FEB - 4 2015

PRINTED: 01/15/2015
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080093	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED B. 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1836 N CANNON BOULVARD, KANNAPOLIS, NC 28083

County: Rowan

(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) COMPLETION DATE
D 000	Initial Comments	D 000	Kannon Creek Assisted Living acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Kannon Creek Assisted Living's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kannon Creek Assisted Living reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
	The Adult Care Licensure Section conducted an Annual and Follow-up survey on 12/17/14 to 12/19/14, and 12/22/14.			
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure ceilings, walls, and floors were clean and in good repair in 2 residents' rooms (Room 103 and 115.) The findings are: A. Observation of the facility during tour on 12/17/14 at 10:20 am and on 12/22/14 at 10:20 am revealed: - Three residents resided in Room 103. - The wall on the west side of the room had 62 spots repaired with spackling compound. - The wall on the east side of the room had 23 pots repaired with spackling compound. - The ceiling on the side of room toward the window had 1 area 10 inches by 14 inches missing textured ceiling compound revealing brown sheet rock facing. - The ceiling on the side of room toward the window had another area 14 inches by 18 inches missing textured ceiling compound revealing brown sheet rock facing. - The ceiling in the middle of the room had a	D 074	D 074 Housekeeping and Furnishings The facility will ensure walls, ceilings, and floors or floor coverings are kept clean and in good repair. The Director of Hillco Support Services completed an inspection of Room 103	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol W Robert — TITLE: Administrator — DATE: 2-3-15

STATE FORM — 03CX11 — If continuation sheet 1 of 1

POC approved 2/6/15 per Carolyn Harmon & also by phone 2/9/15 @ 8:30 AM

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	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1808 N CANNON BOULVARD, KANNAPOLIS, NC 28083

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D 074	Continued From page 1 crack in the textured ceiling running from the end of the light fixture to the east wall (about 4 feet). Based on observation, and attempted interview on 12/17/14, the residents of Room 103 were unable to provide reliable information. Interview on 12/22/14 at 11:22 am with the Maintenance Director revealed: - He had been working at the facility for about 2 months. - He did not have an assistant to help with maintenance. - He was aware some residents' rooms were in need of painting. - He had not done the repairs to the walls in Room 103, therefore the walls must have been patched and unpainted for at least 2 months. - He was not aware Room 103 had 2 large exposed areas and a crack in the ceiling. - He had been doing painting in the facility but his painting had been focused primarily on the hallways and commons areas. - He had a long list of items that needed prompt attention and he would add Room 103 painting to the list. Interview on 12/22/14 at 11:40 am with the Administrator revealed: -The facility was in the process of "fixing things" such as replacing and repairing furniture. -She was working with the Maintenance Director to try to get things done, but it "takes time". Refer to review of the local environmental health report dated 12/02/14. B. Observation on 12/17/14 during the initial tour of the facility at 10:00 am of resident room #115 revealed:	D 074	for needed repairs of the walls, ceilings, and brown sheet rock facing on 1/23/15. The Director of Hillco Support Services also completed an inspection of Room 115 for needed repairs of the paint on the wall and the missing baseboard. The maintenance supervisor completed all needed repairs to Room 103 and Room 115. A Resident Environment Audit Sheet tool was initiated by the facility. The assistant resident care coordinator, activities' director, business office manager, transporter and dietary manager completed a 100% audit of all resident rooms for walls, ceilings, and floors was completed for good repair on 12/30/15. The assistant resident care coordinator, activities' director, business office manager, transporter, and dietary manager will complete a Resident Environment Audit Sheet tool five times weekly x 3 weeks, then weekly times four weeks, and monthly x 3 months. The findings will be addressed at the monthly QI meetings for any further recommendations.	3-15-15

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	HAL060003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1209 N CANNON BOULVARD, KANNAPOLIS, NC 28083

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D 074	Continued From page 2 -The paint was missing from an area near the door, approximately 2.5 foot by 2 foot from the bottom of the wall up toward the middle of wall. -The baseboard was missing from the bottom of the wall approximately 2.5 foot under where the paint was missing from the wall. Interview on 12/17/14 at 9:50 am with a resident revealed: -He had lived in the facility for 15 months. -He said the paint and the baseboard had been missing from the wall in his room the entire time he had lived at the facility. Interview on 12/19/14 at 2:45 pm with the Maintenance Director revealed: -He had been employed at the facility for a few months. -He was aware the wall was not painted and the baseboard was missing in room #115. -He said the residents run the wheelchairs into the wall which knocked the paint and the baseboard off. -He said he was planning to repair the wall and the baseboard as soon as possible. Refer to review of the local environmental health report dated 12/02/14. Review of the local environmental health report dated 12/02/14 revealed: -A facility sanitation grade of 95.5 -One demerit was deducted under Floors, Walls and Ceilings. -Under additional comments included documentation to paint walls that have been repaired so the wall was smooth easily cleanable and nonabsorbent.	D 074	Addendum: Per tele phone conversation with April Roberts on 2/6/15 @ 4:10 pm The date of correction for the facility to be in compliance will be 3/15/15, with the exception of House keeping & Furnishings Citations which will be in the process of being Completed and corrected with a Date of Correction of 4/1/15. (James Krovre discussed an extension of Date of Correction with Western Regional Branch Manager on 1/28/15) Carolyn Harrison	

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D 076	Continued From page 3	D 076		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on interview and observation the facility failed to assure tje chair for a resident in room #112 was in good repair. The findings are: Observation on 12/17/14 at 1:30 pm of room #112 revealed: -Three residents lived in the room. -One of the residents was not interviewable because he was unable to verbally respond. -There was only one chair in the room. -The chair was a tan leather wide high back. -Various areas throughout the chair were cracked, torn and ripped. -The white lining was visible through the cracks, torn and ripped areas. Interview on 12/17/14 at 1:35 pm with a resident revealed: -The chair had been in that condition for a "long-time." -The chair was mainly used by the resident who could not talk. -He and the other resident sat on their bed. Interview on 12/22/14 at 11:40 am with the Administrator revealed: -The facility was in the process of "fixing things"	D 076	D 076 Housekeeping and Furnishings The facility will ensure furniture is clean and in good repair. The facility housekeeping staff cleaned the resident's personal tan leather wide high back chair. The administrator will speak with the resident and his responsible party about his personal chair. The administrator spoke with the resident's sister regarding the personal tan leather wide high back chair in Room 112 on 1/23/15. Resident's sister told the administrator she feels it would upset resident if we took the personal chair and replaced it. Resident sits in chair during the day and night. The housekeeping manager cleaned the tan leather wide high back chair on 1/23/15. The Director of Hillco Support Services completed an inspection of Room 112 for furniture in need of repair on 1/23/15. The Director of Hillco Support Services also completed an inspection of other furniture in need of repair on 1/23/15.	

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D 076	Continued From page 4 such as replacing and repairing furniture. -She was working with the Maintenance Director to try to get things done, but it "takes time".	D 076	A Resident Environment Audit Sheet tool was initiated by the facility. The assistant resident care coordinator, activities' director, business office manager, transporter and dietary manager completed a 100% audit of all resident rooms for furniture in good repair on 12/30/15. The assistant resident care coordinator, activities director, business office manager, transporter, and dietary manager will complete a Resident Environment Audit Sheet tool five times weekly x 3 weeks, weekly x 4 weeks, and then monthly x 3 months. The findings will be addressed at the monthly QI meetings for any further recommendations.	3-15-15 AWR
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the 300 hallway was maintained in an uncluttered manner free of hazards and obstructions. The findings are: Observation during tour of the facility on 12/17/14 from 8:40 am to 9:50 am revealed: -The 300 hallway had access to the kitchen, Food Service Manager's (FSM) office, Activity person office, maintenance office and 9 resident rooms. -2 rooms were occupied by residents. -The following items were observed in the hallway along both sides of the 300 hallway: -9 boxes 2 feet x 3.5 feet stacked on top of each other. -5.5 feet long dresser -10 feet x 4.5 feet Wardrobe closet -2 night stands	D 079	D 079 Housekeeping and Furnishings The facility shall ensure the 300 hallway is maintained in an uncluttered manner free of hazards and obstructions. The maintenance director and dietary manager immediately roomed the boxes, dresser, wardrobe closet, 2 night stands, 2 utility carts, one cart with an	

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D 079	Continued From page 5 -2 utility carts; one cart had an industrial size air blower, and many other items. -Sitting on the floor was another industrial size air blower; 2 motorized wheelchair; hoyer lift; and a cart with three shelves. -A 6.5 feet cart with soiled linen and towels. -The same cart had clean linen, towels and wipes. Based on record review, observation and attempted on 12/17/14 with the resident residing in room 301, it was determined the resident was not interviewable. Interview on 12/17/14 at 9:50 am with a resident in room 302 revealed: -Things were always stored in the hallway. -The items did not bother her or hinder walking through the hallway. Interview on 12/22/14 at 9:30 am with a second resident in room 302 revealed: -The items in the hallway were not her fault. -Staff put them there. -They did not bother her, she walked through hallway without bumping into the items. Interview on 12/17/14 at 9:26 am with the FSM revealed: -The hallway was used for storage and some of the items were waiting to be moved into residents rooms (not the residents who resided on the hallway). -Two more residents resided on the hallway, but they were out of the facility. Interview on 12/17/14 at 9:05 am with a personal care aide (PCA) revealed: -Only three residents resided on the 300 hall. -The furniture in the hallway was to be moved into	D 079	industrial size air blower and many other items, industrial size air blower, 2 motorized wheelchairs, hoyer lift, and a cart with three shelves from the 300 hallway. An inservice was given to staff on "Safety of Hallway" on 12/17/14 by the administrator. A Resident Environment Audit Sheet was initiated by the facility. The assistant resident care coordinator, activities' director, business office manager, transporter and dietary manager completed a 100% audit of the facility for clutter on 12/30/15. Any clutter was removed immediately. The assistant resident care coordinator, activities' director, business office manager, transporter and dietary manager will complete a Resident Environment Audit Sheet tool five times weekly x 3 weeks, then weekly x 4 weeks, and monthly x 3 months. Any clutter will be removed immediately. The findings will be addressed at the monthly QI meetings for any further recommendations.	2-3-15 AWR

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D 079	Continued From page 6 empty rooms. -Some staff, mainly the maintenance person used the hallway for storage because few residents lived on the hallway. -The items in the hallway did not appear to hinder the three residents' movement that lived on the hallway. -The two residents in room 301 were ambulatory and able to go throughout the facility without staff assistance. -The resident in room 301 was hard of hearing, he was sometimes confused and some days required staff assistance to ambulate and get dressed. -There were some days the resident did not need staff help and was able to ambulate and wheel himself around the facility. Interview on 12/17/14 at 11:50 am with the Administrator revealed: -She was unaware of the items being stored on the 300 hallway. -She had talked with staff previously regarding storing items in the hallway and hinder the walking spaces of the residents living on the hallway. -She made sure the items were moved today and will check weekly to ensure no items were stored on the hallway. Interview on 12/22/14 at 8:40 am with the Maintenance Director revealed: -He stored the utility carts, wardrobe closet, night stands and fans on the 300 hallway because there were less residents living on that hallway.	D 079		
D 089	10A NCAC 13F .0306(b)(3) Housekeeping And Furnishings	D 089		

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D 089	Continued From page 7 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to assure chest of drawers were clean and in good repair for 4 of 4 residents' rooms (#103, #202, #208, and # 211). The findings are: A. Observation during the initial tour on 12/17/14 between 8:50 am to 9:35 am revealed: -Room #208, three resident resided in the room. -There were two chest of drawers on the west side of the room. -One chest of drawers was missing the handles on the top drawer. -There was an exposed 3 inch long screw to the left of the drawer where a handle was supposed to be. -One resident in the room was observed having difficulty trying to pull open the drawer with his fingers. -When the drawer was pulled out, the drawer fell forward at a slant almost falling out of the chest of drawers. Interview on 12/17/14 at 9:20 am with a resident revealed: -The chest of drawers had been like it was today since he moved in to the room (a few weeks	D 089	D 089 Housekeeping and Furnishings The facility will ensure: (a) Each bedroom shall have the following furnishings in good repair and clean for each resident: (3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents: The facility will ensure chest of drawers are clean and in good repair for 4 of 4 residents' rooms (#103, #202, #208, and #211). The maintenance director replaced the knobs of the two chest of drawers in Room 208. The Director of Hillco Support Services completed an inspection of Rooms # 103, #202, #208, #211 for furniture in need of repair on 1/23/15. The Director of HIllco Support Services also completed an inspection of other furniture in need of repair on 1/23/15. A Resident Environment Audit Sheet tool was initiated by the facility. The assistant resident care coordinator, activities director, business office manager, transporter and dietary manager completed a 100% audit of all resident rooms for furniture in good repair on 12/30/15.	

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D 089	Continued From page 8 ago). -The chest of drawers had never had any handles on it. -It would make it easier to open if the top drawer had handles on it because he stored his clothes in that drawer. -He used the top 2 drawers and his roommate used the bottom 2 drawers. Interview on 12/17/14 at 9:25 am with the Maintenance Director revealed: -The chest of drawers did have handles on it yesterday (12/16/14). -He had to replace the handles "all the time". -Residents were constantly pulling the handles off. Refer to the local environmental health inspection report dated 12/02/14. Refer to interview on 12/19/14 at 4:10 pm with a medication aide. Refer to interview on 12/22/14 at 11:22 am with the Maintenance Director. Refer to interview on 12/22/14 at 11:40 am with the Administrator. B. Observation on 12/19/14 at 3:00 pm of room #202 revealed: -Three residents resided in the room. -There were three chest of drawers in the room. -One chest of drawers was missing 2 drawers. -One chest of drawers was missing 1 drawer. -The remaining drawers of the chest of drawers were broken and positioned at an angle. Interview on 12/19/14 at 3:05 pm with a resident revealed:	D 089	The assistant resident care coordinator, activities director, business office manager, transporter, and dietary manager will complete a Resident Environment Audit Sheet tool five times weekly x 3 weeks, weekly x 4 weeks, and then monthly x 3 months. The findings will be addressed at the monthly QI meetings for any further recommendations.	3-15-15 AW

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D 089	Continued From page 9 -The drawers had always been this way as they appeared today (12/19/14). -She had to share a chest of drawers with one of the roommates because of the missing drawers. -It would be great to have her own chest of drawers so she would not have to share and would have more room to store her clothing. -She had asked the previous Maintenance Director 6 months ago to fix the chest of drawers and he told her he would add it to his list, but he never fixed it. Refer to the local environmental health inspection report dated 12/02/14. Refer to interview on 12/19/14 at 4:10 pm with a medication aide. Refer to interview on 12/22/14 at 11:22 am with the Maintenance Director. Refer to interview on 12/22/14 at 11:40 am with the Administrator. C. Observation on 12/19/14 at 3:10 pm of room #211 revealed: -There were three chest of drawers in the room. -Three residents resided in the room. -The top drawer of one chest of drawers was broken and positioned in the chest of drawers at an angle.	D 089		
	Interview on 12/19/14 at 3:15 pm with a resident revealed: -The chest of drawers had "always been like that". -He had asked the current Maintenance Director to fix it, but "he had not gotten to it yet". -He" just learned to deal with it".			

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D 089	Continued From page 10 Refer to the local environmental health inspection report dated 12/02/14. Refer to interview on 12/19/14 at 4:10 pm with a medication aide. Refer to interview on 12/22/14 at 11:22 am with the Maintenance Director. Refer to interview on 12/22/14 at 11:40 am with the Administrator. D. Observation on 12/22/14 at 10:30 am of Room #103 revealed the following: - Three residents resided in Room #103. - Three chest of drawers with 4 drawers located on the east wall of the room. - One chest of drawers had the part of the top of the chest missing or peeling veneer which exposed rough and unfinished pressed wood; and 2 drawers that did not properly slide out. - One chest of drawers had the part of the top of the chest missing or peeling veneer which exposed rough and unfinished pressed wood; 1 drawer missing a pull knob; and 2 drawers that did not properly slide out. - One chest of drawers had the part of the top of the chest missing or peeling veneer which exposed rough and unfinished pressed wood; 1 drawer missing a pull knob; and 2 drawers that did not properly slide out. - The bedside table for the resident closest to the entrance door was missing the drawer front for the top drawer. Refer to review of the local environmental health inspection report dated 12/02/14. Refer to interview on 12/19/14 at 4:10 pm with a medication aide.	D 089		

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D 089	Continued From page 11 Refer to interview on 12/22/14 at 11:22 am with the Maintenance Director. Refer to interview on 12/22/14 at 11:40 am with the Administrator. Review of the local environmental health inspection report dated 12/02/14 revealed: -A facility sanitation grade of 95.5. -Two demerits deducted under Furnishings and Patient Contact Items. -Under additional comments included documentation drawers were missing from facility issued dressers. -Tops of chest of drawers and night stands were in bad repair. -The finish (on chest of drawers) had been damaged leaving a surface not easily cleanable and absorbent. Interview on 12/19/14 at 4:10 pm with a medication aide (MA) revealed: -She had not noticed the rooms needing repair like missing drawer faces. -Unless a resident complained, she would not know anything about any of the residents' rooms or if there were needed repairs. -There had been no resident complaints about any concerns or issues with their rooms. Interview on 12/22/14 at 11:22 am with the Maintenance Director revealed: - He had been working at the facility for about 2 months. - He did not have an assistant to help with maintenance. - He was aware some residents had furniture which needed replacing. - He thought the tops of the chest of drawers	D 089		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1808 N CANNON BOULVARD, KANNAPOLIS, NC 28083

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D 089	Continued From page 12 were damaged from residents placing wet items (like beverage cups) on the top of the chest resulting in water damage to the tops. - The facility had been replacing residents' furniture as the budget allowed. Interview on 12/22/14 at 11:40 am with the Administrator revealed: -The facility was in the process of "fixing things" such as replacing and repairing furniture. -She was working with the Maintenance Director to try to get things done, but it "takes time".	D 089		
D 091	10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to furnish one comfortable chair for each resident in 10 of 19 men's rooms (rooms # 102, #107, #112, #120, #204, #205, #208, #209, #210, #211, and #212) and 8 of 16 women's rooms (rooms #103, #104, #116, #119, #201, #202, #206, #207, #302). The findings are:	D 091	D 091 Housekeeping and Furnishings The facility will ensure that: (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from the floor for easy rising; (6) additional chairs available as needed, for use by visitors. The facility initiated a plan to furnish one comfortable chair for each resident in 10 of 19 men's rooms (rooms #102, #107, #112, #120, #204, #205, #208, #209, #210, #211, and #212) and 8 of 16 women's rooms (rooms #103, #104, #116, #119, #201, #202, #206, #207, #302).	

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NAME OF PROVIDER OR SUPPLIER
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D 091	Continued From page 13 A. Observations on 12/19/14 between 3:00 pm to 3:30 pm on the 200 Hallway of the facility (rooms 201 to 302) revealed: -Room #201 had no chairs and three residents. -Room #202 had no chairs and three residents. -Room #204 had no chairs and three residents. -Room #205 had no chairs and three residents. -Room #206 had one folding chair and two residents. -Room #207 had no chairs and three residents. -Room #208 had no chairs and three residents. -Room #209 had no chairs and three residents. -Room #210 had no chairs and three residents. -Room #211 had no chairs and three residents. -Room #212 had no chairs and two residents. -Room #302 had no chairs and two residents. Observations on 12/19/14 between 3:30 pm to 4:15 pm on the 100 Hallway of the facility (rooms 101 to 122) revealed: -Room #102 had no chairs and two residents. -Room #103 had no chairs and three residents. -Room #104 had no chairs and two residents. -Room #107 had no chairs and two residents. -Room #112 had 1 chair and three residents. -Room #116 had no chairs and two residents. -Room #119 had no chairs and two residents. -Room #120 had no chairs and two residents. Interview on 12/19/14 at 3:30 pm with a personal care aide (PCA) revealed: -She worked at the facility for a few months. -The rooms appeared as they were today (12/19/14), and did not notice if there were chairs in the residents' rooms or not. -She rarely went into the residents' rooms, because most of the residents were "pretty" independent. -As far as she knew, residents had not complained about not having chairs in their	D 091	The Director of Hillco Support Services completed an inspection of the above rooms as well as other rooms for furnishings in need of repair on 1/23/15. A Resident Environment Audit Sheet tool was initiated by the facility. The assistant resident care coordinator, activities director, business office manager, transporter and dietary manager completed a 100% audit of all resident rooms for furniture in good repair on 12/30/15. The assistant resident care coordinator, activities director, business office manager, transporter, and dietary manager will complete a Resident Environment Audit Sheet tool five times weekly x 3 weeks, weekly x 4 weeks, and then monthly x 3 months. The findings will be addressed at the monthly QI meetings for any further recommendations.	3-15-15 Am

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D 091	Continued From page 14 rooms. Interview on 12/19/14 at 3:40 pm with a resident revealed: -It would be nice to have a chair to sit in while in the room. -The resident was not aware a chair in the room could be requested. -The room had been "like this" since moving into the room about 2 weeks ago. Interview on 12/19/14 at 4:10 pm with a medication aide (MA) revealed: -She had not noticed anything about chairs or no chairs the residents' rooms. -Unless a resident complained, she would not know anything about any of the residents ' rooms. -There had been no resident complaints about any concerns or issues with their rooms. Interview on 12/22/14 at 11:20 am with Maintenance Director revealed: -He had been working at the facility for a couple of months. -He had been given a long list of things that needed to be repaired and/or replaced. -He had been "doing what he could do" to replace and repair furniture including chairs, but it took time to get things done. Interview on 12/22/14 at 11:40 am with the Administrator revealed: -The facility was in the process of "fixing things" such as replacing and repairing furniture. -She was working with the Maintenance Director to try to get things done, but it "takes time". B. Interview on 12/19/2014 at 3:35 pm with a resident revealed:	D 091		

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D 091	Continued From page 15 -He had never noticed if they had or did not have chairs in their room. -He did not care if there were no chairs in his room because he always went to the activity room if he had visitors. Interview on 12/19/2014 at 3:45 pm with a resident revealed: -She had never had a chair in her room -She had not told the staff because she could ask for a chair. Interview on 12/19/2014 at 3:50 pm with a resident revealed: -The fold up chair in her room was bought by the resident at a local garage sale. -She would really like to have a comfortable chair for visitors and for herself. Interview on 12/19/2014 at 4:00 pm with a Personal Care Aide (PCA) revealed: -She had never noticed chairs in the rooms since she began employment in April 2014. -She heard no complaints from the residents regarding no chairs in the residents' rooms.	D 091		
D 093	10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading. This Rule shall apply to new and existing	D 093	D 093 Housekeeping and Furnishings The facility will ensure: (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading.	

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D 093	Continued From page 16 facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure there was a light overhead of the bed with a switch within reach of residents lying in bed or a bedside lamp for 7 of 19 men's rooms (rooms #102, #107, #205, #208, # 210, #211, and #212) and 7 of 16 women's rooms (Rooms #103, #104, #116, #119, #202, #206, and #207). The findings are: Observations on 12/19/14 between 3:00 pm to 3:30 pm on the 200 Hallway of the facility (rooms 201 to 212) revealed: -An overhead ceiling light with the on/off switch was located next to the entrance door of each room. -The on/off switch could not be accessed by the residents while lying in bed. -Room #202 had no bedside lamps and three residents. -Room #205 had no bedside lamps and three residents. -Room #206 had one bedside lamp (accessible to one resident) and two residents. -Room #207 had no bedside lamps and three residents. -Room #208 had no bedside lamps and three residents. -Room #210 had no bedside lamps and three residents. -Room #211 had no bedside lamps and three residents. -Room #212 had one bedside lamp (accessible to one resident) and two residents. Observations on 12/19/14 between 3:30 pm to 4:15 pm on the 100 Hallway of the facility (rooms	D 093	The facility initiated a plan to ensure there is a light overhead of the bed with a switch within reach of residents lying in a bed or a bedside lamp for 7 of 19 men's rooms (rooms #102, #107, #205, #208, #210, #211, and #212) and 7 of 16 women's rooms (Rooms # 103, #104, #116, #119, #202, #206, and #207) The Director of Hillco Support Services completed an inspection of the above rooms as well as other rooms for lamps on 1/23/15. Battery powered lamps will be provided upon request until construction approves completed work. A Resident Environment Audit Sheet tool was initiated by the facility. The assistant resident care coordinator, activities, director, business office manager, transporter and dietary manager completed a 100% audit of all resident rooms for lamp for each resident on 12/30/15. The assistant resident care coordinator, activities director, business office manager, transporter, and dietary manager will complete a Resident Environment Audit Sheet tool five times weekly x 3 weeks, weekly x 4 weeks, and then monthly x 3 months. The	

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D 093	Continued From page 17 101 to 122) revealed: -An overhead ceiling light with the on/off switch was located next to the entrance door of each room. -The on/off switch could not be accessed by the residents while lying in bed. -Room #102 had no bedside lamps and two residents. -Room #103 had no bedside lamps and three residents. -Room #104 had no bedside lamps and two residents. -Room #116 had no bedside lamps and two residents. -Room #119 had no bedside lamps and two residents. Interview on 12/19/14 at 3:30 pm with a personal care aide (PCA) revealed: -The rooms appeared as they were today (12/19/14), and noticed the residents did have to get out of bed to turn the overhead light on and off. -As far as she knew, residents had not complained about not having bedside lamps in their rooms. Interview on 12/19/14 at 3:40 pm with a resident revealed: -The room appeared today as it did when the resident moved in a few weeks ago. -He had not asked staff for a bedside lamp. -He did not know he could request a bedside lamp. -It would be nice to have a bedside lamp so the resident would not have to get out of bed to turn the ceiling light on and off. Interview on 12/19/14 at 4:10 pm with a medication aide (MA) revealed:	D 093	findings will be addressed at the monthly QI meetings for any further recommendations.	4-1-15 AW

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D 093	Continued From page 18 -She had not noticed anything about the lights or lamps the residents' rooms. -Unless a resident complained, she would not know anything about any of the residents ' rooms. -There had been no resident complaints about any concerns or issues with their rooms. Interview on 12/22/14 at 11:20 am with Maintenance Director revealed: -He had been working at the facility for a couple of months. -He had been given a long list of things that needed to be repaired and/or replaced. -He had been "doing what he could do" to replace and repair furniture including bedside lamps, but it took time to get things done. Interview on 12/22/14 at 11:40 am with the Administrator revealed: -The facility was in the process of "fixing things" such as replacing and repairing furniture. -She was working with the Maintenance Director to try to get things done, but it "takes time". Interview on 12/19/2014 at 3:35pm with a resident revealed: -He had never noticed they had no lamps in their room. -He did not care if there were no lamps in his room. Interview on 12/19/2014 at 3:45pm with a resident revealed: -Admitted she had never had a lamp in her room. -Had not told the staff because she was unaware that she could ask for a bedside lamp. -Stated she would really like to have a bedside lamp in her room and it would help when she was	D 093		

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D 093	Continued From page 19 reading her books. Interview on 12/19/2014 at 3:50pm with a resident revealed: -Stated she would really like to have a lamp in her room. -Had not told the staff because she was unaware she could ask for a bedside lamp.	D 093		
D 107	10A NCAC 13F .0311(b)(1) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (1) Built-in electric heaters, if used, shall be installed or protected so as to avoid burn hazards to residents and room furnishings. This rule apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure built-in electric heating/air conditioning units in residents' rooms were installed or protected so as to avoid hazards to residents for 3 resident's rooms (rooms #116, #121, and #212). The findings are: Observations on 12/19/14 between 3:30 pm to 4:15 pm on the 100 Hallway of the facility (rooms 101 to 122) revealed: A. In room #116, the built-in heating/air conditioning unit was located under the window	D 107	D 107 Other Requirements The facility will ensure other requirements: (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (1) Built-in electric heaters, if used, shall be installed or protected so as to avoid burn hazards to residents and room furnishings. The facility initiated a plan to ensure built-in electric heating/air conditioning units in residents rooms were installed or protected so as to avoid hazards to residents for 3 resident's rooms (rooms #116, #121, and #212). Units were repaired for Rooms #116, #121, and #212. A Resident Environment Audit Sheet tool was initiated by the facility. The	

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D 107	Continued From page 20 on the west side of the room and was missing a front cover. -The built-in heating/air conditioning unit had a slanted top cover with digital controls. -The temperature was set on 70 degrees. -There were exposed copper coils on the left and right side of the built-in heating/air conditioning unit. -There were exposed electrical wiring on the right side of the unit just below the exposed copper coils. Interview on 12/19/14 at 3:48 pm with a resident revealed: -The heating/air conditioning unit "had always looked like that" since she moved into the room several months ago. -The unit "worked fine" and she had not said anything to staff about the unit missing the front cover. Refer to interview on 12/18/14 at 9:15 am with the Maintenance Director. Refer to review of an e-mail correspondence from the Administrator on 12/18/14 at 9:33 am to the corporate office. Refer to interview on 12/19/14 at 4:10 pm with a medication aide. Refer to interview on 12/22/14 at 11:40 am with the Adminsitrator. B. In room #121, the built-in heating/air conditioning unit was located under the window on the south side of the room and was held in place on the wall by gray duct tape. -There was visible gray duct tape on all four sides of the built-in heating/air conditioning unit which	D 107	assistant resident care coordinator, activities director, business office manager, transporter and dietary manager completed a 100% audit of all resident rooms for built-in electric heaters in good repair on 12/30/15. The Director of Hillco Support Services completed an inspection of other electric heating/air conditioning units in resident's rooms on 1/23/15. The assistant resident care coordinator, activities director, business office manager, transporter, and dietary manager will complete a Resident Environment Audit Sheet tool five times weekly x 3 weeks, weekly x 4 weeks, and then monthly x 3 months. The findings will be addressed at the monthly QI meetings for any further recommendations.	2.5.15 AUR

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D 107	Continued From page 21 was 8 inches wide. -The gray duct tape appeared to attach the wall unit to the framework built into the wall to hold the heating/air conditioning unit. -On the bottom of the unit, there was a 1 inch opening covered over by gray duct tape and the outside of the building sunlight was observed coming through the 1 inch opening. Interview on 12/19/14 at 11:40 am with a resident revealed: -The heating/air conditioning unit had been duct taped the way it was today for about 4 years. -The heating/air conditioning unit was too small for the wall frameworks, so the previous maintenance director had duct taped the unit into the frameworks to "make it fit". -The unit worked fine and the resident had no problem with the way it appeared, "as long as it works good". -Sometimes bugs would come in around the unit in the summertime, but the exterminator would come and "spray" every month to keep "down the bugs". -The resident had not told the staff about the heating/air conditioning unit because the unit worked fine just the way it was. Refer to interview on 12/18/14 at 9:15 am with the Maintenance Director. Refer to review of an e-mail correspondence from the Administrator on 12/18/14 at 9:33 am to the corporate office. Refer to interview on 12/19/14 at 4:10 pm with a medication aide. Refer to interview on 12/22/14 at 11:40 am with the Adminsitrator.	D 107		

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D 107	Continued From page 22 C. Observation on 12/17/2014 at 8:45 am in room #212 revealed: -Heating wall unit had duct tape wrapped around the entire edges of the unit securing the front piece. -The control part of the unit is was located under a secured slanted cover. Interview on 12/17/2014 at 8:46 am with a resident revealed: -Heating wall unit had been in this condition since "the state came in the last time, which was over a year ago." -He had to use a pencil in order to reach and set the controls to adjust the temperature because the controls are covered by a grill. -He has to open the window sometimes because it got too warm inside his room. -The previous Maintenance Director "rigged it this way just to get by". -He has informed the current Maintenance Director about the condition of the heater/air conditioner unit. -Has told the Administrator about the unit's condition and she had observed it in his room. Interview on 12/18/2014 at 9:10 am with the Maintenance Director revealed the resident in room #206 complained to him during the week of 12/08/2014 about his heating wall unit's current condition. Interview on 12/18/2014 at 9:20 am with the Administrator revealed: -She thought the unit in room #206 had already been replaced greater than 6 months ago with the last Maintenance Director. -When asked if she ordered the parts on	D 107		

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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
D 107	Continued From page 23 12/17/2014, she stated "Oh, I did order some yesterday" (12/17/14). -The Resident in room #206 never made her aware of the unit condition or complained to her about it. Interview on 12/19/2014 at 4:00 pm with a Personal Care Aide (PCA) concerning room #206 revealed: -She had reported the condition of the wall unit to the previous Maintenance Director within the last 6 months but did not follow up on it. -Was unsure if the current Maintenance Director was aware. Refer to interview on 12/18/14 at 9:15 am with the Maintenance Director. Refer to review of an e-mail correspondence from the Administrator on 12/18/14 at 9:33 am to the corporate office. Refer to interview on 12/19/14 at 4:10 pm with a Medication Aide. Refer to interview on 12/22/14 at 11:40 am with the Adminsitrator. Interview on 12/18/14 at 9:15 am with the Maintenance Director revealed: -He was aware that several heater/air conditioner units in the building needed repair. -He had been working with the corporate office to get several replaced throughout the building. -He had gotten whatever he could get in order to "quick fix" them until the parts arrived. -The parts were ordered by the Administrator on 12/17/2014 and should be arriving next week. Review of an e-mail correspondence from the	D 107		

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	HAL080003		R 12/22/2014

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D 107	Continued From page 24 Administrator on 12/18/14 at 9:33 am to the corporate office revealed: -Need 4 retro (model number for heater/air conditioner units) with cover, left hand plug and controls. -"This is the model that fits correctly for the existing wall sleeve". Interview on 12/19/14 at 4:10 pm with a Medication Aide (MA) revealed: -She had not noticed anything about any of the residents' rooms. -Unless a resident complained, she would not know anything about any of the residents ' rooms. -There had been no resident complaints about any concerns or issues with their rooms. Interview on 12/22/14 at 11:40 am with the Administrator revealed: -The facility was in the process of "fixing things" such as replacing and repairing furniture. -She was working with the Maintenance Director to try to get things done, but it "takes time".	D 107		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the	D 150	D 150 Personal Care Training and Competency Staff B was identified as not successfully completing an 80hr Personal Care Training and Competency Evaluation Program within six months of hire. Staff B's last day of employment was December 24, 2014. Please see Kannon Creek Assisted Living Payroll Termination form.	

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D 150	Continued From page 25 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 7 sampled staff (Staff B) successfully completed an 80-hour Personal Care Training and Competency Evaluation program within six months of hire. The findings are: Review of Staff B's personnel file revealed: -Staff B was hired on 2/14/11. -Staff B was hired as a medication aide/supervisor. -Documentation of medication aide verification dated 6/24/10. -Documentation Staff B completed the Medication aide Clinical Skills Competency validation on 3/01/11. -No documentation Staff B had completed Personal Care Training -Documentation dated 9/20/11 of a Nurse Aide (NA) Registry verification from another state documented Staff B was not listed on the CNA Registry. Interview on 12/22/14 at 9:00 am with Staff B revealed:	D 150	The payroll/bookkeeper will complete a 100% audit of staff files to ensure successful completion of an 80 hour Personal Care Training and Competency Evaluation program (PCT) within six months of hire using a QI tool titled, "Employee File Audit". Any staff identified as not having successfully completed the (PCT) will immediately be scheduled for the (PCT) as appropriate. An inservice will be given on using the "Employee File Audit" tool on 1/20/15 by the administrator. The facility has implemented a system to ensure that staff who provide or directly supervise staff who provide care to residents successfully complete an 80 hour Personal Care Training and Competency Evaluation program within six months of hire. A QI tool will be used "Employee File Audit" to be completed weekly x 3 weeks and monthly x 3 months. The administrator will submit findings to the QI committee on a monthly basis for further recommendations.	2-5-15

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D 150	Continued From page 26 -She had been employed at the facility for 3 years. -She had not completed Personal Care Training. -She had attended "Certified Nurse Aide" school 20 years ago. -She could not produce a certificate to show she had completed "CNA school" because it had "burned up" in a house fire. -She could not contact the "CNA school" she attended to request proof of completion of the "CNA" course because the school had also burned down. -Her work duties included administering medications, and on occasion she did assist residents with bathing, grooming and dressing. Interview on 12/22/14 at 9:15 am with the Administrator revealed: -She had "ran" a verification from the state Staff B had moved from and thought she was listed on the NA Registry in that state. -She did not know Staff B was not listed on the NA Registry for another state. -She was unable to verify Staff B had completed NA training. -Staff B would not be able to perform the duties as a supervisor or PCA duties until Staff B completed Personal Care Training. -She had scheduled Staff B to begin Personnel Care Training next week.	D 150	Management-Type B Violation	
D 183	10A NCAC 13F .0603(a) Management of Facilities with a Capacity or C 10A NCAC 13F .0603 Management of Facilities with a Capacity or Census of 81 or More Residents (a) An adult care home with a capacity or census of 81 or more residents shall be under the direct	D 183	1/13/15 Management has ensured that new locked drawers have been added to each medication cart to allow for sufficient storage space for all of the	

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D 183	Continued From page 27 control of an administrator, who shall be responsible for the operation, administration, management and supervision of the facility on a full-time basis to assure that all care and services to residents are provided in accordance with all applicable local, state and federal regulations and codes. The administrator shall be on duty in the facility at least eight hours per day, five days per week and shall not serve simultaneously as a personal care aide supervisor or other staff to meet staffing requirements while on duty as an administrator or be an administrator for another adult care home except as follows. If there is more than one facility on a contiguous parcel of land or campus setting, and the combined licensed capacity of the facilities is 200 beds or less, there may be one administrator on duty for all the facilities on the campus. The administrator shall not serve simultaneously as a personal care aide supervisor in this campus setting. For staffing chart, see Rule .0606 of this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure all care and services were provided by management to residents in accordance with all applicable local, state, and federal regulations and codes. The findings are: 1. Based on observations and interviews, the facility failed to assure ceilings, walls, and floors were clean and in good repair in 2 residents' rooms (Room 103 and 115.) (Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping & Furnishings) 2. Based on interview and observation the facility failed to assure chair in the residents room was in good repair. (Refer to Tag 076 10A NCAC 13F	D 183	facility's narcotics to be placed in the appropriate medication cart. Narcotics will no longer be placed in the brown box in the medication room or in the black filing cabinets in the RCC (Resident Care Coordinator) office. Management has ensured the new process is as follows: Management is having morning and afternoon administrative meetings to review and discuss the new process and audit tool findings. Any necessary corrections are addressed immediately. When narcotics are delivered to the facility, a medication technician compares the delivery sheet to the medications that are delivered. The narcotic counts are verified with two signatures and then are placed in the appropriate medication carts in the locked narcotic drawers. The declining inventory sheets are completely filled out with the correct identifiers and placed in the narcotic count notebook. The number of narcotic sheets count will be changed during the next shift count to reflect the delivery of new narcotics.	

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D 183	Continued From page 28 .0306(a)(3) Housekeeping & Furnishings) 3. Based on observations, and interviews, the facility failed to assure chest of drawers were clean and in good repair for 4 of 4 residents' rooms (#103, #202, #208, and # 211). (Refer to Tag 089 10A NCAC 13F .0306(b)(3) Housekeeping & Furnishings) 4. Based on observation and interview, the facility failed to furnish one comfortable chair for each resident in 10 of 19 men's rooms (rooms # 102, #107, #112, #120, #204, #205, #208, #209, #210, #211, and #212) and 8 of 16 women's rooms (rooms #103, #104, #116, #119, #201, #202, #206, #207, #302). (Refer to Tag 091 10A NCAC 13F .0306(b)(5)(6)Housekeeping & Furnishings) 5. Based on observations and interviews, the facility failed to assure there was a light overhead of bed with a switch within reach of residents lying in bed or a bedside lamp for 7 of 19 men's rooms (rooms #102, #107, #205, #208, # 210, #211, and #212) and 7 of 16 women's rooms (Rooms #103, #104, #116, #119, #202, #206, and #207). (Refer to Tag 093 10A NCAC 13F .0306(b)(8) Housekeeping & Furnishings) 6. Based on observations and interviews, the facility failed to ensure built-in electric heating/air conditioning units in residents' rooms were installed or protected so as to avoid hazards to residents for 3 resident's rooms (rooms #116, #121, and #212). (Refer to Tag 107 10A NCAC 13F .0311(b)(1) Other Requirements) 7. Based on interviews and record reviews, the facility failed to assure 1 of 7 sampled staff (Staff B) successfully completed an 80-hour Personal Care Training and Competency Evaluation	D 183	The delivery sheets are then placed in the RCC/ARCC (Assistant Resident Care Coordinator) box located in the 100 hall nurse's station. Each weekday morning the RCC and or ARCC will compare the delivery sheets to the narcotics in the narcotic drawers and to the declining inventory sheet to verify all new narcotics are available and secured. The delivery sheet will then be placed in a notebook in the RCC office for narcotic sheet reconciliation. Each zeroed out narcotic sheet will be removed from the narcotic count book by the RCC/ ARCC/MT (Med Tech) and will be placed with the original delivery sheet until all sheets have been zeroed out. After all the narcotic sheets have been reconciled with the original delivery sheet, they will be placed in each resident's personal file folder. The filing cabinets which contain each resident's file folders have been relocated to the RCC office. Empty narcotic containers will be destroyed per HIPAA standards at the facility by the RCC, ARCC, or MT. Management has ensured any discrepancies will be immediately	

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D 183	Continued From page 29 program within six months of hire. (Refer to Tag 150 10A NCAC 13F .0501 Personal Care Training and Competency) 8. Based on observation, interviews and record reviews, the facility failed to assure health care referral and follow-up for 1 of 2 sampled residents with finger stick blood sugars and sliding scale insulin, and scheduled fast acting insulin (Resident #2), and 1 of 7 sampled residents for medication administration and CPAP (continuous positive airway pressure) (Residents #1). (Refer to Tag 273 10A NCAC 13F .0902(b) Health Care) 9. Based on observation, interview, and record review, the facility failed to assure the therapeutic diets Mechanical Soft (MS) for 2 of 2 residents (Residents #15 and #16) were served as ordered. (Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service) 10. Based on observation, record review and interview, the facility failed to assure clarification of a medication order for 2 of 7 sampled residents (Residents #1 and #7) with a physician's order for Novolog sliding scale, Vistaril, Trazodone and Prilosec.(Refer to Tag 344 10A NCAC 13F .1002(a) Medication Orders) 11. Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 2 of 7 sampled residents (Residents #7 and #8), including pain medication, anti-anxiety, acid reflux, anti-psychotic, and antifungal medications, and 2 of 2 sampled residents with physician's orders for sliding scale insulin (Resident #2 and #7). [Refer to Tag 0358 10A NCAC 13F .1004(a) (Type B Violation)].	D 183	addressed with the administrator and pharmacist. The administrator and or ARCC will continue a narcotic documentation and reconciliation audit form to ensure compliance. The audit will be completed for 10% of random charts daily X three weeks, then weekly X four weeks and random monthly checks thereafter. All results will be taken to the executive QI committee for review. Management will oversee the implementation and maintenance of controlled substance pre-employment drug screening. All candidates for employment to include CNAs will have a pre-employment drug screen. Management will ensure Personal Care Training is documented in each employee's file who requires the 80hr Personal Care Training class. Management will oversee that medication orders and the accuracy of the MAR (medication administration record) are in place. Management will oversee the process for healthcare referrals and follow-ups.	

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D 183	Continued From page 30 12. Based on observations, interviews and record reviews, the facility failed to assure accuracy of the Medication Administration Record (MAR) for 5 of 8 residents (Residents #1, #4, #6, #7, and #9). (Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration) 13. Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record of controlled substances for the receipt, administration and disposition of the controlled substances for 7 of 8 sampled residents (Residents #1, #3, #4, #6, #7, and #9) with orders for controlled substances including narcotic pain medications and narcotic anxiety medications. [Refer to Tag 392 10A NCAC 13F .1008(a) (Type B Violation)]. 14. Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record of controlled substances for the receipt, administration and disposition of the controlled substances for 7 of 8 sampled residents (Residents #1, #3, #4, #6, #7, and #9) with orders for controlled substances including narcotic pain medications and narcotic anxiety medications. [Refer to Tag 392 10A NCAC 13F .1008(a) (Type B Violation)]. 15. Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 7 sampled staff (Staff G) hired after 10/1/13 before the employee began working at the facility. (Refer to Tag 992 G.S. & 131D-.45 Examination and Screening) Interview on 12/22/14 at 12:30 pm with the Assistant Resident Care Coordinator (ARCC)	D 183	Management will oversee that physician orders for ground food are the correct consistency. Dietary staff have been retrained and audit tools are in place. Management will oversee that walls, ceilings, and floors are in good repair, hallways are not cluttered, heating and air conditioning units are in good condition, furniture is not in poor condition, and that a chair and lamp are available for each resident in their room. Management has implemented a monitoring system for review and immediate follow-up for areas of noncompliance. All management oversight interventions will be taken to the QI committee for review and further recommendations on a monthly basis ongoing.	2-5-15 Amr

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D 183	Continued From page 31 revealed: -The Administrator was responsible for the daily operations of the facility. -The facility chain of command was as follows: -The personal care aides report to the medication aides, supervisors. -The medication aides, supervisors report to the ARCC. -The ARCC reports to the Resident Care Coordinator (RCC). -The RCC reports to the Administrator. Interview on 12/22/14 at 3:10 pm with the Administrator revealed: -She was responsible for the daily operations of the facility. -She was at the facility "just about every day". -She was on-call 24 hours a day if staff needed her. Interview on 12/22/14 at 4:00 pm with 7 residents revealed: -The Administrator "ran" the facility. -If the residents had any concerns or issues they would either let the Administrator, the ARCC or the RCC know. -It depended on who was available as to which staff they would talk to about any concerns or issues. -The residents would "go to" the ARCC more often because she was the person that was usually available for them to talk to. The facility provided a Plan of Protection as follows: -Immediately, management has ensured new locked drawers have been added to each medication cart to allow for sufficient storage space for all narcotics to be placed in the appropriate medication cart.	D 183		

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D 183	Continued From page 32 -Narcotics will no longer be placed in the brown box in the medication room or in the black filing cabinet in the RCC office. -Management has ensured any discrepancies will be immediately addressed with the Administrator and pharmacist. -The Administrator and or ARCC will continue a narcotic documentation and reconciliation audit form to ensure compliance. -The audit will be completed for 10% of random records daily times 3 weeks, then weekly times 4 weeks and random monthly checks thereafter. -All results will be taken to the executive Quality Improvement (QI) committee for review. Management will oversee and ensure as follows: -The implementation and maintenance of controlled substance pre-employment drug screening. -All candidates for employment to include CNAs will have a pre-employment drug screen. -Personal care Training in documented in each employee's file who require the Personal care Training class. -Medication orders and accuracy of the Medication administration record are in place. -The process for healthcare referral and follow-ups. -Physician orders for ground foods are the correct consistency. -Dietary staff have been retrained and audit tools are in place. -Walls, ceilings and floors are in good repair. -Hallways are not cluttered, heating and air conditioning units are in good condition. -Furniture is not in poor condition, and a chair and lamp are available for each resident in their rooms. -Management has implemented a monitoring system for review and immediate follow-up for	D 183		

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D 183	Continued From page 33 areas of noncompliance. -All management oversight interventions will be taken to the QI committee for review and further recommendations on a monthly basis ongoing. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, FEBRUARY 5, 2015.	D 183		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure health care referral and follow-up for 1 of 2 sampled residents with finger stick blood sugars and sliding scale insulin, and scheduled fast acting insulin (Resident #2), and 1 of 7 sampled residents for medication administration and CPAP (continuous positive airway pressure) (Residents #1). The findings are: A. Review of Resident #2's current FL2 dated 08/01/14 revealed: -Diagnoses included diabetes, renal insufficiency, hypertension, hypoglycemia, and dyslipidemia. - An order for Levemir (Long acting insulin analog) 70 units subcutaneously 2 times a day. - An order for Novolog (Rapid acting insulin analog) 5 units subcutaneously 3 times a day with meals.	D 273	D 273 Health Care Resident #2's physician was notified of resident #2's refusals to have blood sugars obtained and to allow staff to administer his insulin as ordered by the physician. The physician was contacted and new orders were obtained. An inservice will be given to 100% of medication technicians on ensuring healthcare referral and follow-up to meet the routine and acute healthcare needs of residents. The inservice will include administering medications as ordered, notifying physician of refusals of evening doses of Novolog and notification of refused medications to be completed by 2/4/15. The facility will utilize a QI monitoring tool to monitor complete documentation of resident refusals. A	

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D 273	Continued From page 34 - An order for FSBS (finger stick blood sugars) 3 times daily. - An order for Novolog Insulin with sliding scale insulin (SSI) three times daily parameters as follows: FSBS 250-300 = 4 units, FSBS 301-350 = 6 units, FSBS 351-400 = 8 units, FSBS 401-450 = 10 units, FSBS 451-500 = 12 units, FSBS 501-550 = 15 units, FSBS greater than 550 notify the physician. Review of Resident #2's October 2014 Medication Administration Records (MARs) revealed: - Levemir scheduled at 8:00 am and 6:00 pm daily and documented as administered routinely as ordered. - FSBS testing was scheduled three times a day at 7:00 am, 11:00 am, and 5:00 pm. - FSBS values ranged from 61 to 246. - No SSI required; none documented. - Novolog 5 units subcutaneously 3 times a day with meals was listed and scheduled for 7:00 am, 11:00 am and 5:00 pm. - Novolog 5 units at 5:00 pm was documented as refused on the front of the MAR (initials with a circle and refused underneath) from 10/16/14 to 10/25/14. - FSBS values at 7:00 am from 10/17/14 to 10/25/14 ranged 125 to 230. - There was no documentation the physician was notified for the Novolog evening doses being refused from 10/16/14 to 10/25/14. Review of Resident #2's November 2014 MAR revealed: - Novolog 5 units subcutaneously 3 times a day with meals was listed and scheduled for 7:00 am,	D 273	10% sampling of residents' MARS will be monitored five times weekly x 3 weeks, weekly x 3 weeks, and monthly x three months. The resident care coordinator or assistant resident care coordinator will take findings to the monthly QI meetings for further recommendations. Resident #1's physician was notified about CPAP replacement part. The CPAP part arrived 2/2/15. The facility has instituted a system to ensure follow-up to Licensed Health Professional Support (LHPS) nurse recommendations. The LHPS assessment form will have an area for documenting recommendations made by the LHPS nurse. The LHPS nurse will give the LHPS assessment form to the resident care coordinator or assistant resident care coordinator for follow-up. The LHPS Recommendation Follow-Up Tool will be used to monitor follow-up of LHPS nurse recommendations. The tool will be completed on a weekly basis for three weeks, and monthly x 3 months. The resident care coordinator and or assistant resident care coordinator will present the audit	

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	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

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D 273	Continued From page 35 11:00 am and 5:00 pm. - Novolog 5 units at 5:00 pm was documented as refused on the front of the MAR (initials with a circle and refused underneath) on 11/20, 11/23, 11/24, and 11/25. - FSBS values at 7:00 am from 11/21/14 to 11/26/14 ranged 170 to 245. - There was no documentation the physician was notified for the Novolog evening doses being refused on 11/20, 11/23, 11/24, and 11/25. Review of Resident #2's December 2014 MAR revealed: - Novolog 5 units subcutaneously 3 times a day with meals was listed and scheduled for 7:00 am, 11:00 am and 5:00 pm. - Novolog 5 units at 5:00 pm was documented as refused on the front of the MAR (initials with a circle and refused underneath) on 12/01, 12/03, 12/04, 12/08-12/11, 12/13, 12/16 and 12/17. - FSBS values at 7:00 am from 12/09/14 to 12/18/14 ranged from 159 to 252. - There was no documentation the physician was notified for the Novolog evening doses being refused in December 2014. Review of Resident #2's record revealed a hemoglobin A1C lab value on 12/06/14 of 7.0. (Hemoglobin A1c test is a standard tool to determine blood sugar control in residents known to have diabetes. The American Diabetes Association (ADA) recommends a hemoglobin A1c (HgbA1c) target level of less than 7.0 in adults.) Interview on 12/18/14 at 4:25 pm with the Assistant Resident Care Coordinator (ARCC) revealed: - Medication Aides (MA) were responsible to monitor the residents' MARs for incomplete	D 273	findings to the monthly QI committee for further recommendations.	2-5-15

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D 273	Continued From page 36 documentation (holes left undocumented). - Medication aides should notify the physician when residents refused medications and document in the residents' records physician contacts. - The RCC and ARC do random checks for incomplete documentation on the MARs but have no system in place to monitor for notifying the prescriber for refusals. Interview on 12/22/14 at 9:00 am with a day shift medication aide revealed: - She relied on the Medication Administration Record (MAR) to determine how much insulin to administer to a resident. - She looked at the residents' MARs every day for changes to the sliding scale insulin. - She said if a resident does not want the full amount of insulin according to the sliding scale order "I give them what they want." - She said if a resident can tell me how they feel and they are not confused, "I listen to them." - She documented the amount of insulin she actually administered to the resident on the resident MAR. - She did not document on the back of MAR or in nurse progress notes the reason for administering the insulin outside the parameters as ordered by the physician. - She confirmed she did not notify the physician every time a resident refuses insulin or when she administered only partial amounts of insulin per the resident request. Telephone interview on 12/22/14 at 10:15 am with the facility Nurse Practitioner revealed: -It was her expectation that the facility would follow the insulin sliding scale parameters as ordered by the physician or contact the office if the residents were not compliant with the order.	D 273		

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D 273	Continued From page 37 -She could not recall if the facility had contacted the office with FSBS or insulin changes for particular residents, including Resident #2. Telephone interview on 12/22/14 at 12:40 pm with the facility Registered Nurse revealed the facility staff was to notify the physician every time a resident requested a partial amount of insulin to be administered or refused insulin as ordered by the physician. Interviews on 12/22/14 at 12:00 pm and 3:07 pm with the Adminstrator revealed: -She was aware several residents were on sliding scale insulin with parameters as ordered by the physician. -She was not aware Medication Aides (MA) were administering partial dosage of insulin to the residents per the resident request. -She said the facility policy was to follow the orders the physician had written. -She assumed the MAs were following the physician orders for the sliding scale insulin parameters and administering the correct amount of insulin that was ordered to the residents. - MAs should notify a resident's physican for all refusals of insulin. - She thought the facility policy was to notify prescribers after 3 refusals on other medications.	D 273		
	Interview on 12/22/14 at 2:40 pm with the Resident Care Coordinator revealed: -She was aware several residents were on sliding scale insulin with parameters. -She said the facility policy was, if a resident ask for a partial dose of insulin the MAs were not to give it, they were to document refused on MAR and call the physician. -She said the MA can not administer insulin per			

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D 273	Continued From page 38 the resident request without an order. -She said the facility had an inservice for the administration of insulin a few weeks ago. Interview on 12/22/14 at 3:00 pm with a evening shift medication aide revealed: - Residents sometime refused medications including insulin. - She routinely documented refusals on the front of the MAR (circle initials) and tried to remember to document on the back of the MAR. - Facility policy was to call physician after 3 refusals in a row; she might not call for one SSI refusal. - Staff were supposed to document physician contacts in the residents' records. - She had not contacted Resident #2's physician for refusal of SSI or scheduled Novolog. Interview on 12/22/14 at 2:30 pm with Resident #2 revealed: - He had been a diabetic for a long time. - He was aware he was receiving 2 types of insulin, one long acting and one short acting. - He received insulin both scheduled and on a sliding scale. - He sometimes refused the evening meal time insulin if his blood sugar was low (around 120 or less) because he was concerned his blood sugar would drop too low if he did not eat much of the evening meal. - He was not aware if his physician or nurse practitioner was aware of his refusals. B. Review of Resident #1's current FL2 dated 10/07/14 revealed: -Diagnoses included sleep apnea, chronic obstructive pulmonary disease (COPD), bipolar affective disorder, anxiety disorder, acid reflux, dysphagia, diabetes.	D 273		

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D 273	Continued From page 39 -Medication orders and treatment on the current FL2 included continuous positive air pressure (CPAP) at bedtime. Review of the Resident Register revealed Resident #1 was admitted to the facility 10/25/13. Review of Resident #1's October, November and December 2014 Medication Administration Records (MARs) revealed: -CPAP was not listed on the MAR. Review of a Licensed Health Professional Support (LHPS) review dated 08/16/14 revealed: -The Registered Nurse (RN) preparing the review documented the resident had a CPAP machine to use while sleeping. -The RN comments and recommendations were: -The resident expressed he was trying to do as ordered and wear the CPAP. -The RN noted that machine was clean but needed a new nasal piece. -The nurse noted "he still has not received one." Review of the LHPS review dated 11/22/14 revealed: -The resident had a CPAP machine to use while sleeping. -The machine was clean, but still needed a new nasal piece. -"He still has not received one." Observation on 12/19/14 at 11:10 am of Resident #1's CPAP machine revealed: -It was sitting on a bedside table next to the bed. -The hose was attached, but the nasal piece was broken. -The machine was able to power on, but without the nasal piece no air flowed to the resident's face.	D 273		

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D 273	Continued From page 40 Interview and observation on 12/19/14 at 11:12 am with Resident #1 revealed: -Prior to coming to the facility he did a sleep study. -The sleep therapist said he had sleep apnea and ordered the CPAP. -He had been unable to use the machine since April 2014. -The machine needed a new nasal piece. -Without the nasal piece air did not flow through the mask to his face. -The nurse that visits the facility was aware. -He also told the previous RCC and current RCC that he needed a new nasal piece. -The resident was observed falling asleep during conversation and loudly snoring. Interview on 12/19/14 at 11:22 am with Resident #1's family member revealed: -"He does that all the time, all he does is sleep." -The family said when the resident was awake he was alert, but the minute he sat down he fell asleep. -The resident had COPD and sleep apnea. -He needed the CPAP machine. -The CPAP had not worked in seven or eight months. -The LHPS nurse that comes to the facility was aware of the broken nasal piece. -The nurse said she told facility staff, but nothing has been done. Interview on 12/19/14 at 11:45 am and 3:04 pm with the LHPS nurse revealed: -When she did the LHPS reviews in May 2014 she made the previous RCC aware the nasal piece needed to be repaired. -She also documented the need for the repair on the LHPS reviews.	D 273		

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D 273	Continued From page 41 -In August 2014 she again made staff aware the nasal piece needed to be repaired and she documented on her report. -When doing the LHPS review on 11/22/14, she observed the machine was still not working. -She documented on her report. -Also she used her cell phone to take pictures of the machine to find the supplier to repair the machine. -It was the facility's responsibility to contact the supplier to get the machine fixed. -She recalled verbally telling the previous RCC a couple of times Resident #1's CPAP needed to be repaired. -The RCC stated there was a problem with the resident's physician. -Sometimes she visited the facility after 5:00 pm and on weekend. -She recalled writing and leaving a note for management staff because it was after hours. Interview on 12/19/14 at 11:30 am with the sleep center revealed: -They were unaware Resident #1 needed a new nasal piece for his CPAP machine. -It had been almost two years since they had seen Resident #1. -They would be able to get the part for Resident #1's machine, but the resident would be considered a new patient. Interview on 12/19/14 at 12:00 pm and 2:20 pm with the Resident Care Director (RCC) revealed: -She does not recall seeing a note or any documentation left by the LHPS nurse stating Resident #1's CPAP needed a nasal piece. -She did not review LHPS reviews to see recommendations. -No one at the facility reviewed LHPS reviews; they were filed in the resident's record.	D 273		

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D 273	Continued From page 42 -She was unaware the nasal piece on Resident #1's CPAP needed to be replaced. -The RCC before her was aware and she recalled the RCC working on it. -She was unaware the steps the RCC had taken to get the nasal piece replaced. -She was unable to recall Resident #1 telling her that he needed a new nasal piece for this CPAP machine. -She was sure no contact had been with Resident #1's physician regarding the nasal piece because she did not know about the nasal piece. -She stated, also the resident came to the facility with the CPAP and the physician was unaware the resident had the machine. Interview on 12/19/14 at 3:45 pm with the nurse at Resident #1's physician's office revealed: -They were unaware the resident had a CPAP machine. -No one had informed them the machine needed a new nasal piece. -If the resident had sleep apnea it was very important the nasal piece be replaced to help the resident sleep better and function during the day.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview, and record	D 310	D 310 Nutrition and Food Service The facility failed to ensure the therapeutic diets Mechanical Soft (MS) for 2 of 2 residents (Residents # 15 and # 16) were served as ordered. The trays for Residents #15 and #16 were immediately corrected and served to Residents # 15 and # 16.	

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D 310	Continued From page 43 review, the facility failed to assure the therapeutic diets Mechanical Soft (MS) for 2 of 2 residents (Residents #15 and #16) were served as ordered. The findings are: A. Review of Resident #15's current FL2 dated 05/01/14 revealed: -Diagnoses included anorexia, mental retardation, schizoaffective disorder, psychosis, anxiety, hypertension, left extremity weakness, and hard of hearing. -An order for regular ground diet. Review of the diet list posted in the kitchen revealed Resident #15 was to be served a MS diet. Review of the facility therapeutic diet menus revealed: -A MS menu was available for use by the food service staff. -A ground diet was the same as a MS diet. -The lunch on 12/17/14 for residents ordered a MS diet was to consist of grounded hot dog on a bun, battered corn nuggets, baked beans, spiced pears, milk and beverage of choice. Observation of the lunch meal served on 12/17/14 at 11:42 am revealed: -Resident #15 was served whole extra-long hot dog on a bun topped with chili, baked bean, cole slaw, cupcake with icing, and milk. -The resident was seated at the "feeding table." -The resident was sleep at the table for 20 minutes. -Two staff tried to arouse the resident. -The resident woke up. -The personal care aide (PCA) at the table used a spoon and cut the hot dog in 7 pieces.	D 310	A 100% of dietary staff was inserviced by the dietary manager on 12/17/14 as follows: following tray cards, properly preparing regular ground foods, and the difference between ground and chopped foods. A QI tool "Meal Delivery Audit" will be used to audit therapeutic diets. The dietary manager and or designee will review tray cards to ensure residents with ground foods are receiving ground foods daily x 3 weeks, randomly weekly x 4 weeks, and monthly to ensure correct diets are given. The dietary manager will report findings at the monthly QI meeting for further recommendations.	2-5-15

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D 310	Continued From page 44 -The resident ate the meal without assistance. -The resident consumed 100% of the meal. Interview on 12/14/14 at 12:45 pm with the PCA revealed: -Resident #15 was able to feed himself. -She was aware the resident was ordered a MS diet. -When a resident is ordered MS diet the meat was always cut-up at the table. -She said Resident #15 was unable to respond verbally. Based record review, observation and attempt interview on 12/17/14 and 12/18/14, it was determined that Resident #15 was not interviewable. Refer to interview on 12/17/14 at 12:50 pm with the Food Service Manager. Refer to interview on 12/17/14 at 1:00 pm with the Cook. B. Review of Resident #16's current FL2 dated 04/09/14 revealed: -Diagnoses included mental retardation, seizure, hypertension, anxiety, edema, anemia, and hypothyroidism. -An order for regular ground (MS) diet. Review of the diet list posted in the kitchen revealed Resident #16 was to be served MS diet. Review of the facility therapeutic diet menus revealed: -A MS menu was available for use by the food service staff. -A ground diet was the same as a MS diet. -The lunch on 12/17/14 for residents ordered a	D 310		

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D 310	Continued From page 45 MS diet was to consist of ground hot dog on a bun, battered corn nuggets, baked beans, spiced pears, milk and beverage of choice. Observation of the lunch meal served on 12/17/14 at 11:30 am revealed: -Resident #16 was served whole extra-long hot dog on a bun topped with chili that was cut-up into 10 pieces, baked bean, cole slaw, cupcake with icing, and milk. -The resident was able to feed himself. -The resident consumed 100% of the meal. Based on record review, observation and attempt interview on 12/17/14 and 12/18/14, it was determined that Resident #16 was not interviewable. Refer to interview on 12/17/14 at 12:50 pm with the Food Service Manager. Refer to interview on 12/17/14 at 1:00 pm with the Cook. Interview on 12/17/14 at 12:50 pm with the Food Service Manager revealed: -The facility had two altered diets, chopped and ground. -The did not realize that MS diet required meats to be ground. -He had always understood MS diet to be chopped meats. -He did not realize that Residents #15 and #16 meats should be grounded. -He will check to ensure that he had the current diet orders. -He had always instructed staff that meats for residents ordered MS diets were to be cut-up. -Sometimes the meat was cut-up by the cook and	D 310		

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D 310	Continued From page 46 sometimes by the staff serving the meal. Interview on 12/17/14 at 1:00 pm with the Cook revealed: -She did not grind the hot dogs today because grinding them smashed the meat and made it was "smashey." -She chopped the meat for all residents ordered MS diet. -Chopped meat was cut-up into bite sized pieces. -She had never ground the meat for residents ordered MS diet. -She did not realize the menu for MS diet required the meat to be ground.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure clarification of a medication order for 1 of 7 sampled residents (Resident #7) with a physician's order for Novolog	D 344	D 344 Medication Orders The facility failed to ensure clarification of a medication order for 1 of 7 sampled residents (Resident #7) with a physician's order for Novolog sliding scale, Vistaril, and Trazodone. A clarification order was obtained for Resident #7 for her Novolog sliding scale on 12/17/14. O1/20/15, the facility verified the Trazodone and Vistaril orders were correct and documented on a clarification order. An inservice was initiated for the medication technicians (MT) on 12/19/14 on Transcribing Medication Orders and Medication Administration. Areas addressed included: (1) physician	

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NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1808 N CANNON BOULVARD, KANNAPOLIS, NC 28083

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D 344	Continued From page 47 sliding scale, Vistaril, and Trazodone. The findings are: Review of Resident #7's current FL2 dated 05/01/14 revealed: -Diagnoses of diabetes, anemia, hypothyroidism, chronic obstructive pulmonary disease, renal insufficiency, asthma, and edema. 1. Diabetic medications ordered on the current FL2 included: -Humalog (A fasting acting insulin that is used to lower blood glucose level) sliding scale four times daily with parameters of: 62-150= 0 units; 151-200= 2 units; 201-250= 4 units; 251-300= 6 units; 301-350= 8 units; 351-400= 10 units; greater than 400 call the physician. -Humalog 10 units twice daily before lunch and supper. -Lantus (long acting insulin to lower blood glucose level) 35 units in morning and at bedtime. Review of Resident #7's record revealed: -A hospital discharge summary report dated 10/25/14. -The resident was hospitalized for respiratory complications. -Discharge medications included: -Novolog (Fast acting insulin to lower blood sugar) subcutaneously with sliding scale three times daily before meals (greater than 150 = 2 units, +50 = + 2 units). -Novolog 10 units twice daily before meals (Lunch and Supper). -Lantus (slow acting insulin to lower blood sugar) 35 units twice daily. Further review of Resident #7's record revealed: -Hand written medication administration records (MARs) signed by the physician (physician order	D 344	orders must be transcribed (written) on the MAR exactly how the physician writes the order, (2) any incomplete medication orders should be clarified immediately with the physician, (3) medications are given as ordered, (4) all new admits' or readmits' orders from discharge summaries or other paperwork must be clarified and transcribed as ordered. A second inservice was initiated for the medication technicians on 1/22/15 on "Medication Orders". Areas addressed included :(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments. (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or concise; or (3) if multiple admission forms are received upon admission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	

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D 344	Continued From page 48 sheets/POS) on 11/18/14. -Humalog sliding scale four times daily with parameters: 62-150= 0 units; 151-200= 2 units; 201-250= 4 units; 251-300= 6 units; 351-400= 10 units; greater than 400 call the physician. -No parameters that covered for blood sugars 301-350. -Humalog 10 units twice daily before meals (lunch and supper). -Lantus 35 units in morning and at bedtime. Review of Resident #7's October 2014 Blood Glucose Record revealed: -Finger Stick Blood Sugars (FSBS) testing was scheduled four times a day at 7:00 am, 11:00 am, 5:00 pm, and 9:00 pm. -Humalog was documented as administered for blood sugars within sliding scale parameters on 5/1/14 FL2. -Humalog 10 units was documented administered twice daily at 11:00 am and 5:00 pm. -Lantus 35 units was documented twice daily at 10:00 am and 10:00 pm. -FSBS's range from 61 to 398. Review of Resident #7's November 2014 Blood Glucose Record revealed: -FSBS testing was scheduled four times a day at 7:00 am, 11:00 am, 5:00 pm, and 9:00 pm. -Humalog was documented as administered for blood sugars within sliding scale parameters on 5/1/14 FL2. -Humalog 10 units was documented as administered twice daily at 11:00 am and 5:00 pm. -Lantus 35 units was documented as administered twice daily at 10:00 am and 10:00 pm. -FSBS's range from 89 to 420.	D 344	The Medication Clarification Audit tool will be used by the resident care coordinator or the assistance resident care coordinator. If orders are not clear or complete, or if multiple admission forms are received upon admission or readmission and orders on the forms are not the same, then the facility will obtain clarification of the order. The Medication Clarification Audit tool will be completed five times weekly x 3 weeks and monthly x 3 months. The administrator and or designee will bring findings to the monthly QI committee meeting for further recommendations.	2-5-15 AW

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D 344	Continued From page 49 Review of Resident #7's December 2014 Blood Glucose Record revealed: -FSBS testing was scheduled four times a day at 7:00 am, 11:00 am, 5:00 pm, and 9:00 pm. -Humalog was documented as administered for blood sugars within sliding scale parameters on 5/1/14 FL2. -Humalog 10 units was documented as administered twice daily at 11:00 am and 5:00 pm. -Lantus 35 units was documented as administered twice daily at 10:00 am and 10:00 pm. -FSBS's range from 90 to 318. Observation on 12/19/14 at 4:30 pm of Resident #7's medications on hand at the facility revealed: -The printed pharmacy label on the Humalog was sliding scale four times daily with parameters: 62-150= 0 units; 151-200= 2 units; 201-250= 4 units; 251-300= 6 units; 301-350= 8 units; 351-400= 10 units; greater than 400 call the physician, and Humalog 10 units twice daily before lunch and supper. -The dosage per pharmacy printed label for Lantus was 35 units in the morning and 37 units at bedtime, filled 12/08/14. Review of Resident #7's record revealed: -No documentation of contact or communication of any type with Resident #7's physician to clarify the medications Humalog vs. Novolog. -No clarification of the sliding scale order four times vs. three times daily. -No clarification of the sliding scale parameters. -No clarification of the Lantus 35 units twice daily or 35 units in the morning and 37 units at bedtime. Interview on 12/22/14 at 9:25 am with the	D 344		

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D 344	Continued From page 50 dispensing pharmacy staff used to fill Resident #7's medications revealed: -They were unaware of the hospital discharge summary report dated 10/25/14. -The orders should have been sent to the pharmacy or at least to the physician to clarify any medications changes. -They had never dispensed Novolog for Resident #7. -There was not a huge difference in Humalog vs. Novolog, however if he physician ordered Novolog, then that was what should be administered to the resident. -Their records showed a refill request for Lantus dated 10/17/14. -The order changed Lantus to 35 units in the morning and 37 units at bedtime. -He was unaware why the physician increased the bedtime Lantus dosage. -Orders sent to the pharmacy are not sent to the facility. -It was the facility's responsibility to communicate with the physician to obtain and/or clarify orders. -It was their thinking that when the physician changed an order the facility was also notified by the physician. -No one at the facility had called them to clarify the Humalog or Lantus orders. Interview on 12/19/14 at 4:40 pm with Staff D (Medication Aide) on duty revealed: -She had not contacted Resident #7's physician to clarify the medications on the 10/25/14 discharge summary report. -She was aware that in October Resident #7 was in the hospital for respiratory complications. -When the resident returned to the facility she was not on duty. -The medication aide on duty should have compared the medications on the discharge	D 344		

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D 344	Continued From page 51 summary to the current medications. -If discrepancies were identified contact should have been made with the resident's physician to clarify the orders. -The person coming on the next shift was to check behind that medication aide to ensure no orders were missed. -She was unaware how or why medications on Resident #7's hospital discharge summary were not clarified with the resident's physician. -She had not realized Resident #7's Lantus order had changed. -Staff doing the weekly cart audits should have picked up the medication label was different from the MAR. -She was sure Resident #7 physician had not been contacted regarding the change in Lantus, because the change would be documented on the MARs. -Also, there should be some documentation in the resident's record. -If it was not documented it was not clarified. Interview on 12/22/14 at 10:15 am with Resident #7's physician revealed: -The physician had not seen the resident in several months. -She was aware the resident had been hospitalized, but was not aware of medication order changes. -No one at the facility called to clarify Humalog or sliding scale orders. -The physician did change the Lantus but that was in October 2014 before the resident's hospitalization. -There were no notes specific to why the bedtime Lantus dosage had been increased. -If there was a problem, the physician should have been contacted before now. -No one at the facility called to clarify Resident	D 344		

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D 344	Continued From page 52 #7's Lantus order. Based on record review, observation and attempt interview on 12/19/14 and 12/22/14 it was determined that Resident #7 was not interviewable. 2. Review of Resident #7's current FL2 dated 05/01/14 revealed: -Medication orders included Vistaril (used to treat anxiety) 50mg four times daily. Review of Resident #7's record revealed: -A hospital discharge summary report dated 10/25/14. -Medication orders included Vistaril 50mg four times daily. Review of Resident #7's record revealed: -Hand written medication administration records (MARs) signed by the physician (physician order sheets) on 11/18/14 revealed: -Orders included Vistaril 50mg four times daily. Review of Resident #7's November 2014 and December 2014 MARs revealed Vistaril 50mg four times daily was scheduled at 10:00 am, 1:00 pm, 5:00 pm and 10:00 pm. -Staff documented the administration of Vistaril 50mg four times daily from November 1, 2014 through December 22, 2014. Observation on 12/19/14 at 4:30 pm of Resident #7's medications on hand at the facility revealed: -The dosage per pharmacy printed label for Vistaril was 50mg one tablet every 8 hours as needed. -The medication was filled on 12/17/14. Interview on 12/22/14 at 9:20 am with the	D 344		

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D 344	Continued From page 53 dispensing pharmacy staff used to fill Resident #7's medications revealed: -They had an order dated 10/20/14 for Vistaril 50mg every 8 hours as needed. -The prescription label on the medication was the current order according to their record. -On 10/21/14 they dispensed 180 tablets. -Facility staff should not have administered the medication three times daily without doing the required PRN documentation to show why the resident needed the medication. -Facility staff should have clarified the order with the physician to ensure it was the current medication order. Interview on 12/19/14 at 4:48 pm with Staff D, (Medication Aide) revealed: -She was unaware the prescription label on Vistaril medication was different from the order printed on the MAR. -It was the facility's policy if there was a discrepancy the pharmacy or physician should be contacted to clarify the order. -She had not contacted Resident #7's physician to clarify the order. -An audit of the medication cart was done weekly and someone should have picked up that discrepancy and clarified the order. Interview on 12/22/14 at 10:12 am with Resident #7's physician revealed: -The physician had not seen the resident in several months. -During the visit no one at the facility informed there was a discrepancy with the administration of Vistaril. -No one at the facility called to clarify the order. -If the MAR was different from the prescription label, facility staff should have called the physician to clarify the order.	D 344		

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D 344	Continued From page 54 -Vistaril should have been administered as 50mg every 8 hours as needed. 3. Medication orders on the current FL2 dated 05/01/14 included Trazodone (used to treat schizophrenia) 100mg at bedtime. Review of Resident #7's record revealed: -A hospital discharge summary report dated 10/25/14. -Discharge medication orders include Trazodone 100mg at bedtime. Review of Resident #7's November 2014 and December 2014 MARs revealed: -Trazodone 100mg was documented as administered daily at 8:00 pm. -Staff documented the administration of Trazodone 100mg daily from November 1, 2014 through December 21, 2014. Observation on 12/19/14 at 4:30 pm of Resident #7's medications on hand at the facility revealed: -The dosage per pharmacy printed label for Trazodone was 150mg at bedtime. -The medication was filled on 12/17/14. Interview on 12/22/14 at 9:20 am with the dispensing pharmacy staff used to fill Resident #7's medications revealed: -An order dated 07/08/14 for Trazodone 150mg at bedtime. -They pharmacy said they did not have a copy of the physician's order sheet dated 11/18/14 or the FL2 dated 05/01/14. -Trazodone 150mg was dispensed for a quantity of 30 in October, November, and December 2014. -The facility staff should have called to find out why the prescription label was different from the MAR.	D 344		

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D 344	Continued From page 55 -As of today's date no one at the facility had called to clarify the medication order. Interview on 12/22/14 at 10:12 am with Resident #7's physician revealed: -The physician had not seen the resident in several months. The physician did not change the Trazodone order. -The medication dosage should be 150mg at bedtime. -During the resident's last visit, no one at the facility informed there was a discrepancy with Trazodone dosage. Interview on 12/19/14 at 4:48 pm with Staff D, (Medication Aide) on duty revealed: -She was unaware the order for Trazodone had changed. -The medication aide administering the medication should read the prescription label before administering the medication. -The physician should have been contacted to clarify the Trazodone order. -If there was no documentation the order was clarified, then the physician had not been contacted. Based on record review, observation and attempt interview on 12/19/14 and 12/22/14, it was determined that Resident #7 was not interviewable.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358	D 358 Controlled Substances Type B Violation Controlled Substances-Readily Retrievable Records	

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D 358	Continued From page 56 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 2 of 7 sampled residents (Residents #7 and #8), including pain medication, anti-anxiety, acid reflux, anti-psychotic, and antifungal medications, and 2 of 2 sampled residents with physician orders for sliding scale insulin (Resident #2 and #7). The findings are: Tour during initial entrance to the facility revealed: -Interviews with residents revealed they complained about the facility being continuously out of their medications. -The medications were used to treat various health conditions. -The residents said staff did not tell them how or why the medication was out. -The residents said they were sure it was because staff did not request a refill until the last pill was given. -The residents were concerned because some medications were important like pain pills, anxiety meds, or acid reflux pills that were out up to one week. A. Review of Resident #7's current FL2 dated 05/01/14 revealed:	D 358	Narcotic Availability Revision 1/13/15 Management has ensured that new locked drawers have been added to each medication cart to allow for sufficient storage space for all of the facility's narcotics to be placed in the appropriate medication cart. Narcotics will no longer be placed in the brown box in the medication room or in the black filing cabinets in the RCC(Resident Care Coordinator) office. Management has ensured the new process is as follows: When narcotics are delivered to the facility, a medication technician compares the delivery sheet to the medications that are delivered. The narcotic counts are verified with two signatures and then are placed in the appropriate medication carts in the locked narcotic drawers. The declining inventory sheets are completely filled out with the correct identifiers and placed in the narcotic count notebook. The number of narcotic sheets count will be changed during the next shift	

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D 358	Continued From page 57 -Diagnoses of diabetes, anemia, hypothyroidism, chronic obstructive pulmonary disease, renal insufficiency, asthma, and edema. 1. Medication orders did not include Prilosec. Review of Resident #7's record revealed: -Hospital discharge summary report dated 10/25/14. -Discharge medications included Prilosec 20mg daily. -A copy of hand written medication administration records (MARs) (physician order sheets) signed by the physician on 11/18/14. -Orders included Prilosec 20mg once daily. Review of Resident #7's November 2014 and December 2014 MARs revealed Prilosec 20 mg was scheduled at 6:00 am. -Staff documented the administration of Prilosec 20mg daily from November 1, 2014 through December 22, 2014. Observation on 12/19/14 at 4:30 pm of Resident #7's medications on hand at the facility revealed Prilosec was not available for administration. Interview on 12/19/14 at 4:48 pm with a medication aide on duty revealed: -She worked the first shift. -The third shift medication aide would have been responsible for administering the Prilosec. -Prilosec was not on the medication cart. -She was unaware how long the medication had been out. -The medication was scheduled before breakfast and usually administered at 6:00 am. -The medication aide searched for a refill request but was unable to find one.	D 358	count to reflect the delivery of new narcotics. The delivery sheets are then placed in the RCC/ARCC (Assistant Resident Care Coordinator) box located in the 100 hall nurse's station. Each weekday morning the RCC and or ARCC will compare the delivery sheets to the narcotics in the narcotic drawers and to the declining inventory sheet to verify all new narcotics are available and secured. The delivery sheet will then be placed in a notebook in the RCC office for narcotic sheet reconciliation. Each zeroed out narcotic sheet will be removed from the narcotic count book by the RCC/ ARCC/MT (Med Tech) and will be placed with the original delivery sheet until all sheets have been zeroed out. After all the narcotic sheets have been reconciled with the original delivery sheet, they will be placed in each resident's personal file folder. The filing cabinets which contain each resident's file folders have been relocated to the RCC office. Empty narcotic containers will be destroyed per HIPAA standards at the facility by the RCC, ARCC, or MT.	

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D 358	Continued From page 58 Interview on 12/22/14 at 9:20 am with the dispensing pharmacy staff used to fill Resident #7's medications revealed: -Prilosec 20mg once daily was dispensed for quantity of 30 on 10/13/14 and 11/10/14. -The medication was not on automatic refill and the facility had to request the medication be re-filled. -Based on the dispensing history of the medication, the medication would have run out between December 10-13, 2014. -As of today, December 22, 2014 the facility had not called to request a refill of the medication. Interview on 12/22/14 at 9:43 am with the Resident Care Coordinator revealed: -Resident #7 should not have run out of the Prilosec. -It was the facility policy when medications were 5 days down the Medication Aide on the cart was to reorder the medication. -Weekly cart audits were done by Medication Aides to ensure medications did not run out. -She was unaware that residents complained about continually running out of medication. Based on record review, observation and attempt interview on 12/17/14 and 12/19/14 it was determined that Resident #7 was not interviewable.	D 358	Management has ensured any discrepancies will be immediately addressed with the administrator and pharmacist. The administrator and or ARCC will continue a narcotic documentation and reconciliation audit form to ensure compliance. The audit will be completed for 10% of random charts daily X three weeks, then weekly X four weeks and random monthly checks thereafter. All results will be taken to the executive QI committee for review.	2-5-15
	2. Review of medications ordered on the 05/01/14 FL2 revealed Prolixin 10mg was ordered twice daily. -Review of a Hospital discharge summary report dated 10/25/14 revealed discharge medications included: Prolixin 10mg twice daily was ordered.			

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NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

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D 358	Continued From page 59 Review of a copy of hand written medication administration records (MARs) (physician order sheets) signed by the physician on 11/18/14 revealed orders included Prolixin 10mg twice daily. Review of Resident #7's November 2014 and December 2014 MARs revealed Prolixin 10mg twice daily was scheduled at 10:00 am and 10:00 pm. -Staff documented the administration of Prolixin 10mg twice daily from November 1, 2014 through December 22, 2014. Observation on 12/19/14 at 4:30 pm of Resident #7's medications on hand at the facility revealed Prolixin was not available for administration. Interview on 12/19/14 at 4:48 pm with a medication aide on duty revealed: -Prolixin was not on the cart. -The medication was ordered twice daily, so she assumed the last pill was administered today at 10:00 am. -She was unsure if the day shift administered the medication. -She was unable to locate a refill request for the medication. -It was the facility's policy to request a refill of medications with 2-3 tablets left.	D 358		
	Interview on 12/22/14 at 9:20 am with the dispensing pharmacy staff used to fill Resident #7's medications revealed: -Prolixin 10mg twice daily was dispensed for quantity of 60 on 10/13/14 and 11/10/14. -The medication was not on automatic refill and the facility had to request the medication be re-filled. -Based on the dispensing history of the			

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D 358	Continued From page 60 medication it would have run out around December 10-13, 2014. -As of today, December 22, 2014 the facility had not requested a refill of the medication. Interview on 12/22/14 at 9:43 am with the Resident Care Coordinator revealed: -Resident #7 should not have run out of the Prolixin. -Staff should have called when the medication was down to no less than 3-4 pills. -Also, the weekly cart audits by the Medication Aides should have identified it was time to reorder the medication. -If the re-order was not caught during the cart audit, the medication Aide administering the medication should have reordered the medication. Based on record review, observation and attempt interview on 12/17/14 and 12/19/14 it was determined that Resident #7 was not interviewable. 3. Review of medication ordered on the 05/01/14 FL2 revealed Cogentin 1mg daily was ordered. Review of hospital discharge summary report dated 10/25/14 revealed Cogentin 1 mg at bedtime was ordered. Review of a copy of hand written medication administration records (MARs) (physician order sheets) signed by the physician on 11/18/14 revealed orders included Cogentin 1mg at bedtime. Review of Resident #7's November 2014 and December 2014 MARs revealed Cogentin 1mg was documented daily at 8:00 pm.	D 358		

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D 358	Continued From page 61 -Staff documented the administration of Cogentin 1mg daily from November 1, 2014 through December 21, 2014. Observation on 12/19/14 at 4:30 pm of Resident #7's medications on hand at the facility revealed Cogentin was not available for administration. Interview on 12/19/14 at 4:48 pm with a medication aide on duty revealed: -The resident was out of the Cogentin medication. -She was unable to locate a refill request. -The last dosage must have been administered yesterday. -When there were 2-3 dosages left, the medication Aide on duty should have requested a refill. Interview on 12/22/14 at 9:20 am with the dispensing pharmacy staff used to fill Resident #7's medications revealed: -Cogentin 1mg daily was dispensed for quantity of 30 on 10/13/14 and 11/10/14. -The medication was not on automatic refill and the facility had to request the medication be re-filled. -Based on the dispensing history of the medication it would have run out around December 10-13, 2014. -As of today, December 22, 2014 the facility had not requested a refill of the medication. Interview on 12/22/14 at 9:43 am with the Resident Care Coordinator revealed: -Resident #7 should not have run out of the Cogentin. -She did not know what to say regarding why staff did not reorder the medication according to the facility's policy.	D 358		

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D 358	Continued From page 62 Based on record review, observation and attempt interview on 12/17/14 and 12/19/14 it was determined that Resident #7 was not interviewable. 4. Review of Resident #7's current FL2 dated 05/1/14 revealed: -Diagnoses included diabetes, chronic obstructive pulmonary disease, renal insufficiency and anemia. -An order for Finger Stick Blood Sugar (FSBS) daily before meals and at bedtime. -Humalog Insulin (A fasting acting insulin that is used to lower blood glucose level) parameter sliding scale (SSI) 4 times daily as follows: -FSBS 62-150= 0 units -FSBS 151-200=2 units -FSBS 201-250=4 units -FSBS 251-300=6 units -FSBS 301-350-8 units -FSBS 351-400=10units -FSBS greater than 400 notify the physician. Review of Resident #7's record revealed: -Hospital discharge summary report dated 10/25/14. -Discharge medications included Novolog subcutaneously with sliding scale three times daily before meals (greater than 150 = 2 units, +50 = + 2 units).	D 358		
	Review of Resident #7's November 2014 Blood Glucose Record revealed: -FSBS testing was scheduled four times a day at 7:00 am, 11:00 am, 5:00 pm, and 9:00 pm. -FSBS's range from 89 to 420. -Documentation of 7 occurrence Humalog SSI was administered incorrectly as ordered by the physician as follows: -On 11/5/14 at 11:00 am FSBS 219 No			

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D 358	Continued From page 63 documentation Humalog SSI was administered should have received 4. -On 11/14/14 at 5:00 pm FSBS 242 received 6 units of Humalog SSI and should have received 4 units. -On 11/15/14 at 5:00 pm FSBS 220 received 6 units of Humalog SSI and should have received 4 units. -On 11/18/14 at 9:00 pm FSBS 175 no documention of Humalog SSI administered should have received 2 units. -On 11/19/14 at 11:00 am FSBS 226 received 6 units of Humalog SSI should have received 4 units. -On 11/20/14 at 11:00 am FSBS 136 received 2 units of Humalog SSI should have received no Humalog SSI. -On 11/28/14 FSBS 288 at 9:00 pm received no Humalog SSI should have received 6 units. -No documentation the physician was notified the 7 doses of Humalog SSI were not administered as ordered. Review of Resident #7's December 2014 Blood Glucose Record revealed: -FSBS testing was scheduled four times a day at 7:00 am, 11:00 am, 5:00 pm, and 9:00 pm. -FSBS's range from 90 to 318. -Documentation 5 occurrence Humalog SSI was administered incorrectly outside as ordered by the physician as follows: -On 12/5/14 at 9:00 pm FSBS 249 received 6 units of Humalog SSI should have received 8 units. -On 12/13/14 at 7:00 am FSBS 186 no documentation Humalog SSI was administered should have received 2 units. -On 12/14/14 at 5:00 pm FSBS 252 received 4 units of Humalog SSI should have received 6 units.	D 358		

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D 358	Continued From page 64 -On 12/15/14 at 5:00 pm FSBS 230 no documentation of Humalog SSI administered should have received 4 units. -On 12/18/14 at 5:00 pm FSBS 223 received 2 units of Humalog SSI should have received 4 units. -No documentaion the physician was notified the 5 doses of Humalog SSI were administered incorrectly as ordered. Based on record review, observation, and attempt interview on 12/22/14, it was determined Resident #7 was not interviewable. Interview on 12/22/14 at 9:00 am with a medication aide revealed: -She relied on the Medication Administration Record (MAR) to determine how much insulin to administer to the resident. -She looked every day at the MAR for changes to the SSI parameters for the residents. -She said if a resident does not want the full amount of insulin according to the SSI orders " I give them what they want." -If a resident can tell me how they feel and they are not confused, " I listen to them." -She documented on the MAR the actual amount of insulin she administered to the resident. -She stated she does not notify the physician every time the resident refused the insulin or when she administered only partial amounts of insulin per the resident request. Telephone interview on 12/22/14 at 10:15 am with the facility Nurse Practitioner revealed: -She was aware Resident #7 was on SSI with coverage 4 times daily. -She was not aware the facility were administering partial dosage of insulin to the residents per the resident's request.	D 358		

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D 358	Continued From page 65 -It was her expectation that the facility would follow the SSI parameters as ordered by the physician or contact the office if the resident were not compliant with the order. -She could not recall if the facility had contacted the office with FSBS or insulin changes for Resident #7. Telephone interview on 12/22/14 at 12:40 pm with the facility Registered Nurse revealed: -She was aware some residents were refusing the amount of insulin they were to receive and requested a different amount of insulin administered. -She said the facilty staff were to notify the physician every time a resident requested a partial amount of insulin or refused insulin as ordered by the physician. Interview on 12/22/14 at 12:00 pm with the Adminstrator revealed: -She was not aware Medication Aides (MA) were administering partial dosage of insulin to the residents per the resident request. -She said the facility policy was to follow the orders the physician had written. -She assumed the MAs were following the physician orders for the sliding scale insulin parameters and administered the correct amount of insulin ordered for the residents. Interview on 12/22/14 at 2:40 pm with the Resident Care Coordinator revealed: -She was aware residents requested partial doses of insulin be administered which were different from the SSI parameters ordered by the physican. -She said the facility policy was, if a resident asked for a partial dose of insulin the MAs were not to give it, they were to document refused on	D 358		

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D 358	Continued From page 66 MAR and call the physician. -She said the MA can not administer insulin per the resident request without an order. -She said the facility had an inservice for insulin administration a few weeks ago. B. Interview on 12/17/14 at 10:22 am with Resident #8 during the tour of the facility revealed: -She had severe nerve damage in her right leg and was ordered Zanaflex. -The beginning of the month she was out of the medication and suffered with pain. -She was often out of her medications and staff did not tell why her medications were always running out. Review of Resident #8's current FL2 dated 10/07/14 revealed: -Diagnoses of seizure disorder, bipolar disorder, nausea, hyper-triglyceridemia, chronic neuropathy pain, and dyspepsia. -Medication orders included Zanaflex (used to treat pain) 2mg three tablets (6mg) four times daily. Review of Resident #8's November 2014 medication administration record (MAR) revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily. -Staff documented the administration of the medication daily at 5:30 am, 12:00 pm, 4:00 pm, and 8:00 pm. Review of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily. -Staff documented the administration of the medication daily at 5:30 am, 12:00 pm, 4:00 pm, and 8:00 pm.	D 358		

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D 358	Continued From page 67 -Staff documented on the back of the MAR on 12/01/14 and 12/02/14 the medication was out. Observation on 12/19/14 at 9:45 am of Resident #8's medications on hand revealed: -Review of the dosage on the pharmacy printed label for Zanaflex bottle revealed 4mg one and one-half tablets four times daily. -The medication was filled on 12/03/14 for quantity of 180. Interview on 12/18/14 at 10:50 am with the pharmacy used to dispense Resident #8's medications revealed: -On 12/02/14 the facility called to request the medication be refilled, but there were no refills. -The pharmacy contacted the resident's physician for a new prescription. -The new order dated 12/03/14 was for 4mg one and one-half tablet four times daily. -The pharmacy stated the medication order had not changed, but the dosage amount was different based on the tablets available at the pharmacy. -The medication was dispensed 11/03/14 for 4mg one and one-half tablets quantity 180. -Facility staff should not administer three tablets as on the MAR, but 6mg of the medication. -The pharmacy said no one at the facility had called to clarify the medication dosage instructions. -Administering the medication incorrectly could possibly be one reason why the medication did not last one month. -The medication was dispensed on 11/03/14 for quantity 180 tablets and on 12/03/14 for a quantity of 180 tablets. -If administered according to dosage instructions on the prescription label the medication should not have run out.	D 358		

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D 358	Continued From page 68 Second interview on 12/18/14 at 4:20 pm with Resident #8 revealed: -The Zanaflex 2mg was what staff gave her. -Some staff gave her three 3 tablets four times daily and some staff gave her one and one-half tablet four times daily. -She did not question, she thought staff knew what they were doing. Interview on 12/18/14 at 3:55 pm with the a second medication aide revealed: -She worked the first shift and administered Resident #8's Zanaflex daily at 12:00 pm according to the instructions printed on the MAR, three tablets. -She did not realize the prescription label on the medication read 4mg one and one-half tablet. -The medication dosage should have been checked with the pharmacy to ensure they did not make a mistake printing the label. -The person doing the weekly cart audits should have found the discrepancy and reported it. C. Review of Resident #1's current FL2 dated 10/07/14 revealed: -Diagnoses of reflux esophagitis, dysphagia, diabetes, bipolar affective disorder, hyperlipidemia, sleep apnea, chronic obstructive pulmonary disease, anxiety disorder, adenocaranoma of prostate and emphysema. -Medication orders included Prilosec (used to treat acid reflux) 40mg once daily. Review of Resident #1's record revealed an order dated 10/20/14 for Prilosec 40mg twice daily. Review of Resident #1's October, November, and December 2014 medication administration record (MAR) revealed:	D 358		

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D 358	Continued From page 69 -Prilosec 40mg was printed on the MAR as one tablet once daily. -Staff documented the administration of the medication daily at 6:00 am. Observation on 12/18/14 at 10:32 am of Resident #1's medications on hand at the facility revealed: -The dosage per pharmacy printed label was 40mg twice daily. -The medication was filled on 11/21/14 for a quantity of 120 tablets. Interview on 12/18/14 at 3:00 pm with the dispensing pharmacy staff used to fill Resident #1's medications revealed: -They had an order dated 10/20/14 for Prilosec 40mg twice daily. -The medication was filled on 11/21/14 for a quantity of 120. -The medication had not been refilled again because the facility had not requested a refill. Interview on 12/19/14 at 8:40 am with Resident #1 revealed: -He had a hernia and acid reflux. -He visited the physician in October 2014. -The physician verbally said that he was going to increase the acid medication. -The facility has never given him an increased amount of the medication, so he thought the doctor did not increase the medication. -The current dosage of Prilosec does not help his acid reflux. -He did not ask facility staff about the medication because he trusted them to administer the medication as ordered. Interview on 12/19/14 at 9:30 am with the nurse at Resident #1's physician's office revealed: -The physician saw the resident in October 2014.	D 358		

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D 358	Continued From page 70 -The physician did an endoscope and based on the results Prilosec was increased to twice daily to help with the indigestion. -Based on the documentation in their records, no one at the facility had contacted the physician regarding the resident not. -The medication should be administered twice daily. Interview on 12/19/14 at 10:35 am with Staff C, (Medication Aide) revealed: -She was unaware Resident #1 order for Prilosec had changed to twice daily. -The medication was administered once daily as documented on the MAR. -Because the medication only had one entry on the MAR, she was sure the medication was not administered twice daily. -If the medication aide administering medications identified the prescription label was different from the MAR, the medication aide was to check the resident's record for an order. -The medication aide was to also contact the pharmacy or the resident's physician to see if the order had changed. -It also was the facility's policy when orders were received the medication aide on duty was to write the new order on the MAR and send the order to the pharmacy. -Medication aides did a weekly cart audits to identify discrepancies in medications and MAR. -She was unaware how the order to increase Prilosec had been missed since October 2014. C. Review of Resident #2's current FL2 dated 08/01/14 revealed: -Diagnoses included diabetes, renal insufficiency, hypertension, hypoglycemia, and dyslipidemia. - An order for FSBS (finger stick blood sugars) 3 times daily.	D 358		

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D 358	Continued From page 71 - An order for Novolog Insulin with sliding scale insulin (SSI) three times daily parameters as follows: FSBS 250-300 = 4 units, FSBS 301-350 = 6 units, FSBS 351-400 = 8 units, FSBS 401-450 = 10 units, FSBS 451-500 = 12 units, FSBS 501-550 = 15 units, FSBS greater than 550 notify the physician. Review of Resident #2's November 2014 Medication Administration Records (MARs) revealed: - FSBS testing was scheduled three times a day at 7:00 am, 11:00 am, and 5:00 pm. - FSBS values ranged from 67 to 298. - Documentation SSI was administered incorrectly 3 of 6 opportunities when SSI should have been administered as follows: - 11/04/14 at 7:00 am FSBS=246, documented 5 units- should have received 4 units, - 11/12/14 at 7:00 am FSBS=252, documented 0 units, should have received 4 units, - 11/27/14 at 7:00 am FSBS=267, documented 0 units but should have received 4 units. Review of Resident #2's December 2014 MARs from 12/1/14 to 12/18/14 revealed: - FSBS testing was scheduled three times a day at 7:00 am, 11:00 am, and 5:00 pm. - FSBS values ranged from 91 to 334. - Documentation SSI was administered incorrectly 5 of 8 opportunities when SSI should have been administered as follows: - 12/01/14 at 7:00 am FSBS=334, documented 0 units- should have received 8 units, - 12/08/14 at 11:00 am FSBS=281, documented 5 units, should have received 4 units, - 12/11/14 at 7:00 am FSBS=250, documented 5	D 358		

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	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

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D 358	Continued From page 72 units, should have received 4 units, - 12/11/14 at 11:00 am FSBS=251, documented 5 units, should have received 4 units, - 12/17/14 at 7:00 am FSBS=260, documented 0 units but should have received 4 units. Review of Resident #2's record revealed a hemoglobin A1C lab value on 12/06/14 of 7.0. (Hemoglobin A1c test is a standard tool to determine blood sugar control in residents known to have diabetes. The American Diabetes Association (ADA) recommends a hemoglobin A1c (HgbA1c) target level of less than 7.0 in adults.) Interview on 12/22/14 at 9:00 am with a day shift medication aide revealed: -She relied on the Medication Administration Record (MAR) to determine how much insulin to administer to a resident. -She said if a resident can tell me how they feel and they are not confused, "I listen to them." -She documented the amount of insulin she actually administered to the resident on the resident MAR. -She does not document on the back of MAR or in nurse progress notes the reason for administering the insulin outside the parameters as ordered by the physician. Interview on 12/22/14 at 3:00 pm with an evening shift medication aide revealed: - Residents sometime refused medications including insulin. - She routinely documented refusals on the front of the MAR (circle initials) and tried to remember to document on the back of the MAR. - She was not sure if Resident #2 received his sliding scale according to physician orders because the documentation was not clear.	D 358		

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D 358	Continued From page 73 Telephone interview on 12/22/14 at 10:15 am with the facility Nurse Practitioner revealed: -It was her expectation that the facility would follow the insulin sliding scale parameters as ordered by the physician or contact the office if the residents were not compliant with the order. -She could not recall if the facility had contacted the office with FSBS or insulin changes for particular residents, including Resident #2. Telephone interview on 12/22/14 at 12:40 pm with the facility Registered Nurse revealed: -She was aware residents in the facility were ordered sliding scale insulin with parameters. -She was aware some residents refused the amount of insulin they were to receive and requested a different amount. -She said the facility staff was to notify the physician every time a resident requested a partial amount of insulin to be administered or refused insulin as ordered by the physician. Interviews on 12/22/14 at 12:00 pm and 3:07 pm with the Adminstrator revealed: -She was aware several residents were on sliding scale insulin with parameters as ordered by the physician. -She was not aware medication aides (MA) were administering partial dosage of insulin to the residents per the resident request. -She said the facility policy was to follow the orders the physician had written. -She assumed the MA were following the physician orders for the sliding scale insulin parameters and administering the correct amount of insulin that was ordered to the residents. Interview on 12/22/14 at 2:40 pm with the Resident Care Coordinator revealed:	D 358		

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D 358	Continued From page 74 -She was aware several residents were on sliding scale insulin with parameters. -She was aware residents were requesting partial doses of insulin be administered that were different from the sliding scale parameters ordered by the physician. -She said the facility policy was, if a resident asked for a partial dose of insulin the MAs were not to give it, they were to document refused on MAR and call the physician. -She said the MA can not administer insulin per the resident request without an order. -She said the facility had an inservice for the administration of insulin a few weeks ago. Interview on 12/22/14 at 2:30 pm with Resident #2 revealed: - He had been a diabetic for a long time. - He was aware he was receiving 2 types of insulin, one long acting and one short acting. - He received insulin both scheduled and on a sliding scale. - He sometimes refused the evening meal time insulin if his blood sugar was low (around 120 or less) because he was concerned his blood sugar would drop to low if he did not eat much of the evening meal. - He was not aware if his physician or nurse practitioner was aware of his refusals. Refer to interview on 12/18/14 at 4:25 pm with the Assistant Resident Care Coordinator. Interview on 12/18/14 at 4:25 pm with the Assistant Resident Care Coordinator revealed: - Medication Aides (MAs) were responsible to monitor the residents' MARs for incomplete documentation (holes left undocumented). - The RCC and ARC do random checks for incomplete documentation on the MARs but have	D 358		

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D 358	Continued From page 75 no system in place to monitor for notifying the prescriber for refusals. The facility provided a Plan of Protection as follows: - Residents identified with medication concerns will be reviewed to ensure medications are available per the physician's orders. - All appropriate staff will be trained with return demonstration as warranted. - Audits will be completed by the Administrator or designee for 10% of random records daily for 3 weeks, then weekly for 4 weeks, and random monthly checks thereafter. - All results will be taken to the executive Quality Assurance committee for review. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, FEBRUARY 5, 2015.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367	D 367 Medication Administration The facility failed to assure accuracy of the Medication Administration Record (MAR) for 5 of 8 residents (Residents #1, #4, #6, #7, and #9). MARS for Residents #1, #4, #6, #7 and #9 were compared to medications on the cart on 12/19/15. A QI tool "Cart Audit" was utilized by the resident care coordinator (RCC), assistant resident care coordinator (ARCC) and med tech (MT). Any discrepancies were addressed immediately.	

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D 367	Continued From page 76 medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure accuracy of the Medication Administration Record (MAR) for 5 of 8 residents (Residents #1, #4, #6, #7, and #9). The findings are: A. Review of Resident #4's current FL2 dated 03/1/14 revealed: -Diagnoses included peripheral neuropathy and chronic pain. -An order for Norco 10/325 mg tablet (A combination Opioid narcotic and acetaminophen used to treat moderate to severe pain) every six hours as needed (PRN) for pain.	D 367	100% of all other residents' MARS were compared to the medications in the medication carts on 12/19/15. A QI tool "Cart Audit" was utilized by the RCC, ARCC, and MT. Any discrepancies were addressed immediately. An inservice was completed for the medication techs titled "Accuracy of the Medication Administration Record (MAR)" on 1/22/15. A QI tool "Daily Narcotic Audit" will be used to ensure accuracy of the MAR. A 10% sampling of resident medications will be audited daily x three weeks, weekly x 3 weeks, monthly x 3 months by the administrator and or designee. The administrator and or designee will report findings to the QI committee meeting monthly for further recommendations.	2-5-15
	Interview on 12/17/14 at 9:30 am with Resident #4 revealed: -She can take the Norco 10/325 mg tablet every 6 hours PRN for her pain. -She said the facility ran out of her pain medicine often. Review of Resident #4's October 2014 Medication Administration Record (MAR) revealed: -Documentation on the MAR indicated Norco 10/325 mg tablet was administered 49 times during the month of October. -Three pages of control substance sheets with a total of 89 tablets of Norco 10/325 mg were			

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D 367	Continued From page 77 documented as signed out the month of October to Resident #4. Review of Resident #4's November 2014 MAR revealed: -Documentation on the MAR indicated Norco 10/325 mg tablet was administered 30 times during the month of November. -Three pages of control substance sheets for a total of 89 tablets of Norco 10/325 mg were documented as signed out for the month of November to Resident #4. Review of Resident #4's current December 2014 MAR revealed: -Documentation on the MAR indicated Norco 10/325 mg tablet was administered 17 times from 12/1/14 to 12/17/14. -A control substance sheet was unavailable from 12/1/14 to 12/9/14. -A control substance sheet from 12/10/14 to 12/17/14 with 29 doses of Norco 10/325 mg tablets documented as signed out to Resident #4. Observation of Resident #4's medications on hand on 12/17/14 at 3:30 pm revealed. -A pharmacy generated dispensed card with 30 dispensed Norco 10/325 mg tablets with 1 remaining tablet of Norco 10/325 with the instruction to give 1 every 6 hours as needed for pain. -Another pharmacy generated dispensed card of 30 Norco 10/325 mg tablets with 30 remaining with the instruction to give 1 every 6 hours as needed for pain. -Both labels revealed the dispensed date 12/1/14. Interview on 12/18/14 at 10:40 am with a medication aide (MA) revealed: -She said she documented on the front of the	D 367		

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D 367	Continued From page 78 MAR and the back of the MAR if a resident was requesting pain medication that was not scheduled. -She said it was the responsibility of the MAs to look over the MAR for empty spaces "holes" every shift. Interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC) revealed: -She was aware documentation on MAR was an on going problem in the facility. -She said the facility pharmacist had conducted an inservice in November 2014 for the MAs regarding proper documentation and administration of medications. -She said the facility nurse had conducted an inservice on administration and documentation of medications in October 2014. -She said the MAs should be checking the MAR every shift for empty blocks "holes". -She said when the MAs finish documenting on a control substance sheet they give it to her or the ARCC to file. -She was aware the facility did not have a current system in place for following-up the documentaion of control substance on the MAR and matching verification on the control substance count sheet. Telephone interview on 12/19/14 at 10:30 am with a second MA revealed: -She did recall signing out Norco 10/325 mg tablets for Resident #4 on the MAR and on a control substance count sheet. -She was aware that some MAs were not signing out the control substance on the MAR, they were just documenting on the control substance count sheet. -She said some of the MAs only sign out narcotics on the control substance count sheet	D 367		

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D 367	Continued From page 79 because, "we are just too busy". -She said it was the oncoming MA's responsibility to check for "holes" in the MARs. -She recently realized she was not comparing the narcotic count sheet to the accuracy of the MAR. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 12:00 pm and 3:00 pm with the ARCC (Assistant Resident Care Coordinator). Refer to interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 10:30 am with a medication aide. Refer to telephone interview on 12/19/14 at 11:45 am with the Facility Nurse. Refer to second interview with the ARCC on 12/22/2014 at 10:15 am. B. Review of Resident #9's current FL2 dated 8/1/2014 revealed: -Diagnoses included bipolar, anxiety, hypertension, chronic obstructive pulmonary disease, hepatitis C, insomnia, depression, chronic neck and back pain, history of cocaine abuse, myofascial pain syndrome, polysubstance abuse, history of suicide attempt, sciatica, urinary retention, diabetes, hyponatremia, bursitis and anemia.	D 367		

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D 367	Continued From page 80 -An order for Dilaudid 4 mg 1 tablet every 6 hours as needed for pain. (Dilaudid is a narcotic pain reliever.) Interview on 12/17/14 at 8:45 am with Resident #9, during initial facility tour, revealed: -Has had problems getting his Dilaudid medication at times, especially on 2nd and 3rd shift. -The staff told him they were out of the medication. -He called pharmacy and they told him he should have another week's supply remaining. -He had to go to the staff and remind them to give it to him. -The staff never came to him and asked if he needed it. Review of Resident #9's record revealed pharmacy dispensing records documented 120 tablets of Dilaudid 4 mg were dispensed on 10/3/2014. Review of Resident #9's Control Substance Count Sheet (CSCS) for Dilaudid 4 mg dispensed 10/3/2014 documented 60 tablets were administered from 10/7/2014 to 10/22/2014. Review of Resident #9's October 2014 MAR revealed: -An entry for Dilaudid 4 mg 1 tablet every 6 hours as needed. -From 10/8/2014-10/22/2014, there were 31 Dilaudid 4 mg tablets documented as administered to Resident #9. (29 Dilaudid 4 mg tablets from 10/8/2014-10/22/2014 signed out on the CSCS were not documented on the MAR). -No Control Substance Count Sheet was available for the additional 60 tablets dispensed on 10/3/2014.	D 367		

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D 367	Continued From page 81 Further review of the October 2014 MAR revealed: -13 Dilaudid 4 mg tablets were documented as administered from 10/22/2014-10/30/2014. Review of Resident #9's November 2014 MAR revealed: -From 11/1/2014-11/7/2014, there were 9 Dilaudid 4 mg tablets documented as administered. -No Control Substance Count Sheet was available from 10/22/2014-11/7/2014. -It could not be determined that 35 Dilaudid 4mg, dispensed on 10/3/2014, were appropriately administered or accounted for. Review of Resident #9's record revealed pharmacy dispensing records documented 120 tablets of Dilaudid 4 mg were dispensed on 10/28/2014. Review of Resident #9's Control Substance Count Sheet for Dilaudid 4 mg dispensed 10/28/2014 documented 30 tablets were administered from 11/7/2014 to 11/22/2014. Review of Resident #9's November 2014 MAR revealed: -From 11/7/2014-11/22/2014, there were 26 Dilaudid 4 mg tablets documented as administered to Resident #9. (4 Dilaudid 4 mg tablets from 11/7/2014-11/22/2014 were not correctly documented on the MAR). -It could not be determined if Resident #9 received medication as ordered. -No Control Substance Count Sheet was available for the additional 90 tablets dispensed on 10/28/2014. Continued review of the November 2014 MAR	D 367		

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D 367	Continued From page 82 from 11/23/2014-11/30/2014 revealed: - Eight Dilaudid 4 mg tablets were documented as administered. -No Control Substance Count Sheet was available from 11/22/2014-11/25/2014. -From 11/1/2014-11/7/2014, there were 9 Dilaudid 4 mg tablets documented as administered. -It could not be determined that 76 Dilaudid 4mg, dispensed on 11/3/2014, were appropriately administered or accounted for. Interview with Assistant Resident Care Coordinator (ARCC) on 12/22/2014 at 10:15 am revealed: -She was unaware of where the missing control substance logs were for 10/23/2014-11/6/2014 and 11/22/2014- 11/25/2014. -She was not aware of Resident #9 running out of Dilaudid 4mg. -She knew that Resident #9 received it regularly every 6 hours because he sat his alarm clock to remind him to ask for it. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 12:00 pm and 3:00 pm with the ARCC (Assistant Resident Care Coordinator). Refer to interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 10:30 am with a medication aide.	D 367		

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D 367	Continued From page 83 Refer to telephone interview on 12/19/14 at 11:45 am with the Facility Nurse. Refer to second interview with the ARCC on 12/22/2014 at 10:15 am. C. Review of Resident #6's current FL2 dated 7/16/14 revealed: -Diagnoses included generalized anxiety, chronic pain, and chronic hepatitis C. 1. Record review revealed a physician's order for Klonopin 0.5mg twice daily as needed (Klonopin is used to treat anxiety disorders). Review of the October 2014 Medication Administration Record (MAR) revealed: -An entry for Klonopin 0.5mg take 1 tablet twice daily as needed. -Documentation of Klonopin 0.5 mg administered 16 times from 10/01/14 to 10/31/14. -No documentation of Klonopin 0.5 mg administered on 8 days on the MAR. -There were a total of 15 Klonopin 0.5 mg tablets documented as administered from 10/01/14 to 10/31/14. Review of the Controlled Substance Count Sheet from 10/02/14 to 10/16/14 revealed: -A total of 30 Klonopin 0.5 mg tablets were received on 9/26/14. -Documentation of Klonopin 0.5 mg administered 24 times between 10/02/14 to 10/16/14. -There were a total of 30 Klonopin 0.5 mg tablets documented as administered from 10/02/14 to 10/16/14. -There was no Controlled Substance Count Sheet available for 10/17/14 to 10/26/14. Review of the November 2014 MAR revealed:	D 367		

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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
D 367	Continued From page 84 -An entry for Klonopin 0.5mg take 1 tablet twice daily as needed. -Documentation of Klonopin 0.5 mg administered 21 times from 11/01/14 to 11/30/14. -No documentation of Klonopin administered on 11 days on the MAR. -There were a total of 21 Klonopin 0.5 mg tablets documented as administered from 11/01/14 to 11/30/14. Review of the Controlled Substance Count Sheet from 10/27/14 to 11/11/14 revealed: -A total of 60 Klonopin 0.5 mg tablets were received on 10/24/14. - Documentation of Klonopin administered twice daily from 10/27/14 to 11/11/14. -There were a total of 30 Klonopin 0.5 mg tablets documented as administered from 10/27/14 to 11/11/14. Review of the Controlled Substance Count Sheet from 11/12/14 to 11/28/14 revealed: -A total of 30 Klonopin 0.5 mg tablets were received on 11/08/14. -Documentation of Klonopin 0.5 mg administered 30 times between 11/12/14 to 11/28/14. -There were a total of 30 Klonopin tablets documented as administered from 11/12/14 to 11/28/14. Review of the December 2014 MAR revealed: -An entry for Klonopin 0.5mg take 1 tablet twice daily as needed. -Documentation of Klonopin 0.5 mg administered 17 times from 12/01/14 to 12/17/14. -No documentation of Klonopin administered on 12/01/14, 12/04/14, 12/12/14, and 12/14/14. -There were a total of 15 Klonopin 0.5 mg tablets documented as administered from 12/01/14 to 12/17/14.	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 85 Review of the Controlled Substance Count Sheet from 11/29/14 to 12/11/14 revealed: -A total of 30 Klonopin 0.5 mg tablets received on 11/27/14. -Documentation of Klonopin 0.5 mg administered 30 times between 11/29/14 to 12/11/14. -There were a total of 30 Klonopin 0.5 mg tablets documented as administered from 11/29/14 to 12/11/14. Review of the Controlled Substance Count Sheet from 12/12/14 to 12/18/14 revealed: -There were a total of 13 Klonopin 0.5mg tablets documented as administered from 12/12/14 to 12/18/14. Observation of medications on hand on 12/18/14 at 2:00 pm revealed: -Klonopin 0.5 mg was available for administration, and labeled with Resident #6's name. -There were 16 tablets remaining of 30 tablets dispensed on 11/22/14. Interview on 12/18/14 at 8:30 am with Resident #6 revealed: -He had resided at the facility for about 1 year. -He was aware of the medications he received. -He only received Klonopin 0.5.mg as needed twice a day. -He never received the Klonopin 0.5 mg more than twice a day. -He usually requested 1 Klonopin 0.5mg during the day and again 1 more time before bedtime. -He received Klonopin 1 mg 3 times each day at scheduled times, so there was no need for him to request the Klonopin 0.5 mg more often than twice a day. Interview on 12/18/14 at 4:00 pm with the	D 367		

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D 367	Continued From page 86 Assistant Resident Care Coordinator (ARCC) revealed: -All narcotics have to be reordered from a physician's prescription. -Only standing medications were sent from the contract pharmacy on an auto fill cycle. -Resident #6 had 2 Klonopin orders, one for Klonopin 1mg three times a day and the Klonopin 0.5mg as needed two times a day. -He only received the as needed Klonopin (0.5 mg) when he asked for it. -Not sure why Klonopin 0.5 mg administered to Resident #6 on the Controlled Substance Count Sheets did not reflect the accurate administration dates and times on the MARs. -The MAs were supposed to document on the MARs every time prn (as needed) medications were given. Telephone interview on 12/22/14 at 9:30 am with a third shift medication aide (MA) revealed: -Sometimes she would administer Klonopin 0.5 mg to Resident #6 after 12:00 midnight, and it would be counted for the next day. -Resident #6 was supposed to receive Klonopin 0.5 mg twice a day as needed. -She did not pay attention to when the resident last received Klonopin 0.5 mg, she would just give it to him when he asked for it. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 12:00 pm and 3:00 pm with the ARCC (Assistant Resident Care Coordinator).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 87 Refer to interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 10:30 am with a medication aide. Refer to telephone interview on 12/19/14 at 11:45 am with the Facility Nurse. Refer to second interview with the ARCC on 12/22/2014 at 10:15 am. 2. Review of Resident #6's current FL2 dated 7/16/14 revealed a physician's order for Ultram 50 mg 1 tablet every 6 hours as needed for chronic pain. Review of the October 2014 Medication Administration Record (MAR) revealed: -An entry for Ultram 50 mg take 1 tablet every 6 hours as needed. -There were a total of 20 Ultram 50 mg tablets documented as administered from 10/01/14 to 10/31/14. Review of the November 2014 MAR revealed: -An entry for Ultram 50 mg take 1 tablet every 6 hours as needed. -There were a total of 11 Ultram 50 mg tablets documented as administered from 11/01/14 to 11/30/14. Review of the Controlled Substance Count Sheet from 10/29/14 to 11/19/14 revealed: -There were a total of 19 Ultram 50 mg tablets documented as administered from 10/29/14 to 11/19/14. -There were no additional Controlled Substance Count Sheets for Ultram 50 mg available for	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 88 review. Observation of medications on hand on 12/18/14 at 2:00 pm revealed: -Ultram 50mg was available for administration, and labeled with Resident #6's name. -There were 11 tablets remaining of 30 tablets dispensed on 08/29/14. -There were 3 bingo punch cards (total of 90 tablets) with a dispense date on 11/12/14 available stored in a file cabinet in the Resident Care Coordinator's office. Interview on 12/18/14 at 8:45 am with Resident #6 revealed: He had lived at the facility for about 1 year. -He was aware of the medications he was administered. -He could not recall the last time he was administered Ultram 50 mg. -He had not taken the Ultram in the last "2 or 3" of months. Interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC) revealed: -All narcotics have to be reordered from a physician's prescription. -Only standing medications were sent from the contract pharmacy on an auto fill cycle. -Not sure what happened to the missing Controlled Substance Count Sheets for Resident #6's Ultram. -Not sure why Ultram 50 mg administered to Resident #6 on the Controlled Substance Count Sheets did not reflect the accurate administration dates and times on the MARs. -The MAs were supposed to document on the MARs every time prn (as needed) medications were given.	D 367		

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D 367	Continued From page 89 Telephone interview on 12/19/14 at 10:25 am with a second shift medication aide revealed: -Resident #6 had not requested the Ultram 50 mg at night. -The resident had not been administered the Ultram 50 mg since November 2014. -Resident #6 received a new pain medication prescription that worked better for him. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 12:00 pm and 3:00 pm with the ARCC (Assistant Resident Care Coordinator). Refer to interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 10:30 am with a medication aide. Refer to telephone interview on 12/19/14 at 11:45 am with the Facility Nurse. Refer to second interview with the ARCC on 12/22/2014 at 10:15 am. D. Review of Resident #7's current FL-2 dated 05/01/14 revealed diagnoses included diabetes, anemia, asthma, and edema. Review of Resident #7's record revealed a physician's order for Hydrocodone/APAP 5/325 one tablet every 4 hours as needed for pain.	D 367		

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D 367	Continued From page 90 [Hydrocodone/APAP 5/325 is a combination of hydrocodone (a narcotic pain reliever) and acetaminophen used to treat moderate to severe pain.]. Telephone interview on 12/22/14 at 10:00 am with the pharmacy provider revealed: - Resident #7 was dispensed 120 Hydrocodone/APAP 5/325 tablets on 09/27/14. - No controlled medication had been returned to the pharmacy for Resident #7. Review of Resident #7's October 2014 and November 2014 Medication Administration Records (MARs) and facility Controlled Substance Count Sheets (CSCS) revealed the following: - Hydrocodone/APAP 5/325 one tablet every 4 hours as needed for pain was listed on the October 2014 MAR and prn (as needed) listed for administration time. - The MAR had 16 doses of Hydrocodone/APAP 5/325 documented on the front (for administration) of the MAR and 15 doses documented on the back (for effectiveness) of the MAR from 10/6/14 to 10/31/14. - The CSCS documentation for Hydrocodone/APAP 5/325 revealed 41 tablets were documented as administered to Resident #7 from 10/6/14 to 10/31/14. - Comparison of the October 2014 MAR and CSCS sheet revealed administration of 25 doses of Hydrocodone/APAP 5/325 tablets was not documented on Resident #7's MAR from 10/6/14 to 10/31/14. - No reason or justification for the administration of Hydrocodone/APAP 5/325 as needed and documentation for the resulting effect on the resident was documented for 25 doses.	D 367		

Division of Health Service Regulation

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D 367	Continued From page 91 Review of Resident #7's November 2014 MAR and facility CSCS revealed the following: - Hydrocodone/APAP 5/325 one tablet every 4 hours as needed for pain was listed on the November 2014 MAR and prn (as needed) listed for administration time. - The MAR had 10 doses of Hydrocodone/APAP 5/325 documented on the front (for administration) of the MAR and 10 doses documented on the back (for effectiveness) of the MAR from 11/01/14 to 11/30/14. - The CSCS documentation for Hydrocodone/APAP 5/325 revealed 30 tablets were documented as administered to Resident #7 from 11/01/14 to 11/30/14. - Comparison of the November 2014 MAR and CSCS sheet revealed administration of 20 doses of Hydrocodone/APAP 5/325 that were not documented on Resident #7's MAR from 11/01/14 to 11/30/14. - No reason or justification for the administration of Hydrocodone/APAP 5/325 as needed and documentation for the resulting effect on the resident was documented for 20 doses.	D 367		
	Review of Resident #7's December 2014 MAR and facility Controlled Substance Count Sheets (CSCS) revealed the following: - Hydrocodone/APAP 5/325 one tablet every 4 hours as needed for pain was listed on the December 2014 MAR and prn (as needed) listed for administration time. - The MAR had 10 doses of Hydrocodone/APAP 5/325 documented on the front (for administration) of the MAR and 10 doses documented on the back (for effectiveness) of the MAR from 12/01/14 to 12/17/14. - The CSCS documentation for Hydrocodone/APAP 5/325 revealed 15 tablets were documented as administered to Resident #7			

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D 367	Continued From page 92 from 12/01/14 to 12/17/14. - Comparison of the November 2014 MAR and CSCS sheet revealed administration of 5 doses of Hydrocodone/APAP 5/325 were not documented on Resident #7's MAR from 12/01/14 to 12/17/14. - No reason or justification for the administration of Hydrocodone/APAP 5/325 as needed and documentation for the resulting effect on the resident was documented for 5 doses. Observation on 12/17/14 of Resident #7's Hydrocodone/APAP 5/325 on hand for administration revealed a full bingo card of 30 tablets plus 4 tablets remaining on a partial card in the medication cart. Interview on 12/18/14 at 10:40 am with a day shift medication aide revealed: - She documented on the front and the back of the MAR when she administered pain medication that were not a scheduled medication for the resident. - The pharmacy delivered medcations and narcotics to medication aides as well as the Resident Care Coordinator (RCC). - The facility policy was staff signed for all control substances. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 12:00 pm and 3:00 pm with the ARCC (Assistant Resident Care Coordinator).	D 367		

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D 367	Continued From page 93 Refer to interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 10:30 am with a medication aide. Refer to telephone interview on 12/19/14 at 11:45 am with the Facility Nurse. Refer to second interview with the ARCC on 12/22/2014 at 10:15 am. E. Review of Resident #1's current FL2 dated 10/07/14 revealed: -Diagnoses included bipolar affective disorder, anxiety disorder, depression, chronic low back pain and osteoarthritis. 1. Medication orders on the FL2 dated 10/07/14 included: -Klonopin 1mg three times daily as needed (PRN) for anxiety. Review of the October 2014 Medication Administration Record (MAR) revealed: -Klonopin 1mg take 1 tablet three times a day as needed for anxiety was documented on the MAR administered 34 times from 10/01/14 to 10/31/14. -Documentation on the back of the MAR revealed: -20 entries did not document if the medication was effective. Review of the Controlled Substance Count Sheet from 10/01/14 to 10/16/14 (no sheets for 10/17/14 to 10/31/14) revealed: -Staff documented the administration of Klonopin 1mg 37 times between 10/01/14 through 10/16/14. -16 entries on the Controlled Substance Count	D 367		

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D 367	Continued From page 94 Sheet were not documented on the MAR. Review of the November 2014 MAR revealed: -An entry for Klonopin 1mg take 1 tablet three times a day as needed for anxiety. -Staff documented the administration of Klonopin 1mg 30 times from 11/01/14 to 11/30/14. -Documentation on the back of the MAR revealed: -6 entries did not document if the medication was effective. Review of the Controlled Substance Count Sheet from 11/09/14 to 11/30/14 revealed: -Staff documented the administration of Klonopin 1mg 56 times between 11/09/14 through 11/30/14. -29 entries on the Controlled Substance Count Sheet were not documented on MAR. Review of the December 2014 MAR revealed: -Klonopin 1mg take 1 tablet three times a day as needed for anxiety was documented administered 23 times from 12/01/14 to 12/17/14. -Documentation on the back of the MAR revealed: -17 entries did not document the medication was effective. Review of the Controlled Substance Count Sheet from 12/01/14 to 12/17/14 revealed: -Staff documented the administration of Klonopin 1mg 47 times between 12/01/14 through 12/17/14. -24 entries on the Controlled Substance Count Sheet were not documented on MAR. Based on MARs and the Controlled Substance Count Sheet it was revealed: -In October 2014 Klonopin 1mg was administered	D 367		

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D 367	Continued From page 95 36 times without proper PRN documentation. -In November 2014 Klonopin 1mg was administered 35 times without proper PRN documentation. -In December 2014 Klonopin 1mg was administered 41 times without proper PRN documentation. 2. Medication orders on the current FL2 dated 10/07/14 included: -Ultram 50mg 2 tablets every 8 hours (three times daily) as needed (PRN) for pain. Review of the October 2014 Medication Administration Record (MAR) revealed: -Ultram 50mg take 2 tablet =100mg every 8 hours as needed for pain was documented on the MAR administered 36 times from 10/01/14 to 10/31/14. -Documentation on the back of the MAR revealed: -17 entries did not document the effectiveness of the medication. Review of the Controlled Substance Count Sheet from 10/04/14 to 10/26/14 revealed: -Staff documented the administration of Ultram 100mg 60 times between 10/01/14 through 10/26/14. -35 entries on the Controlled Substance Count Sheet were not documented on the MAR. Review of the November 2014 MAR revealed: -Ultram 50mg take 2 tablets every 8 hours as needed for pain was documented on the MAR administered 30 times from 11/01/14 to 11/30/14. -Documentation on the back of the MAR revealed: -6 entries did not document the effectiveness of the medication.	D 367		

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D 367	Continued From page 96 Review of the Controlled Substance Count Sheet from 11/06/14 to 11/29/14 revealed: -Staff documented the administration of Ultram 100mg 60 times between 11/06/14 through 11/29/14. -36 entries on the Controlled Substance Count Sheet were not documented on the MAR. Review of the December 2014 MAR revealed: -Ultram 50mg take 2 tablets every 8 hours as needed for pain was documented administered 19 times from 12/01/14 to 12/17/14. -Documentation on the back of the MAR revealed: -17 entries did document the effectiveness of the medication. Review of the Controlled Substance Count Sheet from 12/03/14 to 12/17/14 revealed: -Staff documented the administration of Ultram 100mg 39 times between 12/01/14 through 12/17/14. -20 entries on the Controlled Substance Count Sheet were not documented on the MAR. Based on MAR documentation and the Controlled Substance Count Sheet it was revealed: -In October 2014 Ultram 50mg 2 tablets was administered 52 times without proper PRN documentation. -In November 2014 Ultram 50mg 2 tablets was administered 42 times without proper PRN documentation. -In December 2014 Ultram 50mg 2 tablets was administered 37 times without proper PRN documentation. Interview on 12/19/14 at 10:35 am with a medication aide revealed: -It was the facility requirement that medication	D 367		

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D 367	Continued From page 97 aides document as needed medication as follows: -Initial the front of the MAR. -Write on the back of the MAR, the date, time, the medication name, reason, and the effect of the medication. -Staff on each shift was to check and ensure proper PRN documentation was done. -They checked to ensure PRN documentation on the MAR included: staff initials on the front, documentation on the back (date, time, staff initials, medication name, dosage, and effective of the medication) of the MAR. -She admits to not being able to always do PRN documentation because sometimes she was rushed to medications administered. -When she checked PRN documentation for medications such as Klonopin or Ultram behind co-workers she only looked for initials on the front of the MAR and did not check the back of the MAR. -She did not check documentation on the controlled substance sheet to ensure it matched the MAR. -Most times when administering controlled substance medications she only documented on the controlled substance sheet because she was always rushed and did not have time to document on the MAR. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 12:00 pm and 3:00 pm with the ARCC (Assistant Resident Care Coordinator).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

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D 367	Continued From page 98 Refer to interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 10:30 am with a medication aide. Refer to telephone interview on 12/19/14 at 11:45 am with the Facility Nurse. Refer to second interview with the ARCC on 12/22/2014 at 10:15 am. Review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist revealed a notation in the comment section MAR documention PRN reason, route, timing, and effectiveness were missing some documentation. Interview on 12/18/14 at 12:15 pm with the RCC revealed: -She was aware documentation of controlled substance was an on-going problem in the facility. -She had identified that some medication aides were not doing proper PRN medication documentation. -She requested an in-service to try and help staff remember to do PRN medication documentation. -Each shift was to check behind each other to ensure proper PRN medication documentation. -Staff knew that documentation had to be in two places on the MAR and on the controlled substance sheet. -She trusted staff to do their job and she did not check behind them. -The facility pharmacist had conducted an in-service in November 2014 for the MAs regarding proper documentation and	D 367		

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D 367	Continued From page 99 administration of medications. -The facility did not have a current system in place for reviewing control substance on the MAR and then matching it to the control substance count sheet. Interview on 12/18/14 at 12:00 pm and 3:00 pm with the ARCC (Assistant Resident Care Coordinator) revealed: - She was aware the MAs (medication aides) were documenting control substance incorrectly on the MAR. - The facility had several meetings to discuss clarification and accuracy of the MAR's. - The ARCC and the RCC were responsible to maintain control drug storage and distribution. - Medication Aides were responsible to check behind the outgoing shift for omissions of documentation on the MARS. Telephone interview on 12/19/14 at 10:30 am with a medication aide revealed: -She was aware that some MA's were not signing out the control substance on the MAR, they were just documenting on the control substance count sheet. -She said some of the MA's only sign out narcotics on the control substance count sheet because, "we are just too busy". -She said it was the oncoming MA's responsibility to check for "holes" in the MAR's. -She recently realized she was not comparing the narcotic count sheet to the accuracy of the MAR. Interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant revealed: -She found some issues and concerns related to documentation of narcotics last month (November 2014) during the pharmacy review at the facility.	D 367		

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D 367	Continued From page 100 -The facility administration was aware of the concerns related to documentation had contacted her to conduct an in-service on documentation of narcotics. -She completed the in-service in November 2014. Telephone interview on 12/19/14 at 11:45 am with the facility Registered Nurse revealed: -She worked in the facility 3 days a week. -She was aware for about 3 months the MAs were documenting medications incorrectly on the MAR's. -She completed an inservice on medication administration and documentation in adult care homes for the MAs and facility staff on 10/15/14 as well as on 12/4/14 -She said the facility recently hired new nursing staff and also changed the nurse station area. Second interview with the ARCC on 12/22/2014 at 10:15 am revealed: -She was aware theMAs were documenting administration of controlled substance incorrectly on the MAR. -The facility had several meetings and inservices to discuss clarification and accuracy of the MARs. -She was unaware of where the missing Controlled Substance Count Sheets for Resident #6 were at. -She attempted to locate the missing Controlled substance Count Sheets, but could not find them.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These	D 392	D 392 Controlled Substances Type B Violation Controlled Substances-Readily, Retrievable Records	

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D 392	Continued From page 101 records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record of controlled substances for the receipt, administration and disposition of the controlled substances for 6 of 8 sampled residents (Residents #1, #3, #4, #6, #7, and #9) with orders for controlled substances including narcotic pain medications and narcotic anxiety medications. The findings are: A. Review of Resident #6's current FL2 dated 7/23/14 revealed: -Diagnoses included generalized anxiety, chronic pain, and chronic hepatitis C. 1. Record review revealed a physician's order for Klonopin 0.5mg twice daily as needed (prn) (Klonopin is used to treat anxiety disorders). Review of the October 2014 Medication Administration Record (MAR) revealed: -An entry for Klonopin 0.5mg take 1 tablet twice daily as needed. -Documentation of Klonopin 0.5 mg administered 16 times from 10/01/14 to 10/31/14. Review of Resident #6's Controlled Substance Count Sheet from 10/02/14 to 10/16/14 revealed: -A total of 30 Klonopin 0.5 mg tablets was dispensed on 9/26/14. -Documentation of Klonopin 0.5 mg administered	D 392	Narcotic Availability Revision 1/13/15 Management has ensured that new locked drawers have been added to each medication cart to allow for sufficient storage space for all of the facility's narcotics to be placed in the appropriate medication cart. Narcotics will no longer be placed in the brown box in the medication room or in the black filing cabinets in the RCC(Resident Care Coordinator) office. Management has ensured the new process is as follows: When narcotics are delivered to the facility, a medication technician compares the delivery sheet to the medications that are delivered. The narcotic counts are verified with two signatures and then are placed in the appropriate medication carts in the locked narcotic drawers. The declining inventory sheets are completely filled out with the correct identifiers and placed in the narcotic count notebook. The number of narcotic sheets count will be changed during the next shift	

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D 392	Continued From page 102 24 times between 10/02/14 to 10/16/14. -There was no Controlled Substance Count Sheet available for 10/17/14 to 10/26/14. Review of the November 2014 MAR revealed: -An entry for Klonopin 0.5mg take 1 tablet twice daily as needed. -Documentation of Klonopin 0.5 mg administered 21 times from 11/01/14 to 11/30/14. Review of the Controlled Substance Count Sheet from 10/27/14 to 11/11/14 revealed: -A total of 60 Klonopin 0.5 mg tablets was dispensed on 10/24/14. -Documentation of Klonopin 0.5 mg administered 30 times between 10/27/14 to 11/11/14. Review of the Controlled Substance Count Sheet from 11/12/14 to 11/28/14 revealed: -A total of 30 Klonopin 0.5 mg tablets were received on 11/08/14. -Documentation of Klonopin 0.5 mg administered 30 times between 11/12/14 to 11/28/14. Review of the December 2014 MAR revealed: -An entry for Klonopin 0.5mg take 1 tablet twice daily as needed. -Documentation of Klonopin 0.5 mg administered 17 times from 12/01/14 to 12/17/14. Review of the Controlled Substance Count Sheet from 11/29/14 to 12/11/14 revealed: -A total of 30 Klonopin 0.5 mg tablets was dispensed on 11/27/14. -Documentation of Klonopin 0.5 mg administered 30 times between 11/29/14 to 12/11/14. Review of the Controlled Substance Count Sheet from 12/12/14 to 12/18/14 revealed: -Documentation of Klonopin 0.5 mg administered	D 392	count to reflect the delivery of new narcotics. The delivery sheets are then placed in the RCC/ARCC (Assistant Resident Care Coordinator) box located in the 100 hall nurse's station. Each weekday morning the RCC and or ARCC will compare the delivery sheets to the narcotics in the narcotic drawers and to the declining inventory sheet to verify all new narcotics are available and secured. The delivery sheet will then be placed in a notebook in the RCC office for narcotic sheet reconciliation. Each zeroed out narcotic sheet will be removed from the narcotic count book by the RCC/ ARCC/MT (Med Tech) and will be placed with the original delivery sheet until all sheets have been zeroed out. After all the narcotic sheets have been reconciled with the original delivery sheet, they will be placed in each resident's personal file folder. The filing cabinets which contain each resident's file folders have been relocated to the RCC office. Empty narcotic containers will be destroyed per HIPAA standards at the facility by the RCC, ARCC, or MT.	

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D 392	Continued From page 103 13 times between 12/12/14 to 12/18/14. Review of the facility Narcotic Cabinet Sign IN/OUT sheet for control substance located in the narcotic storage file cabinet revealed no documentation Klonopin 0.5 mg for Resident #6 had been signed in or out. Observation of medications on hand for Resident #6 on 12/18/14 at 2:00 pm revealed: -Klonopin 0.5 mg was dispensed on 11/22/14 with 16 tablets remaining of 30 tablets dispensed. -There were no additional Klonopin 0.5 mg for Resident #6 located in the facility. Review of faxed information from the contract pharmacy on 12/18/14 revealed: -Klonopin 0.5 mg 60 tablets were dispensed on 10/24/14. -Klonopin 0.5 mg 60 tablets were dispensed on 11/22/14. According to the October, November and December 2014 Controlled Substance Count Sheets, and dispensing records for Klonopin 0.5 mg from 10/24/14 to 12/17/14, a total of 62 tablets of Klonopin 0.5 mg were unaccounted for. Interview on 12/18/14 at 8:30 am with Resident #6 revealed: -He had resided at the facility for about 1 year. -He was aware of the medications he received. -He only received Klonopin 0.5 mg as needed twice a day. -He never received the Klonopin 0.5 mg more than twice a day. Telephone interview on 12/22/14 at 9:30 am with a third shift medication aide (MA) revealed: -Sometimes she would administer Klonopin 0.5	D 392	Management has ensured any discrepancies will be immediately addressed with the administrator and pharmacist. The administrator and or ARCC will continue a narcotic documentation and reconciliation audit form to ensure compliance. The audit will be completed for 10% of random charts daily X three weeks, then weekly X four weeks and random monthly checks thereafter. All results will be taken to the executive QI committee for review.	2-5-15

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D 392	Continued From page 104 mg to Resident #6 after 12:00 midnight, and it would be counted for the next day. -Resident #6 was supposed to receive Klonopin 0.5 mg twice a day as needed. -She did not pay attention to when the resident last received Klonopin 0.5 mg, she would just give it to him when he asked for it. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 10:40 am with a Medication Aide. Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse. 2. Review of Resident #6's current FL2 dated 7/16/14 revealed a physician's order for Ultram 50 mg 1 tablet every 6 hours as needed for chronic pain. Review of the October 2014 Medication Administration Record (MAR) revealed: -An entry for Ultram 50 mg take 1 tablet every 6 hours as needed. -Documentation of Ultram 50 mg administered 20 times from 10/01/14 to 10/31/14. Review of the November 2014 MAR revealed:	D 392		

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D 392	Continued From page 105 -An entry for Ultram 50 mg take 1 tablet every 6 hours as needed. -Documentation of Ultram 50 mg administered 9 times from 11/01/14 to 11/30/14. Review of the Controlled Substance Count Sheet from 10/29/14 to 11/19/14 revealed: -Documentation of Ultram 50 mg administered 19 times between 10/29/14 to 11/19/14. -There were no additional Controlled Substance Count Sheets for Ultram 50 mg available for review. Review of the December 2014 MAR revealed: -An entry for Ultram 50 mg take 1 tablet every 6 hours as needed. -No documentation Ultram 50 mg was administered from 12/01/14 to 12/17/14. Review of the facility Narcotic Cabinet Sign IN/OUT sheet for control substance located in the narcotic storage file cabinet revealed no documentation Ultram 50 mg for Resident #6 had been signed in or out. Observation of medications on hand for Resident #6 on 12/18/14 at 2:00 pm revealed: -Ultram 50mg was dispensed on 08/29/14 with 11 tablets remaining of 30 tablets dispensed. -There were 3 bingo punch cards (30 tablets each for a total of 90 tablets) with a dispense date on 11/12/14 stored in a file cabinet in the Resident Care Coordinator's office. Review of faxed information from the contract pharmacy on 12/18/14 revealed: -Ultram 50 mg 120 tablets were dispensed on 11/12/14. According to the October, November and	D 392		

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D 392	Continued From page 106 December 2014 Controlled Substance Count Sheets, and dispensing records for Ultram 50 mg from 11/12/14 to 12/17/14, a total of 30 tablets of Ultram 50 mg were unaccounted for. Interview on 12/18/14 at 8:45 am with Resident #6 revealed: He had lived at the facility for about 1 year. -He was aware of the medications he was administered. -He could not recall the last time he was administered Ultram 50 mg. Telephone interview on 12/19/14 at 10:25 am with a second shift medication aide revealed: -Resident #6 had not requested the Ultram 50 mg at night. -The resident had not been administered the Ultram 50 mg since November 2014. -Resident #6 received a new pain medication prescription that worked better for him. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to interview on 12/18/14 at 10:40 am with a Medication Aide. Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse.	D 392		

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D 392	Continued From page 107 B. Review of Resident #4's current FL2 dated 03/1/14 revealed: -Diagnoses included chronic pain and peripheral neuropathy. -An order for Norco 10/325 mg tablets (a combination Opioid narcotic with acetaminophen used to treat moderate to severe pain) every six hours as needed (PRN) for pain. Interview on 12/17/14 at 9:30 am and on 12/19/14 at 10:10 am with Resident #4 revealed: -She had lived at the facility for 9 years. -She was very familiar with her medications and was able to identify each one she took. -She said the facility ran out of her pain medication often. -She was aware her Norco 10/325 mg tablet was administered PRN four times a day for pain control. -She had all over body pain every day. -She usually asked for her Norco 10/325 mg tablet 3 times a day, maybe 4 times. -She said some of the Medication Aides (MA) acted mad when she asked for her pain medication. -She said two weeks ago she asked for her Norco tablet and was told by a MA she was out of pain medication and would need to wait till Monday until the pharmacy opened to get her medication. -The facility was out of her Norco for a few days the first part of December 2014. -She said the MA administered her another resident pain medication a Norco 5/325 mg tablet. -She had taken the Norco 5/325 mg tablet one time, but it did not help her pain. -She is not aware of the documentation the facility used to document the administration of her medications. -The resident said she called her friend (contact	D 392		

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D 392	Continued From page 108 person) and told her she was out of Norco, her pain medicine. Review of Resident #4's October 2014 Medication Administration Record (MAR) revealed: -Documentation on the MAR indicated Norco 10/325 mg tablets was administered 49 times during the month of October. -Three pages of control substance sheets with a total of 89 tablets of Norco 10/325 mg were documented as signed out during the month of October to Resident #4. Review of Resident #4's November 2014 MAR revealed: -Documentation on MAR indicated Norco 10/325 mg tablets was administered 30 times during the month of November. -Three pages of control substance sheets for the month of November for 89 tablets of Norco 10/325 mg were documented as signed out to Resident #4. Review of Resident #4's current December 2014 MAR revealed: -Documentation on the MAR indicated Norco 10/325 mg tablets was administered 17 times from 12/1/14 to 12/17/14. -A control record for recording the Norco 10/325 mg (including the date of administration, quantity administered, and quantity remaining) was not maintained by the facility from 12/1/14 to 12/9/14. -A control substance sheet was available from 12/10/14 to 12/18/14 with 29 doses of Norco 10/325 mg documented as administered to Resident #4. Observation of Resident #4's medications on hand on 12/17/14 at 3:30 pm revealed:	D 392		

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D 392	Continued From page 109 -A pharmacy generated dispensed card indicating 30 tablets of Norco 10/325 mg tablets were dispensed with a remaining count of 1 Norco 10/325 mg remaining. -Another pharmacy generated dispensed card with 30 tablets of Norco 10/325 remained for dispensing. -Both labels revealed the dispensed dated 12/1/14. -In the medication room a locked narcotic box on wall contained no additional Norco 10/325 mg for Resident #4. -The locked control substance file cabinet in the Resident Care Coordinator (RCC) office contained no additional pharmacy generated cards of Norco 10/325 mg tablets for Resident #4. Review of the facility Narcotic Cabinet Sign IN/OUT sheet for control substance located in the narcotic file cabinet revealed: -There was no documentation that narcotics were signed in nor out for Resident #4 before 11/24/14. -Documentation on 12/1/14 three pharmacy generated dispensed cards of Norco 10/325 mg for a total of 90 tablets were signed in for Resident #4. -Documentaion on 12/5/14 that 30 Norco 10/325 mg tablets were signed out to Resident #4. -Documention on 12/15/14 that 30 Norco 10/325 mg tablets were signed out to Resident #4. -No other documentation that Norco 10/325 mg tablets were signed in or out on the Narcotic Cabinet Sign in/out sheet. Telephone interview on 12/17/14 at 4:15 pm with the facility dispensing pharmacist revealed: -He had dispensed 120 Norco 10/325 mg tablets on 9/27/14, 11/3/14, and on 12/1/14 to the facility for Resident #4.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1808 N CANNON BOULVARD, KANNAPOLIS, NC 28083

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D 392	Continued From page 110 -The order was for Norco 10/325 mg tablets, take 1 every 6 hours as needed for pain. Review of the facility's Consolidated Delivery Sheet from the contract pharmacy revealed the pharmacy dispensed 120 tablets of Norco 10/325 mg on 9/27/14, 11/3/14 and 12/1/14 for Resident #4. Interview on 12/18/14 at 12:00 pm with the ARCC revealed: -She was aware the MAs were documenting control substance incorrectly on the MAR. -The facility had several meetings to discuss clarification and accuracy of the MAR. -She was aware the readily retrievable records (Control Substance Records) were not completely filled out with the quantity received, dispensed dates, and prescription number for the narcotics. -She was unaware a readily retrievable record for the accountability for Resident #4's control substance Norco 10/325 mg tablets was missing from 12/1/14 to 12/9/14. -She said the MAs bring the control substance count sheet to her or the RCC when it was completed and they file the control substance sheet for 2 or 3 years. Interview on 12/18/14 at 12:15 pm with the RCC revealed: -She recalled pharmacy delivering Norco 10/325 mg tablets for Resident #4 on 12/1/14. -She recalled documenting 90 Norco 10/325 mg tablets and placing them into the locked narcotic file cabinet in her office. -She recalled giving a MA a pharmacy generated dispensed card of 30 Norco 10/325 mg tablets for Resident #4 on 12/1/14. -She can not recall which MA she gave the Norco 10/325 mg tablet pharmacy dispense card to nor	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 111 does she have documentation of the transaction. -She said the policy was to obtain 2 signatures for transactions of narcotics from the locked file cabinet to the MAs. -She had initated the Narcotic Cabinet Sign IN/OUT sheet the end of November 2014 due to some residents in the facility were prescribed stronger control substance. Telephone interview on 12/18/14 at 4:30 pm with Resident #4's contact person revealed: -She visited Resident #4 two or three times a week. -She said Resident #4 was very familiar with the medications she took. -She said Resident #4 called her and said the facility was out of her pain medication and offered her another residents pain medication which was a Norco 5/325 mg. -She had spoken to the MA and the Supervisor in Charge (SIC) to ask why Resident #4's pain medication was not in the facility and who was in charge of ordering the medications. -She spoken to the administrator to discuss Resident #4 being without her pain medication. -She said the administrator contacted the physician for a hard scrip for the Norco 10/325 mg for Resident #4. Telephone interview on 12/19/14 at 10:30 am with the Medication Aide revealed: -She did recall Resident #4 being without Norco 10/325 mg tablet the first part of December 2014. -She did recall borrowing a Norco tablet from another resident to administer to Resident #4 the first of December 2014 due to Resident #4 being out of her Norco 10/325 mg tablet. -She said she borrowed a Norco 10/325 mg tablet from another resident to to give Resident #4. -She did recall getting a second signature due to	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 112 borrowing a narcotic from another resident. -She did recall signing out the Norco 10/325 mg tablet for Resident #4 on the MAR and on a control substance count sheet when she administered the Norco to Resident #4. -She was unaware a control substance record was unavailable for the Norco 10/325 mg from 12/1/14 to 12/9/14. -She said the MAs count the control substance on the medication carts every shift. Interview on 12/19/14 at 5:00 pm with the ARCC revealed: -She was aware Resident #4 was out of Norco 10/325 mg tablets on November 30th 2014. -She was aware MAs were borrowing Norco tablets from another resident to administer to Resident #4 -She called the pharmacy December 1, 2014 to inquire when the Norco 10/325 mg tablets were to be delivered to the facility. -She thought it took 3 days to get the Norco 10/325 mg tablets to the facility for Resident #4. -She did not sign the Norco 10/325 mg into the facility nor into the locked narcotic file cabinet. -She was not aware a readily retrievable record (control substance record) for the accountability of the Norco 10/325 (including date of administration, quantity administered and quantity remaining) was not maintained by the facility from 12/1/14 to 12/9/14. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Refer to interview on 12/18/14 at 10:40 am with the Medication Aide. Refer to interview on 12/18/14 at 12:15 pm with	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 113 the RCC. Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse. C. Review of Resident #3's current FL2 dated 5/29/2014 revealed: -Diagnoses included psychosis, bipolar, hypertension, and hyperlipidemia. -An order for Xanax 1 mg scheduled at 8:00am and 2:00pm. -An order for Xanax 0.5 mg given at 8:00 pm (Xanax is used to treat anxiety). Interview on 12/17/2014 at 3:50 pm with Resident #3 revealed: -She was administered Xanax 1 mg at 8:00am and 2:00pm and Xanax 0.5 mg at 8:00 pm. -The facility ran out of her Xanax 1mg and they began utilizing the Xanax 0.5 mg, giving her 2 tabs for the 8:00am and 2:00pm dose. -"It's rare that you get everything". -She made the Administrator aware by asking her "why am I even here if I can't get my medicines like I am supposed to get". -She was told by the Resident Care Coordinator (RCC) and Assistant Resident Care Coordinator (ARCC) that the medication tote did not come in from pharmacy. -She then called the pharmacy herself and they told her that it had never been ordered by the primary care physician for refill. "-It's not right that I have to tell them when I am	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 114 out and it's time for a refill". Review of the Xanax 0.5 mg Controlled Substance Count Sheet for the months of October, November and December 2014 revealed: -In October 2014, there were 2 tabs signed out on 8 separate occurrences. -In November 2014, there were 2 tabs signed out on 5 separate occurrences. -In December 2014, there were 2 tabs signed out on 5 separate occurrences. Review of Resident #3's October 2014 Medication Administration Record (MAR) revealed: -An entry for Xanax 1 mg scheduled for administration at 8:00am and 2:00pm. -Documentation Xanax 1 mg was administered 62 times during the month of October 2014 without documented omissions. -Controlled Substance Count Sheets for Xanax 1 mg were found to be missing on dates 10/6/2014-10/31/2014. Further review of Resident #3's October 2014 MAR revealed: -An entry for Xanax 0.5 mg scheduled for administration at 8:00pm. -Xanax 0.5 mg was documented as administered 31 times during the month of October 2014. -Controlled Substance Count Sheets for Xanax 0.5 mg were found to be missing on dates 10/10/2014-10/31/2014. Review of Resident #3's November 2014 MAR revealed: -An entry for Xanax 1 mg scheduled for administration at 8:00am and 2:00pm. -Xanax 1 mg was documented as administered	D 392		

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D 392	Continued From page 115 60 times during the month of November 2014 without documented omissions. -Controlled Substance Count Sheets for Xanax 1 mg were found to be missing on dates 11/1/2014-11/16/2014. Further review of the November 2014 MAR revealed: -An entry for Xanax 0.5 mg scheduled for administration at 8:00pm. -Xanax 0.5 mg was documented as administered 30 times during the month of November. -Controlled Substance Count Sheets for Xanax 0.5 mg were found to be missing on dates 11/1/2014-11/2/2014. Review of Resident #3's December 2014 MAR revealed: -An entry for Xanax 1 mg scheduled for administration at 8:00am and 2:00pm. -Xanax 1 mg was documented as administered 35 times during the month of December 2014 without documented omissions. -Controlled Substance Count Sheets for Xanax 1 mg were found to be missing on dates 12/5/2014-12/15/2014. Further review of the December 2014 MAR revealed: - Xanax 0.5 mg was documented as administered 17 times during the month of December. -Controlled Substance Count Sheets for Xanax 0.5 mg were found to be missing on dates 12/7/2014-12/12/2014. Observation of Resident #3's medications on hand on 12/18/14 at 10:30 am revealed: -A bingo punch card with a tablet count of 55 of Xanax 1 mg with a correct count and dispensed date of 12/15/2014.	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 116 -Another bingo punch card with the tablet count of 13 of Xanax 0.5 mg. The dispense date was 12/11/2014. Interview with the Resident Care Coordinator on 12/19/2014 at 4:15 pm revealed: -They have had to borrow because another resident ran out of their Xanax for a "few days". -There is not documentation that the medication was borrowed or returned. -We just try to remember to give it back to the resident when the other resident's control substance is delivered. -We are working on a process to track the changes when we borrow control substances from another resident. -She was unaware that Resident #3 was out of her Xanax 1 mg or 0.5 mg. -Unsure of where the missing control sheets are for Xanax 1 mg during the dates of 10/6/2014-11/16/2014, and 12/5/2014-12/15/2014. -Unsure of where the missing control sheets are for Xanax 0.5 mg during the dates of 10/10/2014-11/2/2014 and 12/7/2014-12/12/2014. -The process is when the MA's finish documenting on a control substance sheet they give it to her or the ARCC to file in their office. -She was aware the facility did not have a current system in place to follow-up the signing out of control substances on the MAR and the matching verification on the control substance count sheet. -The facility pharmacist had conducted an inservice in November 2014 for the MA's regarding proper documentation and administration of medications. -The facility nurse had conducted an inservice on administration and documentation of medications in November 2014.	D 392		

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D 392	Continued From page 117 Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Refer to interview on 12/18/14 at 10:40 am with a Medication Aide. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse. D. Review of Resident #9's current FL2 dated 8/1/2014 revealed: -Diagnoses included bipolar, anxiety, hypertension, chronic obstructive pulmonary disease, hepatitis C, insomnia, depression, chronic neck and back pain, history of cocaine abuse, myofascial pain syndrome, polysubstance abuse, history of suicide attempt, sciatica, urinary retention, diabetes, hyponatremia, bursitis and anemia. -An order for Dilaudid 4 mg 1 tablet every 6 hours as needed for pain. (Dilaudid is a narcotic pain reliever.) Interview on 12/17/14 at 8:45 am with Resident #9 during initial facility tour, revealed: -Has had problems getting his Dilaudid medication at times, especially on 2nd and 3rd shift. -The staff told him they were out of the medication.	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED R 12/22/2014

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D 392	Continued From page 118 -He called pharmacy and they told him he should have another week's supply remaining. -He had to go to the staff and remind them to give it to him. -The staff never came to him and asked if he needed it. Review of Resident #9's pharmacy dispensing logs documented #120 Dilaudid 4 mg were dispensed for Resident #9 on 10/3/2014. Review of Resident #9's facility control substance count sheet (CSCS) for Dilaudid 4 mg dispensed 10/3/2014 documented 60 tablets were administered from 10/7/2014 to 10/22/2014. Review of Resident #9's October 2014 Medication Administration Record (MAR) revealed: -An entry for Dilaudid 4 mg 1 tablet every 6 hours as needed. -From 10/8/2014-10/22/2014, there were 31 Dilaudid 4 mg tablets documented as administered to Resident #9. (29 Dilaudid 4 mg tablets from 10/8/2014-10/22/2014 signed out on the CSCS were not documented on the MAR). -No control substance count sheet was available for the additional 60 tablets dispensed on 10/3/2014. Further review of the October 2014 MAR revealed 13 Dilaudid 4 mg tablets were documented as administered from 10/22/2014-10/30/2014. Review of the November 2014 MAR revealed: -From 11/1/2014-11/7/2014, there were 9 Dilaudid 4 mg documented as administered. -No control substance count sheet was available from 10/22/2014-11/7/2014.	D 392		

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D 392	Continued From page 119 -It could not be determined that 35 Dilaudid 4mg, dispensed on 10/3/2014, were appropriately administered or accounted for. Review of Resident #9's record revealed pharmacy dispensing records documented #120 Dilaudid 4 mg were dispensed for Resident #9 on 10/28/2014. Review of Resident #9's facility control substance count sheet for Dilaudid 4 mg dispensed 10/28/2014 documented 30 tablets were administered from 11/7/2014 to 11/22/2014. Review of Resident #9's November 2014 MAR revealed: -From 11/7/2014-11/22/2014, there were 26 Dilaudid 4 mg tablets documented as administered to Resident #9. (4 Dilaudid 4 mg tablets from 11/7/2014-11/22/2014 were not correctly documented on the MAR). -It could not be determined if Resident #9 received medication as ordered. -No control substance count sheet was available for the additional 90 tablets dispensed on 10/28/2014. Continued review of the November 2014 MAR from 11/23/2014-11/30/2014 revealed: - Eight Dilaudid 4 mg tablets were documented as administered. -No control substance count sheet was available from 11/22/2014-11/25/2014. -From 11/1/2014-11/7/2014, there were 9 Dilaudid 4 mg tablets documented as administered. -It could not be determined that 76 Dilaudid 4mg, dispensed on 11/3/2014, were appropriately administered or accounted for. Interview with Assistant Resident Care	D 392		

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D 392	Continued From page 120 Coordinator (ARCC) on 12/22/2014 at 10:15 am revealed: -She was aware the Medication Aides (MAs) were documenting control substance incorrectly on the MAR. -The facility had several meetings and inservice to discuss clarification and accuracy of the MARs. -She was unaware of where the missing control substance logs were for 10/23/2014-11/6/2014 and 11/22/2014- 11/25/2014. -She was not aware of Resident #9 running out of Dilaudid 4mg. -She knew that Resident #9 received it regularly every 6 hours because he set his alarm clock to remind him to ask for it. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Refer to interview on 12/18/14 at 10:40 am with a Medication Aide. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse. E. Review of Resident #7's current FL-2 dated 05/01/14 revealed diagnoses included diabetes, anemia, asthma, and edema.	D 392		

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D 392	Continued From page 121 1. Review of Resident #7's record revealed a physician's order dated 07/13/31 for Ultracet 37.5/325 by mouth 3 times a day. (Ultracet 37.5/325 is a combination of tramadol and acetaminophen used to treat mild to moderate pain.) Telephone interview on 12/22/14 at 10:00 am with the pharmacy provider revealed: - The following dispensing dates for Ultracet 37.5/325 for Resident #7; On 10/21/14 a total of 90 tablets were dispensed, and on 11/21/14 a total of 90 tablets were dispensed. - No controlled medication had been returned to the pharmacy for Resident #7. Review of Resident #7's October and November 2014 Medication Administration Records (MARs) and facility Controlled Substance Count Sheets (CSCS) revealed the following: - Ultracet 37.5/325 one tablet 3 times a day was listed on the October 2014 MAR and scheduled for administration at 6:00 am, 2:00 pm and 8:00 pm. - Two doses were documented on the MAR as administered on 10/22/14. - Resident #7 was in the hospital from 10/22/14 to 10/25/14. - Resident #7 received 19 doses documented on the October MAR from 10/25/14 to 10/31/14. - No CSCS was available for tracking administration and disposition of Ultracet 37.5/325 from 10/25 to 11/03/14 (a total of 30 doses not tracked on a CSCS). Review of Resident #7's November 2014 MARs and facility CSCS revealed the following: - Ultracet 37.5/325 one tablet 3 times a day was listed on the November 2014 MAR and scheduled for administration at 6:00 am, 2:00 pm and 8:00	D 392		

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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
D 392	Continued From page 122 pm. - Resident #7 received 9 doses documented on the November MAR from 11/01/14 to 11/03/14. - No CSCS was available for tracking administration and disposition of Ultracet 37.5/325 from 10/25 to 11/03/14 (a total of 30 doses not tracked on a CSCS). Review of Resident #7's November and December 2014 MARs and CSCS for Ultracet 37.5/325 revealed: - Documentation of administration on the MARs and CSCS for the remaining 60 tablets from the dispensing of 90 on 10/21/14. - Documentation of administration on the MARs and CSCS for the 90 tablets from the dispensing of 77 on 11/21/14 and documentation for 13 tablets that remained on hand on 12/19/14. Based on observation and attempted interview on 12/17/14 and 12/22/14, Resident #7 was determined not to be interviewable. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Refer to interview on 12/18/14 at 10:40 am with a Medication Aide. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45	D 392		

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	HAL080003		R 12/22/2014

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D 392	Continued From page 123 am with the facility nurse. 2. Review of Resident #7's FL-2 dated 05/01/14 revealed a physician's order for Ativan 1 mg 3 times a day (Ativan is used to treat anxiety.) Telephone interview on 12/22/14 at 10:00 am with the pharmacy provider revealed: - The following dispensing dates for Ativan 1 mg for Resident #7; on 10/13/14 a total of 90 tablets were dispensed, and on 11/14/14 a total of 90 tablets were dispensed. - No controlled medication had been returned to the pharmacy for Resident #7. Review of Resident #7's October and November 2014 Medication Administration Records (MARs) and facility Controlled Substance Count Sheets (CSCS) revealed: - Ativan 1mg one tablet 3 times a day was listed on the October 2014 MAR and scheduled for administration at 6:00 am, 2:00 pm and 8:00 pm. - Resident #7 received 19 doses of Ativan 1 mg from 10/16/14 to 10/22/14. - Resident #7 was in the hospital from 10/22/14 to 10/25/14. - Resident #7 received 19 doses of Ativan 1 mg documented on the October MAR from 10/25/14 to 10/31/14. - No CSCS was available for tracking administration and disposition for 60 tablets of Ativan 1 mg (quantity of 90 dispensed on 10/13/14) from 10/16/14 to 11/08/14. A total of 60 doses were not tracked on a CSCS. Review of Resident #7's November 2014 MARs and facility CSCS revealed the following: - Ativan 1mg one tablet 3 times a day was listed on the October 2014 MAR and scheduled for administration at 6:00 am, 2:00 pm and 8:00 pm.	D 392		

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D 392	Continued From page 124 - Resident #7 received 22 doses of Ativan 1 mg documented on the November 2014 MAR from 11/01/14 to 11/08/14. - No CSCS was available for tracking administration and disposition for 60 tablets of Ativan 1 mg (quantity of 90 dispensed on 10/13/14) from 10/16/14 to 11/08/14. A total of 60 doses were not tracked on a CSCS. Continued review of Resident #7's November and December 2014 MARs and CSCS revealed documentation for administration on the MAR and tracking of disposition for the Ativan 1 mg dispensed by the pharmacy on 11/14/14. Based on observation and attempted interview on 12/17/14 and 12/22/14, Resident #7 was determined not to be interviewable. Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Refer to interview on 12/18/14 at 10:40 am with a Medication Aide. Refer to interview on 12/18/14 at 12:15 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse. F. Review of Resident #1's current FL2 dated	D 392		

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D 392	Continued From page 125 10/07/14 revealed: -Diagnoses included bipolar affective disorder, anxiety disorder, depression, chronic low back pain and osteoarthritis. 1. Medication orders on the FL2 dated 10/07/14 included: -Klonopin 1mg three times daily as needed for anxiety. Review of the October 2014 Medication Administration Record (MAR) revealed: -An entry for Klonopin 1mg take 1 tablet three times a day as needed (PRN) for anxiety. -Staff documented the administration of Klonopin 1mg 34 times from 10/01/14 to 10/31/14. Review of the Controlled Substance Count Sheet from 10/01/14 to 10/16/14 revealed: -Staff documented the administration of Klonopin 1mg 37 times between 10/01/14 through 10/16/14. -21 of the 37 entries matched documentation on the resident's MAR. -There were no Controlled Substance Count Sheets available for 10/17/14 to 10/31/14 to compare with the MAR. Review of the November 2014 MAR revealed: -Klonopin 1mg take 1 tablet three times a day as needed for anxiety was printed on the MAR. -Staff documented the administration of Klonopin 1mg 30 times from 11/01/14 to 11/30/14. Review of the Controlled Substance Count Sheet from 11/09/14 to 11/30/14 revealed: -Staff documented the administration of Klonopin 1mg 56 times between 11/09/14 through 11/30/14. -27 of the 56 entries matched documentation on	D 392		

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D 392	Continued From page 126 the resident's MAR. -There were no Controlled Substance Count Sheets available for 11/01/14 through 11/08/14 to compare with the MARs. Review of the December 2014 MAR revealed: -Klonopin 1mg take 1 tablet three times a day as needed for anxiety was printed on the MAR. -Staff documented the administration of Klonopin 1mg 23 times from 12/01/14 to 12/17/14. Review of the Controlled Substance Count Sheet from 12/01/14 to 12/17/14 revealed: -Staff documented the administration of Klonopin 1mg 47 times between 12/01/14 through 12/17/14. -23 of the 47 times matched documentation on the resident's MAR. Review of the facility Narcotic Cabinet Sign IN/OUT sheet for control substance revealed: -A quantity of 30 Klonopin 1mg was signed out on 11/27/14. -No documentation Klonopin 1mg was signed any other date. Observation on 12/18/14 at 10:32 am of Resident #1's medications on hand at the facility revealed: -Klonopin 1mg was available for administration. -The medication was labeled with Resident #1's name. -There were 15 tablets remaining of bubble packed 30 tablets dispensed on 11/17/14. Observation on 12/18/14 at 10:30 am of the narcotic overflow locked "brown box" revealed: -No Klonopin was in the overflow box for Resident #1. Review of the faxed "Patient statement" sheet	D 392		

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D 392	Continued From page 127 from the contract pharmacy on 12/18/14 revealed: -Klonopin 1mg was dispensed on 09/08/14 for a quantity of 90, 10/15/14 for quantity of 90, and on 11/17/14 for a quantity of 90, total 270. Based on October, November 2014 and December 2014 MARs, Controlled Substance Count Sheet and "Patient statement" sheet from the pharmacy it was determined the total Klonopin 1mg unaccounted for was 69. Refer to Control Substance Documentation Inspection completed on 11/17/14. Interview on 12/18/14 at 11:10 am with the pharmacy revealed: -Klonopin was not on automatic refill. -The facility had to request a refill of the medication. -They dispensed Klonopin for a quantity of 90 on 09/08/14, 10/15/14, and 11/17/14. -As of today's date no medication had been sent back to the facility. -Facility documentation should account for all medication dispensed. Interview on 12/19/14 at 8:40 am with Resident #1 revealed: -He lived at the facility a little over one year. -He shared a room with his wife. -The medication aides at the facility administered all his medications. -Klonopin was ordered to help with anxiety. -He did not need or received the medication every day. -He sometimes forget to ask about the medication because a lot of times he did not need the medication. -Some medication aides asked if he wanted the	D 392		

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D 392	Continued From page 128 medication. -If he said no, they would come back later and ask again, but most medication aides did not ask at all. -Staff did not administer Klonopin to him daily. -Sometimes he got the medication twice daily in the morning and in the evening, but never more than that. -At the most Klonopin was administered to him 3-4 days per week. Interview on 12/19/14 at 10:35 am with Staff E (Medication Aide) revealed: -If Resident #1 does not get Klonopin he becomes agitated with other residents and staff. -Resident #1 routinely asked for Klonopin and "someone" at the facility was trying to get the order changed from as needed (PRN) to routine. -She was unaware who or how long "someone" had been working on getting the Klonopin changed to routine. -The facility's process for the administration of PRN controlled medications was to document with initials on the front of MAR, reasons with effect on the back of the MAR, and then document on the controlled substance sheet. -It was also the facility's policy that medication aides were to check behind co-workers to ensure PRN medication process was accurately followed. -They checked to ensure the MAR was initialed on the front, documentation on the back (date, time, staff initials, medication name, dosage, and effective of the medication) of the MAR. -When she checked PRN documentation for medications such as Klonopin behind co-workers she only looked for initials on the front of the MAR and did not check the back of the MAR. -She did not check documentation on the controlled substance sheet to ensure it matched	D 392		

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D 392	Continued From page 129 the MAR. -Most times when administering controlled substance medications she only documented on the controlled substance sheet because she was always rushed and did not have time to document on the MAR. -If there was no documentation on the controlled substance sheet then the medication was not administered. -She did not know what could have happened to Resident #1's missing dosages of Klonopin. Refer to interview on 12/18/14 at 10:40 am with Staff C Medication Aide. Refer to interview on 12/18/14 at 12:15 pm with the RCC. Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse. 2. Medication orders on the current FL2 dated 10/07/14 included: -Ultram 50mg 2 tablets every 8 hours (three times daily) as needed (PRN) for pain. Review of the October 2014 Medication Administration Record (MAR) revealed: -Ultram 50mg take 2 tablet =100mg every 8 hours as needed for pain was printed on the MAR. -Staff documented the administration of Ultram 100mg 36 times from 10/01/14 to 10/31/14. Review of the Controlled Substance Count Sheet	D 392		

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D 392	Continued From page 130 from 10/04/14 to 10/26/14 revealed: -Staff documented the administration of Ultram 100mg 60 times between 10/01/14 through 10/26/14. -25 of the 60 times did matched MAR documentation. -There were no Controlled Substance Count Sheets available for 10/01/14 to through 10/03/14 and 10/27/14 through 10/31/14 to compare with the MARs. Review of the November 2014 MAR revealed: -Ultram 50mg take 2 tablets every 8 hours as needed for pain was printed on the MAR. -Staff documented the administration of Ultram 100mg 30 times from 11/01/14 to 11/30/14. Review of the Controlled Substance Count Sheet from 11/06/14 to 11/29/14 revealed: -Staff documented the administration of Ultram 100mg 60 times between 11/06/14 through 11/29/14. -24 of the 60 times did matched MAR documentation. -There were no Controlled Substance Count Sheets available for 11/01/14 through 11/06/14 and 11/30/14 to compare with the MARs. Review of the December 2014 MAR revealed: -Ultram 50mg take 2 tablets every 8 hours as needed for pain was printed on the MAR. -Staff documented the administration of Ultram 100mg 19 times from 12/01/14 to 12/17/14. Review of the Controlled Substance Count Sheet from 12/03/14 to 12/17/14 revealed: -Staff documented the administration of Ultram 100mg 39 times between 12/01/14 through 12/17/14. -19 of the 39 times did matched MAR	D 392		

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D 392	Continued From page 131 documentation. Review of the facility Narcotic Cabinet Sign IN/OUT sheet for control substance revealed: -A quantity of 90 Ultram 100mg was signed out on 12/01/14. -A quantity of 30 Ultram 100mg was signed out on 12/03/14. Observation on 12/18/14 at 10:32 am of Resident #1's medications on hand at the facility revealed: -Ultram 50mg 2 tablets (=100mg) was available for administration. -The medication was labeled with Resident #1's name. -There were 38 tablets (19 days) remaining of the 60 tablets dispensed on 11/28/14. Observation on 12/18/14 at 10:30 am of the narcotic overflow locked "brown box" revealed: -1 pack of 60 tablets, a 30-day supply of Ultram was available in the overflow box for Resident #1. -The dispensing date on the prescription label was 11/28/14. Review of the faxed "Patient statement" sheet from the contract pharmacy on 12/18/14 revealed: -Ultram 50mg 2 tablets every 8 hours was dispensed on 09/16/14 for a quantity of 180 tablets, 10/21/14 for quantity of 180 tablets, and on 11/28/14 for a quantity of 180 tablets, totaling dosage 270. Based on October, November 2014 and December 2014 MARs, Controlled Substance Count Sheet and Patient statement from the pharmacy it was determined the total Ultram 100mg unaccounted for was 42.	D 392		

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D 392	Continued From page 132 Refer to review of the Control Substance Documentation Inspection completed on 11/17/14. Interview on 12/18/14 at 11:10 am with the pharmacy revealed: -Ultram 50mg 2 tablets every 8 hours was not on automatic refill. -The facility requested a refill of the medication on 09/16/14, 10/21/14, and 11/28/14. -Each time the medication was dispensed for a quantity of 180 tablets for 30 day supply. -According to their records no Ultram had been returned to the pharmacy. Interview on 12/19/14 at 8:40 am with Resident #1 revealed: -He lived at the facility a little over one year. -He had chronic back pain. -The only pain medication ordered for him was Ultram. -He did not know what the medication looked like. -He was able to ask for the medication when his back was hurting. -The medication aides at the always administered Ultram with Klonopin. -Most of the time he forgot to ask for the medication because he did not need the medication. -He did not get the medication daily because his back did not hurt daily. -The medication was administered at the most once daily. -Seldom did he ask for the medication twice daily Interview on 12/19/14 at 10:35 am with Staff E, (Medication Aide) revealed: -Resident #1 was able to tell her when he was in pain and he knew to ask for pain medication. -Resident #1's Ultram was always administered	D 392		

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D 392	Continued From page 133 with Klonopin. -She did not know why, but thought one made the other work better. -Resident #1 did not ask for Ultram daily. -She was unaware what could have happened to the missing dosages of Ultram. Refer to interview on 12/18/14 at 10:40 am with a Medication Aide. Refer to interview on 12/18/14 at 12:15 pm with the RCC. Refer to interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant. Refer to telephone interview on 12/19/14 at 11:45 am with the facility nurse. --- Review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist revealed: -Control drug declining count sheet were incomplete with missing counts and missing codes. -Control drug shift change forms some were incomplete with missing signatures. -MAR documentation for PRN reason, route, timing, and effectiveness was missing some documentation. -Control drug shift change form for accurate documentation of number of sheets was documented as "NO" with missing counts noted on the comment section.	D 392		

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D 392	Continued From page 134 Interview on 12/18/14 at 10:40 am with a Medication Aide revealed: -She was employed at the facility since May 2104. -She documented on the front and the back of the MAR when she administered pain medication that was not a scheduled medication to the resident. -The pharmacy delivered medications and narcotics to MAs as well as the Resident Care Coordinator (RCC). -It was the facility policy to sign for all controlled medications. -If the controlled medication was not needed on the medication cart, they were placed in the drop box which was located in the medication room. -The invoice was signed by two MAs and secured to the controlled medication with a rubber band before placed into the brown drop box. -The brown drop box had a slot on top of the box where staff placed the controlled medications. -Only the RCC and the Assistance Resident Care Coordinator (ARCC) had a key to the brown drop box. -If the RCC or the ARCC were in the facility, the MAs could give the controlled medications to them to secure in the locked narcotic file cabinet located in their office. Interview on 12/18/14 at 12:15 pm with the RCC revealed: -She was aware documentation of controlled substance was an on-going problem in the facility. -She said the facility pharmacist had conducted an inservice in November 2014 for the MAs regarding proper documentation and administration of medications. -She said she conducted an inservice on 10/9/14 on medication and narcotic sheet documentation. -She was aware the facility did not have a current system in place for reviewing control substances	D 392		

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D 392	Continued From page 135 on the MAR and then matching it to the control substance count sheet. Interview on 12/18/14 at 4:00 pm with the Assistant Resident Care Coordinator (ARCC) revealed: -She had been employed at the facility for 1 year. -All narcotics have to be reordered from a physician's prescription. -Only standing medications were sent from the contract pharmacy on an auto fill cycle. -The ARCC was not sure what happened to the missing Controlled Substance Count Sheets for residents. Telephone interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant revealed: -She found some issues and concerns related to documentation of narcotics last month (November 2014) during the pharmacy review at the facility. -The facility administration was aware of the concerns related to documentation and had contacted her to conduct an in-service on documentation of narcotics. -She completed the in-service in November 2014. Telephone interview on 12/19/14 at 11:45 am with the Facility Nurse revealed: -She worked in the facility 3 days a week. -She said she was unaware of any issues with documentation of narcotics until a few months ago. -She completed an inservice on the administration and documentation of medications in adult care homes for the MAs and facility staff in October 2014 and December 2014. -She said the facility had new nursing staff and had also changed the nurse station area.	D 392		

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	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

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D 392	Continued From page 136 The facility provided a Plan of Protection as follows: -Immediately, all residents identified with medication concerns will be reviewed to ensure medications are available per the physician's orders. -Count sheets have been reconciled and corrected with 2 witness; to ensure counts are accurate. -All residents' medications have been audited to count sheets and medication cards have bee reconciled to ensure counts are accurate. -All appropriate staff will be trained on the following process: -When narcotics are delivered, the medication aide on duty will verify the medications with the correct counts compared to the delivery sheets located in the delivery totes. -Two signatures will be required to verify the narcotic counts are correct. -The delivery sheet will be signed and placed in the RCC box in the medication room. - Any narcotics received will be placed on the medication cart and entered on the count sheet to ensure continued accuracy. -When a resident's narcotic needs replacing, the RCC and/or designee will remove the zeroed out narcotic sheet from the control book along with the empty narcotic container from the medication cart narcotic drawer. -The RCC and/or designee will then put a new numbered narcotic sheet with each blister pack, bottle, box, or narcotic on the resident's medication cart. -The zeroed out narcotic sheet/empty blister pack, bottle, or box will be taken to the RCC office by the RCC and or designee. -The narcotic sheet will then be stapled to the delivery sheet in the secured locked narcotic	D 392		

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D 392	Continued From page 137 cabinet inventory book for the black file cabinet. -The empty narcotic container will be sent to the pharmacy by the RCC and/or designee. -The RCC or designee will verify that the narcotics have been placed in the cart and that each packet has a numbered sign in sheet. -A copy of the delivery sheet will be placed in the secured locked narcotic cabinet inventory book for the black file cabinet and the remaining narcotics will be placed in the secured, locked black file cabinet in the RCC office. -A controlled substance declining inventory sheet will also be completed for each corresponding container that has been delivered. -The Administrator will complete a narcotic documentation and reconciliation audit form to ensure compliance. -The audit will be completed for 10% of random records daily times 3 weeks, then weekly times 4 weeks, and random monthly checks thereafter. -All results will be taken to the executive Quality Assurance committee for review. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, February 5, 2015.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and	D912	D 912 Declaration of Residents' Rights The facility will ensure every resident receives care and services which are adequate, appropriate, and in compliance with rules and regulations as related to infection prevention, medication administration, controlled substance, and management of facilities.	

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D912	Continued From page 138 interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to infection control prevention, medication administration, controlled substance, and management of facilities. The findings are: 1. Based on observation, interview and record review, the facility failed to assure adequate and appropriate infection control measures were implemented for blood glucose monitoring regarding the use of shared glucometers for 5 of 6 residents with orders for glucose monitoring. (Residents #2, #10, #12, #13, and #14.) [Refer to Tag 932 G.S. 131D-4.4A(b) (Type B Violation)]. 2. Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 2 of 7 sampled residents (Residents #7 and #8), including pain medication, anti-anxiety, acid reflux, anti-psychotic, and antifungal medications, and 2 of 2 sampled residents with physician's orders for sliding scale insulin (Resident #2 and #7). [Refer to Tag 0358 10A NCAC 13F .1004(a) (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record of controlled substances for the receipt, administration and disposition of the controlled substances for 6 of 8 sampled residents (Residents #1, #3, #4, #6, #7, and #9) with orders for controlled substances including narcotic pain medications and narcotic anxiety medications. [Refer to Tag 0392 10A NCAC 13F .1008(a) (Type B Violation)].	D912	An inservice was initiated for facility staff on 12/19/14 on "Residents' Rights" by the administrator. 100% of facility staff will be inserviced on "Resident's Rights". An inservice "Residents' Rights" was given by Patricia G Cowan, Ombudsman on 12/22/14. A second inservice on "Residents' Rights" is scheduled for 1/27/15. Any staff who are not in attendance will be inserviced by the administrator utilizing the Ombudsman's inservice materials. The facility has implemented an "Employee File Audit" to ensure Residents' Rights training has been completed. The bookkeeper will audit all new hires for completion of "Residents' Rights" training on an ongoing basis. The bookkeeper will report any findings to the monthly QI meeting on a monthly basis x 3 months for further recommendations. 100% of facility staff will be inserviced on the Residents' Rights to receive care and services related to infection prevention, medication administration, controlled substance, and management	

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D912	Continued From page 139 4. Based on observations, interviews and record reviews, the facility failed to assure all care and services were provided by management to residents in accordance with all applicable local, state, and federal regulations and codes. [Refer to Tag 0183 10A NCAC 13F .0603(a) (Type B Violation)].	D912	of facilities. The inservice will be initiated on 1/22/15 by the administrator and or assistant resident care coordinator. The inservice will include: (1) adequate and appropriate infection control measures regarding blood glucose monitoring and glucometers, (2) administration of medications and insulin, (3) proper filing of controlled substance documentation, (4) facility management will ensure all care and services are provided by the facility to residents in accordance with all applicable local, state, and federal regulations and codes.	2-5-15
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff	D932	D 932 Infection Prevention Requirements Type B To abate the violation the facility completed a 100% review FL-2's for diagnosis of diabetics with Hep C and HIV. 100% of all glucometers were disinfected per manufacturer guidelines. Additional glucometers were received on 12/18/14. The facility will monitor disinfecting of shared glucometers with a QI Auditing Tool. 100% of med techs were inserviced on disinfecting glucometers	

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D932	Continued From page 140 with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure adequate and appropriate infection control measures were implemented for blood glucose monitoring regarding the use of shared glucometers for 5 of 6 residents with orders for glucose monitoring. (Residents #2, #10, #12, #13, and #14.) The findings are: Based on interview with the Resident Care Coordinator on 12/17/14, the facility had 29 residents receiving finger stick blood sugar checks. Review of the records (FL2s) for residents' receiving finger stick blood sugars revealed 2 of the 29 residents had a blood borne pathogen disease listed on their diagnoses (One with Hepatitis C and One with Human	D932	with returned demonstration by the facility RN. The facility has three glucometers on each medication cart: one clean, one being disinfected, and one ready for use. No medication tech was allowed to do blood sugar checks until inserviced by facility RN. Resident care coordinator and or designee will review Disinfecting Glucometer QI auditing tool daily x 3 weeks, then randomly weekly x 4 weeks, then ongoing monthly, any issues identified will be immediately corrected. The resident care coordinator and or designee reviews of the Disinfecting Glucometer QI auditing tool will be reviewed monthly QI meeting to ensure the system is working. The quarterly executive QI meeting will review findings and make recommendations for updates as needed.	2-5-15 AW

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D932	Continued From page 141 Immunodeficiency Virus). Based on the Center for Disease Control (CDC) guidelines for infection control, the recommendations are that blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list the disinfection information, the glucometer should not be shared between residents. Review of the facility's written Cleaning and Disinfection of Glucometers Policy included recommendations provided for guidance for cleaning and decontamination of glucometers that may be contaminated with blood and body fluids as follows: - Clean glucometer surface when visible blood or bloody fluids are present by wiping with a cloth dampened with soap and water to remove any visible organic material. - If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal or HBV/HIV label claim or a dilute bleach solution of 1:10 to 1:100 concentration. Telephone interview on 12/17/14 at 1:39 pm with a representative of the manufacturer for the Brand A glucometer revealed the glucometer was approved for use on multiple residents if properly disinfected, according to the manufacturer of the disinfectant's direction, with an EPA approved germicidal wipe. Telephone interview on 12/17/14 at 1:55 pm with	D932		

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D932	Continued From page 142 a representative of the manufacturer for the Brand B glucometer revealed the glucometer was recommended for single use only; not approved for use on multiple residents. (Based on manufacturer's guidelines the Brand B glucometer should not be shared.) Observation on 11/17/14 at 11:18 am of Staff D, day shift Medication Aide, revealed: - She was working on a medication cart (Cart C) on the 100 Hall. - She was assisted by the Assistant Resident Care Coordinator (ARCC). - A resident was sitting in a wheel chair beside the medication cart. - The ARCC wrapped a Brand A glucometer in a wipe and placed it one top of a small stack of white paper towels on the right hand side of the top of the medication cart. - The ARCC prepared an insulin injection and administered to the resident. Continued observation of the cart revealed an opened box of (Brand Name) germicidal disposable wipe: The 2 minute germicidal wipe / Bactericidal-tuberculocidal - Virucidal - Hepatitis B Virus. (The manufacturer's direction were to use a wipe to thoroughly wet the surface, use as many as necessary to maintain the surface visibly wet for 2 minutes; allow to air dry.) Interview on 12/17/14 at 11:19 am with Staff D and the RCC revealed: - The resident had just received a finger stick blood sugar check. - The FSBS was obtained using the glucometer wrapped in the wipe. - The glucometer (Brand A) used was identified as belonging to a roommate of the resident in the wheel chair.	D932		

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D932	Continued From page 143 - Staff D stated the resident in the wheelchair did not have a glucometer of his own. - Staff were using other residents' glucometers to obtain FSBS checks for the resident in the wheel chair and any other resident that did not have their own glucometer. - Staff used the wipes to disinfect the glucometers prior to use on a different resident. Observation on 12/17/14 between 11:30 am and 12:15 pm of the glucometers stored on the medication carts in the facility revealed 19 glucometers stored as follows: - Cart A had 5 Brand A glucometers labeled with a resident's name and stored in separate zip-loc bags labeled with the residents' name. - Cart B had 2 Brand A glucometers labeled with a resident's name and stored in separate zip-loc bags labeled with the residents' name. - Cart C had 6 Brand A glucometers labeled with a resident's name and stored in separate zip-loc bags labeled with the residents' name. - Cart D had 4 Brand A glucometers labeled with a resident's name and stored in separate zip-loc bags labeled with the residents' name. - Cart E had 2 Brand A glucometers labeled with a resident's name and stored in separate zip-loc bags labeled with the residents' name. A. On 12/17/14 at 1:20 pm the Resident Care Coordinator (RCC) provided 5 Brand B glucometers (residents' name removed). Interview with the RCC on 12/17/14 at 1:20 pm revealed: - The Brand B glucometers were the remaining stock of the previous glucometers used by the facility. - She stated the glucometers were not currently being used by the facility but were used prior to	D932		

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D932	Continued From page 144 residents receiving new glucometers in September 2014. - She stated the facility had not disposed of the glucometers but were not currently using them. 1. Review of the history of FSBS values stored in one of the Brand B glucometers (not approved for use on multiple residents) revealed: - No resident's name was located on the glucometer. - Time and date could not be verified as set correctly. - Multiple FSBS values obtained within a short period of time. - Examples of the reading stored in the memory of the glucometer were as follows: On 11/12 at 4:21 pm FSBS=165, On 11/12 at 4:17 pm FSBS=157, On 11/12 at 4:14 pm FSBS=197, On 11/12 at 4:03 pm FSBS=230, On 11/12 at 11:01 am FSBS=157, On 11/12 at 11:00 am FSBS=108, On 11/12 at 10:52 am FSBS=180, On 11/12 at 10:48 am FSBS=182, On 11/2 at 11:19 am FSBS=293, On 11/2 at 11:15 am FSBS=215, On 11/2 at 11:12 am FSBS=272, On 11/2 at 11:10 am FSBS=130. Refer to interview on 12/17/14 at 11:22 am with a day shift Medication Aide. Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/19/14 at 10:50 am with a night shift Medication Aide. Refer to interview on 12/22/14 at 11:50 am with	D932		

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D932	Continued From page 145 the Resident Care Coordinator (RCC). 2. Review of the history of FSBS values stored in a second one of the Brand B glucometers (not approved for use on multiple residents) revealed: - No resident's name was located on the glucometer. - Time and date could not be verified as set correctly. - Multiple FSBS values obtained within a short period of time. - The last 5 consecutive reading stored in the memory of the glucometer were as follows: On 11/05 at 10:56 am FSBS=126, On 11/05 at 10:54 am FSBS=131, On 11/05 at 7:07 am FSBS=101, On 11/05 at 7:06 am FSBS=128, On 11/05 at 7:04 am FSBS=100. Based on manufacturer guideline the glucometer should not be shared. Refer to interview on 12/17/14 at 11:22 am with a day shift Medication Aide. Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/19/14 at 10:50 am with a night shift Medication Aide. Refer to interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC). B. Review of Resident #14's current FL2 dated 4/25/14 revealed diagnoses included dementia Alzheimer's type, Schizoaffective disorder, and diabetes.	D932		

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D932	Continued From page 146 Review of Resident #14's record revealed current physician's orders dated 09/09/14 and 10/14 (signed but not dated) for finger stick blood sugar (FSBS) daily scheduled for 7:00 am. Review of the history of the Brand A glucometer labeled with Resident #14's name on 12/17/14 at 1:14 pm revealed: - The date displayed on the glucometer was correct but the time was 3 hours behind the current time of day. (At 1:14 pm the time displayed on the glucometer was 10:18 am. - None of the FSBS values in the glucometer's history for December 2014 matched values documented on Resident #14's December Medication Administration Record (MAR). - FSBS values recorded in the glucometer's history were not consistent with the scheduled 7:00 am FSBS. - FSBS values recorded in the glucometer's history were not daily. - Multiple FSBS values were recorded the same day with some reading 3 minutes or less apart. (Based on the manufacturer's guideline for the disinfecting wipes, the minimum time required for proper disinfecting would be 2 minutes wet time plus time for air drying for a total of at least 4 minutes.) Examples of times when multiple FSBS were recorded in a short period of time in the Brand A glucometer's history were as follows: - On 12/17/14 at 8:36 am FSBS=127, at 8:33 am FSBS=330. - On 11/28/14 at 8:13 am FSBS=218, at 8:10 am FSBS=262. - On 11/28/14 at 8:06 am FSBS=168, at 8:04 am FSBS=290. - On 11/15/14 at 8:13 am FSBS=152, at 8:10 am FSBS=251, and again at 8:10 am FSBS=247.	D932		

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D932	Continued From page 147 - On 11/15/14 at 4:18 am FSBS=111, at 4:16 am FSBS=127, at 4:14 am FSBS=72, and at 4:13 am FSBS=120. (FSBS of 127 and 72 corresponded to values documented on 2 other residents' MARs for the corresponding time.) Interview on 12/22/14 at 3:03 pm with Resident #14 revealed: - He thought staff always used his glucometer to check his FSBS but he was not sure. - He did not recall seeing the staff cleaning his glucometer before or after use. - He thought all resident had their own glucometers. Refer to interview on 12/17/14 at 11:22 am with a day shift Medication Aide. Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/19/14 at 10:50 am with a night shift Medication Aide. Refer to interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC). C. Review of Resident #10's current FL2 dated 09/15/14 revealed: -Diagnoses included diabetes. -A physician's order for Finger stick Blood Sugars (FSBS) daily at 7:00 am. Review of the history of the Brand A glucometer labeled with Resident #10's name revealed: -The date was accurate for the current date. -The time displayed on the glucometer was 1:34 pm (current time was 10:39 am, which was 3 hours and 5 minutes later than the current time).	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL080003		R 12/22/2014

NAME OF PROVIDER OR SUPPLIER: KANNON CREEK ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1808 N CANNON BOULVARD, KANNAPOLIS, NC 28083

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D932	Continued From page 148 -Two of the FSBS results recorded in the glucometer history for December 2014 matched FSBS results documented on Resident #10's December 2014 Medication Administration Record (MAR). -FSBS results recorded in the glucometer's history were not daily. -Multiple FSBS results were recorded the same day, and were 3 minutes or less apart. (Based on the manufacturer's guideline for the disinfecting wipes, the minimum time required for proper disinfecting would be 2 minutes wet time plus time for air drying for a total of at least 4 minutes.) Examples of times when multiple FSBS were recorded in the glucometer history on the same dates were identified as belonging to other diabetic residents as follows: -On 12/04/14 at 4:06 am, FSBS=103; and at 4:10 am, FSBS=125. -On 12/04/14 at 8:17 am, FSBS=76; at 8:20 am, FSBS=156; and at 8:24 am, FSBS=198. -On 12/07/14 at 4:32 am, FSBS=105; at 4:36 am, FSBS=348; at 4:42 am, FSBS=186; at 4:47 am, FSBS=99; at 4:51 am, FSBS=199; at 5:02 am, FSBS=110; at 5:11 am, FSBS=170; and at 5:15 am, FSBS=184. -On 12/07/14 at 1:23 pm, FSBS=365; and at 1:26 pm, FSBS=109. -On 12/07/14 at 2:37 pm, FSBS=112; and at 2:40 pm, FSBS=99. -On 12/07/14 at 4:25 am, FSBS-100; at 4:26 am, FSBS=231; at 4:30 am, FSBS=135, at 4:32 am, FSBS=149; at 4:34 am, FSBS=178; at 4:37 am, FSBS=371; and at 4:40 am, FSBS=220. -On 12/11/14 at 4:41 am, FSBS=45; and at 4:44 am, FSBS=84 (result matched FSBS result on the December 2014 MAR for Resident #10). -On 12/12/14 at 8:02 am, FSBS=345; at 8:05 am, FSBS=234; at 8:11 am, FSBS=163; at 8:14 am,	D932		

Division of Health Service Regulation

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D932	Continued From page 149 FSBS=197; and 8:16 am, FSBS=292. -On 12/12/14 at 1:09 pm, FSBS=233; at 1:13 pm, FSBS=105; at 1:23 pm, FSBS=252; and at 1:27 pm, FSBS=224. -All above FSBS results from 12/04/14 to 12/12/14 matched FSBS results of 11 different residents for the same dates and times. Interview on 12/22/14 at 11:40 am with Resident #10 at revealed: -She had resided at the facility for a couple of months. -She did not have her own glucometer. -Staff checked her blood sugars daily, once in the morning. -Staff used other residents' glucometers to check her blood sugars, because she did not have her own glucometer. -The glucometer used to check her blood sugars always had someone else's name on it. -She had seen staff disinfect the glucometer used on her. -She had observed staff wipe the glucometer down with a wipe.	D932		
	Refer to interview on 12/17/14 at 11:22 am with a day shift medication aide. Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/19/14 at 10:50 am with a night shift medication aide. Refer to interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC). D. Review of Resident #2's current FL2 dated 08/01/14 revealed:			

Division of Health Service Regulation

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D932	Continued From page 150 -Diagnoses included diabetes. -An order for FSBS (finger stick blood sugars) 3 times daily. Review of the history of the Brand A glucometer labeled with Resident #2's name revealed: -The date and time displayed on the glucometer was accurate to the current date and time. -Two of the FSBS results recorded in the glucometer history for November 2014 matched FSBS results documented on Resident #2's November 2014 Medication Administration Record (MAR). -None of the FSBS results recorded in the glucometer's history for December 2014 matched FSBS results documented on Resident #2's December 2014 MAR. -FSBS results recorded in the glucometer's history were not daily. -Multiple FSBS results were recorded the same day, and were 3 minutes or less apart. (Based on the manufacturer's guideline for the disinfecting wipes, the minimum time required for proper disinfecting would be 2 minutes wet time plus time for air drying for a total of at least 4 minutes.) Examples of times when multiple FSBS were recorded in the glucometer history on the same dates were as follows: -On 11/18/14 at 7:01 am, FSBS=159; at 5:16 am, FSBS=78; and at 5:26 am, FSBS=173. -On 12/15/14 at 7:08 am, FSBS=244; at 7:25 am, FSBS=273; at 7:27 am, FSBS=129 (FSBS=129 matched FSBS result for the same date and time of another resident); at 7:32 am, FSBS=211; and at 10:59 am, FSBS=126. Interview on 12/19/14 at 11:40 am with Resident #2 revealed: -He had resided at the facility for 4 years.	D932		

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D932	Continued From page 151 -Staff checked his blood sugars three times a day and if his blood sugar was high, he got an insulin shot. -He had his own glucometer. -The glucometer staff used to check his blood sugars always had his name on it. Refer to interview on 12/17/14 at 11:22 am with a day shift medication aide. Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/19/14 at 10:50 am with a night shift medication aide. Refer to interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC). E. Review of Resident #13's record revealed: -A current FL2 dated 4/9/2014 with diagnoses which included diabetes. -A physician order for FSBS checks to be done at 7:00 am and 5:00 pm. On 12/17/2014 at 1:30 pm review of Resident #13's labeled glucometer revealed a history of the following multiple readings that were less than 4 minutes apart. The following readings were identified to belong to diabetic residents other than Resident #13: -12/17/2014 at 11:08 am, results of 252. -12/17/2014 at 11:05 am, results of 218. -12/15/2014 at 5:35 pm, results of 130. -12/15/2014 at 5:34 pm, results of 111. -12/14/2014 at 11:07 am, results of 159. -12/14/2014 at 11:07 am, results of 94. -12/13/2014 at 4:48 pm, results of 246. -12/13/2014 at 4:44 pm, results of 78.	D932		

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D932	Continued From page 152 Interview with Resident #13 on 12/22/2014 at 3:00 pm revealed: -"They use my own glucometer most of the time". -"I see them clean it with something but I don't know what it is". -"They clean my finger real good with alcohol every time". Refer to interview on 12/17/14 at 11:22 am with a day shift Medication Aide. Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/19/14 at 10:50 am with a night shift Medication Aide. Refer to interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC). F. Review of Resident #12's record revealed: -A current FL2 dated 1/22/2014 with diagnoses which included diabetes. -A physician order for FSBS checks to be done at 7:00 am, 11:00 am and 5:00 pm. On 12/17/2014 at 2:00 pm review of Resident #12's labeled glucometer revealed a history of the following multiple readings that were less than 4 minutes apart. The following readings were identified to belong to diabetic residents other than Resident #12: -12/16/2014 at 8:37 am, results of 130. -12/16/2014 at 8:33 am, results of 361. Based on observation and staff interviews, it was determined Resident #12 was not interviewable.	D932		

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D932	Continued From page 153 Refer to interview on 12/17/14 at 11:22 am with a day shift Medication Aide. Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC). Refer to telephone interview on 12/19/14 at 10:50 am with a night shift Medication Aide. Refer to interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC). --- Interview on 12/17/14 at 11:22 am with a day shift medication aide revealed: - She performed FSBS checks for residents during her shift. - She routinely cleaned the residents' glucometer after each FSBS by using the (Brand) disinfecting wipe. - She stated she used a saturated wipe to wipe the glucometer (front, back and ends) and wrapped the cloth around the glucometer. - She stated then placed the covered glucometer on top of the medication (on a clean paper towel) for 2 minutes, removed the wipe, and allowed the glucometer to dry for 1 to 2 minutes and either placed it back in the cart or used it on another resident, if needed. - She was trained in this method of cleaning the glucometers when she started as a medication aide for the facility. (She was not sure which staff trained her.) Interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC) revealed: - The facility does not have a system in place to monitor the disinfecting of the glucometers.	D932		

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D932	Continued From page 154 - The corporate policy is that the facility can share glucometers with proper disinfecting. - The facility does not currently have a system in place to routinely monitor the FSBS history stored in the glucometers for compliance in the timeframe required or disinfecting glucometers per the disinfectant manufacturer's guidelines. - The Administrator and ARCC were not aware glucometers must be approved for use with multiple residents by the manufacturer in order for the facility to share the glucometer. Telephone interview on 12/19/14 at 10:50 am with a night shift Medication Aide revealed: - The residents were supposed to have their own glucometers. - For residents that did not have a glucometer for some reason, staff were trained to disinfect the glucometer by removing a wet (Brand Name) disinfectant wipe, wiping the glucometer, wrapping the glucometer with the wipe and placing on the medication cart for 2 minutes, removing the wipe and allowing the glucometer to air dry. - The disinfecting process required at least 4 minutes to complete. - Staff had received training from the consulting pharmacy nurse for disinfecting glucometers but the training did not require return demonstration. - The policy for sharing glucometers had been in use for about 2 years. Interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC) revealed: - She had been in her current position only a few months. - She was the ARCC prior to becoming the RCC and assisted an RCC that was no longer at the facility. - She was not aware the Brand B glucometer was	D932		

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D932	Continued From page 155 for single resident use only per the manufacturer. - Staff had using the Brand B glucometers on multiple residents but had been trained to disinfect the glucometers between residents. - She was not aware the facility (ARCC or RCC) was responsible to check with the manufacturer to verify a brand of glucometer could be shared. - All diabetic residents had been ordered new glucometer a few months ago (starting in September) but several had not received the new glucometers mainly due to insurance issues. - She did not have a system in place for monitoring glucometer disinfection or routinely checking for staff compliance with disinfecting glucometers. The facility provided a Plan of Protection on 12/17/14 that included: - All (100%) glucometers were disinfected per manufactory guideline. - The facility will receive additional glucometers on 12/18/14. - Will monitor disinfecting of shared glucometers with a facility QI tool. - Inserviced Medication Aides on disinfecting glucometers using returned demonstration on disinfecting glucometers done by RN. - Medication Aides will not be able to do blood sugar until in-serviced by RN. - Resident Care Coordinator/Designee will review Disinfecting Glucometer QI auditing tool daily for 3 weeks, any issues identified will immediately be corrected. - The randomly for 4 weeks, and issued identified will be immediately corrected. - Using QI tool will be reviewed in monthly QI meeting to assure system working. - Will be reviewed quarterly in QI meeting and	D932		

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D932	Continued From page 156 updated as needed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 5, 2014.	D932	D 992 Examination and screening	
D992	G.S.§ 131D-45 Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult	D992	The facility will ensure an examination and screening for the presence of controlled substances is performed before employees begin working at the facility. The facility has a system in place to ensure examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. The examination and screening for the presence of controlled substances is completed before any employee begins working at the facility. The department head will ensure that an examination and screening for the presence of controlled substances is completed when the potential employee is interviewed. The Chain of Custody form will be given to the bookkeeper to be placed in the employee file. The administrator will send the official results to the bookkeeper for the employee file.	

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D992	Continued From page 157 care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 7 sampled staff (Staff G) hired after 10/1/13 before the employee began working at the facility. The findings are: Review of Staff G's personnel file revealed: -Staff G was hired on 4/27/14. -Staff G began employment at the facility on 4/29/14. -Staff G was hired as a personal care aide (PCA). -No documentation a controlled substance exam/screening had been completed. Interview on 12/22/14 at 3:00 pm with Staff G, PCA revealed: -The Administrator asked her to submit to a drug test sometime in June or July 2014. -She turned her "specimen" in to the Resident Care Coordinator (RCC). -She did not know she was supposed to have submitted the controlled substance exam/screening prior to being hired. Interview on 12/22/14 at 3:15 pm with the Administrator revealed: -She, along with the RCC, were responsible for controlled substance exam/screening on new hires. -She thought only medication aides were	D992	An Employee File Audit tool has been implemented to ensure that an examination and screening for the presence of controlled substances has been completed. The bookkeeper will audit all new hires for completion of an examination and screening for the presence of controlled substances on an ongoing basis. The bookkeeper will report any findings to the monthly QI meeting on a monthly basis x 3 months for further recommendations.	2-5-15 AW

Division of Health Service Regulation

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D992	Continued From page 158 supposed to be drug tested prior to hire. -She had reviewed the controlled substance test results for Staff G on the computer, but could not provide a copy of the test results.	D992		

April W Parker, Administrator 2-3-15

KANNON CREEK
Assisted Living

FEB - 4 2015

February 3rd, 2015

Carolyn Harrison
North Carolina Department of Health and Human Services
Division of Health Service Regulation
12 Barbette Drive
Asheville, NC 28806

Dear Ms. Harrison:

Enclosed you will find the Plan of Correction for the Statement of Deficiencies during the survey completed on December 22, 2014.

If you have any questions feel free to contact me at 704-932-5517 Monday through Friday 8:00 am till 5:00 pm

Sincerely

April Roberts,
Administrator
Kannon Creek Assisted Living

1808 North Cannon Blvd. • Kannapolis, NC 28083-2670 • Phone (704) 932-5517 • Fax (704) 932-5005

Shook, Linda

From: Harrison, Carolyn
Sent: Saturday, February 07, 2015 9:38 PM
To: Shook, Linda
Cc: Daina.Frederick@rowancountync.gov; Lisa, Holshouser,
Subject: Kannon Creek Assisted Living HAL-080-003 12-22-14 POCA 2-6-15
Attachments: Kannon Creek Assisted Living 12-22-14 POCA.pdf

Attached is the approved POC from Kannon Creek Assisted Living HAL-080-003 in Rowan County. The POC was approved on 2/6/15.

Carolyn Harrison, RN, BSN
NC Department of Health and Human Services
Adult Care Licensure Section- Division of Health Service Regulation
Home-Based Lexington Region
12 Barbetta Drive, Asheville, NC 28806
Tel. # 336-341-8124
Fax # 336-357-7827
E-mail: carolyn.harrison@dhhs.nc.gov
http://www.ncdhhs.gov/dhsr

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