check blood pressure daily.</p> <p>Interview on 11/4/14 at 10:25am with Resident #1 revealed: -Her blood pressure medication is often given late. -Sometimes it is almost lunch time before she takes it.</p> <p>Review of Resident #1's blood pressure order printed on the October and November 2014 MAR's revealed: -Parameters were added to the order on 9/3/14. -The physician was to be notified if the systolic blood pressure (upper number) was less than 90 and greater than 180 and the diastolic blood pressure (the lower number) was less than 40 and greater than 110.</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 44</p> <p>Review of Resident #1's daily blood pressure's recorded in the electronic MAR's for October and November 2014 revealed: -All were within the parameters identified by the physician. -They ranged from 110/62 to 158/80.</p> <p>Review of Resident #1's 10/8/14 to 10/31/14 and 11/1/14 to 11/7/14 electronic Medication Administration Records (e-MAR) revealed: -An entry each month for Furosemide 20mg daily at 9:00am. -The medication was documented as administered for 31 occurrences out of 31 opportunities.</p> <p>Review of Resident #1's medication administration history for the Furosemide 20mg daily from 10/8/14 until 11/7/14 included the following examples: -The medication was administered outside of the one hour before/after time frame for 11 occurrences out of 31 opportunities. -On 10/13/14 documented as administered at 10:58am. -On 10/14/14 documented as administered at 10:15am. -On 10/15/14 documented as administered at 11:14am. -On 10/17/14 documented as administered at 10:14am. -On 10/20/14 documented as administered at 10:35am. -On 10/22/14 documented as administered at 10:17am. -On 10/24/14 documented as administered at 11:57am. -On 10/25/14 documented as administered at 10:32am. -On 11/2/14 documented as administered at</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 45</p> <p>11:15am. -On 11/4/14 documented as administered at 11:17am. -On 11/5/14 documented as administered at 10:26am.</p> <p>Refer to interview with a medication aide on 11/4/14 at 3:30pm.</p> <p>Refer to interview with a second medication aide on 11/5/14 at 7:15am.</p> <p>Refer to interview with the Resident Care Coordinator on 11/5/14 at 12:30pm.</p> <p>Refer to telephone interview with the facility's pharmacy on 11/7/14 at 10:30am.</p> <p>2. Review of Resident #1's physician order form dated 5/28/14 revealed: -Carvedilol 25mg twice a day.</p> <p>Review of Resident #1's October 2014 electronic Medication Administration Record (e-MAR) revealed: -An entry for Carvedilol 25mg twice a day at 12:00pm and 9:00pm. -The medication was documented as administered within the one hour before/after time frame for 62 occurrences out of 62 opportunities.</p> <p>Review of Resident #1's November 2014 e-MAR revealed: -An entry for Carvedilol 25mg twice a day at 9:00am and 5:00pm. -The medication was documented as administered for 13 occurrences out of 13 opportunities. -5 occurrences out of the 13 opportunities were not within the hour before/after time frame.</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 46</p> <p>-On 11/2/14 the 9:00am dose had been administered at 11:15am. -On 11/2/14 the 5:00pm dose had been administered at 6:20pm. -On 11/3/14 the 9:00am dose had been administered at 1:17pm. -On 11/4/14 the 9:00am dose had been administered at 11:17pm. -On 11/5/14 the 9:00am dose was administered at 10:26am.</p> <p>Review of Resident #1's medication administration history for the Carvedilol 25mg twice a day at 12:00pm and 9:00pm included the following examples: -The medication was administered outside of the one hour before/after time frame for 5 occurrences out of 61 opportunities. -However, those 5 occupancies were out of 13 opportunities documented between 11/1/14 and 11/7/14. -On 11/2/14, 9:00am dose documented as administered at 11:15am. -On 11/2/14, 5:00pm dose documented as administered at 6:20pm. -On 11/3/14, 9:00am dose documented as administered at 1:17pm. -On 11/4/14, 9:00am dose documented as administered at 11:17am. -On 11/5/14, 9:00am dose documented as administered at 10:26am.</p> <p>Refer to interview with a medication aide on 11/4/14 at 3:30pm.</p> <p>Refer to interview with a medication aide on 11/5/14 at 7:15am.</p> <p>Refer to interview with the Resident Care Coordinator on 11/5/14 at 12:30pm.</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 47</p> <p>Refer to telephone interview with the facility's pharmacy on 11/7/14 at 10:30am.</p> <hr/> <p>Interview with a medication aide on 11/4/14 at 3:30pm revealed: -When asked if the facility had enough staff to attend to the residents needs? "No. They try. Terrible turn over." -The medication pass was described as "tough" with "too many meds." -One medication aide passed medications to all residents in the facility. -Distractions for the medication aide during the medication pass included: confused residents, phone calls, family members. -"Its too much for one person."</p> <p>Interview with a second medication aide on 11/5/14 at 7:15am revealed: -There were "not a lot" of 6am medications to administer. -Medications were to be administered one hour before or one hour after the medication's scheduled administration time. -It was "not a problem" getting the medications administered on time. -"We may have already given a med and were just late in clicking it as given in the [electronic medication administration] system. That might show up as a medication having been given early or late. Its hard to know for sure." -"It would work better if some of the 8'oclock meds were done before I came in cause at shift change we have to count the cart and give report. If there's a hiccough of any kind some of the meds will be late."</p> <p>Interview with the Resident Care Coordinator</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 48</p> <p>(RCC) on 11/5/14 at 12:30pm revealed:</p> <ul style="list-style-type: none"> -The medication aides had been instructed to "click off" on the medication at the time they had administered it. -The medication administration history time should be when the medication was administered to the resident. -"If someone forgets to click off on it the they can click on it later." -"We can tell when a med has been given over the one hour after mark, but we can't tell if its been given early." -The computer software did not keep the medication aides from clicking on a medication outside the time frame to indicate it has been administered. -Staff were expected to administer medications within the 1 hour before or 1 hour after a medication's scheduled time <p>Telephone interview with the facility's pharmacy on 11/7/14 at 10:30am revealed:</p> <ul style="list-style-type: none"> -The pharmacy provided and supported technical support of the electronic Medication Administration Record software used by the facility. -"[The software] should warn them if they are [administering medications] too early or too late." -That feature was "turned off" in the facility's software. -"I have turned it on now." -"Now it will prompt for a reason when they try to give the medication too early or too late." -It was the pharmacy's understanding the facility's policy was to administer medication up to 1 hour before a medication was scheduled or 1 hour after the scheduled time for a medication. <p>_____</p> <p>A plan of protection was received from the facility</p>	D 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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 364	<p>Continued From page 49</p> <p>on 11/6/14 and included the following: -The facility will inservice all facility medication aides on correct medication administration and documentation on 11/7/14 at 2pm. -The facility will set an alert on electronic medication administration system for late/early medication administration to 30 minutes on the scheduled time for administration. -The Executive Director and RCC will monitor medication pass on electronic medication administration system daily for 2 weeks and as needed thereafter.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 22, 2014.</p>	D 364		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review, observations and interviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to bed bug infestation and medication administration.</p> <p>The findings are: A. Based on interview, observation and record</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CEDAR MOUNTAIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 11 SHERWOOD RIDGE ROAD BREVARD, NC 28712
---	--

(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
D912	<p>Continued From page 50</p> <p>review, the facility failed to maintain a clean environment free of hazards related to a bedbug infestation in Room 204. [Refer to Tag 0078, 10A NCAC F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].</p> <p>B. Based on observation, interview and record review, the facility failed to assure referral and follow-up to meet the acute care needs of 1 of 3 sampled residents (#3) related to falls and 1 of 7 sampled residents (#5) for medication administration. [Refer to Tag 273, 10A NCAC F .0902(b) Health Care (Type B Violation)].</p> <p>C. Based on observation, interview, and record review, the facility failed to assure medications were administered to residents within one hour before or one hour after for scheduled multi-dose time sensitive medications for 3 of 7 sampled residents (Residents #1, #4, and #7). [Refer to Tag 0364, 10A NCAC F .1004(g) Medication Administration (Type B Violation)].</p>	D912		