

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER TENDER TOUCH FCH	STREET ADDRESS, CITY, STATE, ZIP CODE 2005 ANN AVENUE RALEIGH, NC 27609
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on December 11, 2014.	C 000		
C 172	<p>10A NCAC 13G .0504 (b) Competency Validation For Licensed Health Pro</p> <p>10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Task</p> <p>(b) Competency validation shall be performed by the following licensed health professionals:</p> <p>(1) A registered nurse shall validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter.</p> <p>(2) In lieu of a registered nurse, a respiratory care practitioner licensed under G.S. 90, Article 38, may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19) and (21) of Rule .0903 of this Subchapter.</p> <p>(3) In lieu of a registered nurse, a registered pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(8) of Rule .0903 of this Subchapter</p> <p>(4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a) (22) through (27) of Rule .0903 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 1 of 3 facility staff (Staff C), had been competency validated for</p>	C 172		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 172	<p>Continued From page 1</p> <p>personal care tasks by the Licensed Health Professional Support (LHPS) Nurse such as assistance with ambulation, and a resident with physician order for a resident with continuous oxygen, and inhalation medication by machine. The findings are:</p> <p>Review of record for Staff C revealed:</p> <ul style="list-style-type: none"> - Staff C was hired on 8/19/14 as a Nurse aide (NA). - There was no documentation for LHPS validation. <p>Interview with Staff C on 12/11/14 at 11:55 am revealed:</p> <ul style="list-style-type: none"> - She has been working in the facility for the last two weeks as a fill in NA. - She assists one of the residents with ambulation and help him ambulate with his walker. - There is another resident in the facility with an order for continuous oxygen, but she does not wear her oxygen and has never told Staff C she needed it. <p>Observation on 12/11/14 at 1:30pm revealed Staff C assisting a resident ambulate with a walker.</p> <p>Interview with the Administrator on 12/11/14 at 1:20pm revealed:</p> <ul style="list-style-type: none"> - Staff C had been hired as an NA to fill in for permanent Staff if they were unable to work. - She had been working at the facility as a fill in for the last two weeks. - She works 7:00am-4:00pm. - When she was hired, she was not needed to work, because the facility was fully staffed and she did not need LHPS validation at that time. - Staff C has not been competency validated for oxygen administration and monitoring and 	C 172		

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C 172	Continued From page 2 assisting with ambulation.. - The LHPS nurse has not been to the facility since she started actually working. - The LHPS nurse will be at the facility on Saturday to validate Staff C.	C 172		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the physician was notified of 2 of 3 sampled resident related to elevated blood pressures (#1) and refusal of continuous oxygen (#2). The findings are: 1. Review of current FL-2 for Resident # 3 dated 8/4/14 revealed: - Diagnoses included Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Dementia and Hypertension. - Resident was described as intermittently disoriented. - Respirations were described as normal and desaturation with ambulation. - Documentation of an order for 2 Liters of continuous oxygen via nasal cannula. Review of resident register for Resident #3 revealed the resident was admitted to the facility on 8/11/14.	C 246		

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C 246	<p>Continued From page 3</p> <p>Observation of Resident #3 on 12/11/14 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - She was sitting on the side of her bed not wearing her oxygen. - In her room was an oxygen canister with tubing connected draped over the top of the canister. - A large oxygen concentrator with tubing connected draped over the bed, 2 portable oxygen tanks, and a nebulizer were at the bedside. <p>Interview with Resident #3 on 12/11/14 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - She does not wear her nasal cannula for oxygen administration. - She cannot recall when the last time she wore her nasal cannula. - The staff at the facility know she does not wear her oxygen and they do not make her put it on. - She had been short of breath on a few occasions within the last month, while walking. - Resident did not remember alerting staff when she was short of breath. - She had some wheezing about a month ago. - It had been a long time since she had said anything to staff about being short of breath. <p>Interview with Resident #3's family member on 12/11/14 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - She never puts her oxygen on. - When she goes out in the community with Resident #3, she often gets tired and winded. - There had been a few occasions in the last month where resident had been short of breath and had been wheezing. - She did not alert staff on these occasions. - When they returned to the facility on those days, she would reach into the drawer (during this 	C 246		

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C 246	<p>Continued From page 4</p> <p>interview she reached into drawer to show inhaler, but did not find the inhaler in the drawer) and would give Resident #3 (2) puffs of her inhaler that is usually in the drawer and her breathing got better.</p> <ul style="list-style-type: none"> - The last time she gave Resident #3 the Albuterol inhaler was about a week ago (Albuterol is a medication used to increase air flow to the lungs). - A while back when they did tell staff, they gave her some medication. She does not remember how long ago that was. <p>Interview with the Administrator on 12/11/14 at 1:15pm revealed:</p> <ul style="list-style-type: none"> - She is aware Resident #3 does not put her oxygen on. - Resident #3 had only put her oxygen on 2 times since her arrival at the facility, and that was when she first arrived. - When she first got to the facility she was disoriented, but she is no longer disoriented. - She does not bother her about it, because resident is doing fine without it. - She has a child with breathing problems and she can tell when someone is having problems breathing. - Resident #3 had not had any problems breathing. - She does not have an oximeter (a device used to monitor oxygen saturation) at the facility. - She had not alerted the doctor Resident #3 was refusing to wear her nasal cannula. - She had been concentrating on straightening out other issues with Resident #3, she did not keep up with Resident#3's medications properly. - She is responsible for checking over the FL-2 and making sure the orders are taken off correctly and implemented. - She did not put the oxygen order on the 	C 246		

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C 246	<p>Continued From page 5</p> <p>medication administration record (MAR) since the resident was not using it.</p> <p>Telephone interview with Resident #3's Physicians office representative on 12/11/14 at 4:18 pm revealed:</p> <ul style="list-style-type: none"> - The doctor and physician assistant (PA) were both unavailable to be reached by phone. - Resident #3 was last seen in the office 6/11/14, by the PA for moderate hypoxia due to COPD. - Resident had continued orders for continuous oxygen and nebulizer treatments as needed. - The expectation is that Resident #3 should be using her oxygen on a continuous basis. - There had not been a call to the physician or PA by the Administrator to alert them Resident #3 was not wearing the oxygen as prescribed. - The Administrator called earlier on this same day to speak with the PA regarding the oxygen order for Resident #3. <p>Interview with the Administrator on 12/11/14 at 5:00pm revealed:</p> <ul style="list-style-type: none"> - She will put the oxygen on Resident #3 now. - She will contact the physician or PA to see if the order will be continued or if the oxygen may be discontinued. - She will assure Resident #3 keeps her oxygen on unless there is a change in the order. <p>Observation of Resident #3 on 12/11/14 at 5:10pm revealed, resident wearing nasal cannula, receiving oxygen therapy.</p> <p>Interview with Resident #3 on 12/11/14 at 5:10pm revealed:</p> <ul style="list-style-type: none"> - She feels much better. - It is easier for her to breathe now. 	C 246		

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C 246	<p>Continued From page 6</p> <p>2.) Review of Resident # 1's FL-2 dated 1/13/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included dementia, hypertension, chronic pain, Iron deficiency anemia, and lymphatic disease - Documentaion of orders for blood pressure three times a week <p>Review of Resident # 1's blood pressure check sheets with dates beginning 7/15/14 through 12/9/14 revealed the following sampled elevated blood pressures:</p> <ul style="list-style-type: none"> - On 7/22/14 at 12:30 pm blood pressure reading was 187/66. - On 8/3/14 at 8:35 am blood pressure reading was 189/85 - On 8/3/14 at 11:55 am blood pressure reading was 186/76 - On 8/15/14 at 9:15 am blood pressure reading was 182/75 - On 8/15/14 at 9:45 am blood pressure reading was 202/80 - On 8 /21/14 at 9:15 am blood pressure reading was 193/83 - On 9/25/14 at 1:40 pm blood pressure reading was 182/78 - On 9/25/14 at 2:00 pm blood pressure reading was 178/75 - On 10/20/14 at 8:45 am blood pressure reading was 178/84 - On 10/23/14 at 8:10 pm blood pressure reading was 179/78 - On 10/28/14 at 9:40 am blood pressure reading was 187/88 - On 11/18/14 at 9:00am blood pressure reading was 195/96 - On 11/20/14 at 9:45 am blood pressure reading was 191/91 - On 11/28/14 at 4 :10 pm blood pressure reading was 189/89 	C 246		

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C 246	<p>Continued From page 7</p> <ul style="list-style-type: none"> - On 12/9/14 at 7:20 pm blood pressure reading was 186/74 <p>The facility had no physician orders for parameters for Resident #1's blood pressures.</p> <p>Interview with personal care aide on 12/11/14 at 4:30 pm revealed:</p> <ul style="list-style-type: none"> - The personal care aide is responsible for notifying the administrator and the administrator "will take it from there". - On 11/18/14, Resident # 1's blood pressure reading "scared me". - Resident #1 appeared to "look tired". - The personal care aide called the Administrator and informed her of the elevated reading. - The administrator instructed the personal care aide "to give the resident a lot of water to keep the resident flushed out". - The personal care aide retook the blood pressure and it went down. - The resident stated he felt better. <p>Interview with the Administrator on 12/11/14 at 4:15 pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 was a hospice patient and hospice staff monitored the resident blood pressure prior to 7/15/14. - The administrator is the responsible person to contact the physician regarding the resident's needs. - If the residents' blood pressure is too high or if the resident is complaining, the administrator will notify the physician, when asked "my alarm is if the blood pressure is in the 190's. - The administrator did not notify the physician of the resident elevated blood pressures because they were not above 190. - The personal care aide notified the 	C 246		

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C 246	<p>Continued From page 8</p> <p>administrator of the residents' elevated blood pressures.</p> <ul style="list-style-type: none"> - The administrator stated the resident blood pressure was always up and down. - The administrator told the personal care aide to keep the resident "flushed out" by giving the resident plenty of water. <p>Based on observations, interview and record review Resident #1 was not interviewable.</p> <hr/> <p>The facility's plan of protection dated 12/11/14 revealed:</p> <ul style="list-style-type: none"> - The Administrator will put oxygen on Resident. - The Administrator will contact the physician, to get an as needed order for oxygen. - The Administrator will make sure all Residents are safe from harm, by contacting the physician or calling 911. - The Administrator will alert the physician of what and how the Resident is doing. - The Administrator will be contacting the doctor for elevated blood pressures, refusal of medications, refusal of oxygen, etc ... <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 25, 2015.</p>	C 246		
C 254	<p>10A NCAC 13G .0903(c) Licensed Health Professional Support</p> <p>10A NCAC 13G .0903 Licensed Health Professional Support</p> <p>(c) The facility shall assure that participation by a registered nurse, occupational therapist or</p>	C 254		

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C 254	<p>Continued From page 9</p> <p>physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:</p> <ol style="list-style-type: none"> (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure an on-site evaluation and review for one of two residents (# 3) who required assistance with ambulation, and had orders for oxygen and medication by machine was done by the appropriate licensed health professional. The findings are:</p> <p>Review of the resident register for Resident #3 revealed the resident was admitted to the facility on 8/11/14.</p> <p>Review of current FL-2 for Resident # 3 dated 8/4/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included Pneumonia, Chronic Obstructive Pulmonary Disease, Dementia and Hypertension. - Documentaion of an order for 2 Liters of 	C 254		

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C 254	<p>Continued From page 10</p> <p>continuous oxygen via nasal cannula.</p> <p>Review of resident #3's record revealed documentation of a subsequent order dated 8/15/14 for Albuterol 2.%mg/3ml (0.085 %) nebulizer solution to be given every six hours as needed for short of breath or wheezing, up to four times a day.</p> <p>Observation of Resident #3 on 12/11/14 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - She was sitting on the side of her bed not wearing her oxygen. - In her room was an oxygen canister with tubing connected draped over the top of the canister. - A large oxygen concentrator with tubing connected draped over the bed, 2 portable oxygen tanks, and a nebulizer at the bedside. <p>Review of the record for Resident #3 revealed, there was no documentation the LHPS nurse had evaluated the resident or completed a quarterly review.</p> <p>Interview with Resident #3 on 12/11/14 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - She does not wear her nasal cannula for oxygen administration. - She cannot recall when the last time wore her nasal cannula. - She had been short of breath on a few occasions within the last month. - Resident did always alert staff when she was short of breath. <p>Interview with the Administrator on 12/11/14 at 4:30pm revealed:</p> <ul style="list-style-type: none"> - She is aware Resident #3 has an order for continuous administration of oxygen. 	C 254		

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C 254	<p>Continued From page 11</p> <ul style="list-style-type: none"> - She did not know oxygen administration and medication by machine and inhalation was an LHPS task. - Resident #3 does not wear her nasal cannula for oxygen administration. - She thought because the resident did not wear her nasal cannula, she did not need an LHPS evaluation or quarterly review. - The LHPS nurse had not been to the facility to complete resident evaluations and reviews since Resident #3 had been admitted to the facility. - A Home Health Nurse visited with Resident #3 two times when she was first admitted. - Resident #3 had been discharged from Home Health since she moved into the facility. - She called the LHPS nurse to inform her she had a new resident with LHPS task and she will be at the facility on Saturday to evaluate Resident #3 and complete her quarterly review. 	C 254		
C 912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care referral and follow up. The findings are:</p>	C 912		

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C 912	Continued From page 12 Based on observations, interviews and record reviews, the facility failed to assure the physician was notified of 2 of 3 sampled resident related to elevated blood pressures (#1) and refusal of continuous oxygen (#2). [Refer to tag D246, 10A NCAC 13G .0902(b) (Type B Violation)]	C 912		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure the mandatory, annual in-service training program on infection control was completed for one of one facility medication aides (Staff A). The findings are:	C 934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER TENDER TOUCH FCH	STREET ADDRESS, CITY, STATE, ZIP CODE 2005 ANN AVENUE RALEIGH, NC 27609
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 934	<p>Continued From page 13</p> <p>Review of record for Staff A revealed:</p> <ul style="list-style-type: none"> - Staff A was hired on 6/7/12 as Supervisor in Charge (SIC). - Medication testing and validations were in the record. - There was no documentation in the record for infection control training. <p>Interview with the administrator on 12/11/14 at 1:20pm revealed:</p> <ul style="list-style-type: none"> - Staff A has been administering medications at the facility since the facility opened. - Staff A transcribes the medication orders from the FL-2 to the medication administration record (MAR). - Staff A administers medication to the residents when the Administrator is not available to do so. - She does not think Staff A is an employee of the facility, since all he does is administer medications. - She was under the impression Staff A was not required to have any documentation on file because he only administers medications. <p>Interview with Staff C on 12/11/14 at 11:55 am revealed:</p> <ul style="list-style-type: none"> - She had worked at the facility for two weeks as nurse aide. - she did not administer medications at the facility. - Staff A administered medications to the residents in the mornings. <p>Interview with Staff B on 12/11/14 at 4:45pm revealed, Staff A works at the facility as live in staff on the weekends.</p> <p>Staff A was not available for interview.</p>	C 934		