

FEB - 4 2015

PRINTED: 12/22/2014  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C <b>11/25/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON CITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b> <i>County: Swain</i>
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D 000	<p><b>Initial Comments</b></p> <p>The Adult Care Licensure Section conducted an annual survey, follow-up survey, and complaint investigation onsite November 18-21, 2014 with an exit via telephone on November 25, 2014. The complaint investigation was initiated by the Swain County Department of Social Services on October 30, 2014.</p>	D 000		
D 079	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews the facility failed to maintain the environment in a clean, orderly manner and free from hazards in 7 resident rooms, the common living area, dining room and the only common bath and shower room.</p> <p>The findings are:</p> <p>Observations during the initial tour of the facility on November 18, 2014 at 10:30am through 11:30am revealed:</p> <p>A. The following occupied resident rooms: - Dark brown stained splotches on the bed spread in room 16.</p>	D 079	<p>Bedspread had paint stain on it from a craft project . Bedspread removed and replaced immediately. Co-Director to assess room 16 linens for 2 weeks consecutively to ensure it is clean and orderly.</p>	1-9-15

*(Signature / date on attached cover letter)*  
*Plan of Correction Approved with Addendums* *ls*  
*Brenda Boggs 2-10-15* Page 1 of 89

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<p>D 079</p> <p>Continued From page 1</p> <ul style="list-style-type: none"> <li>- A heavy coat of dust/debris on an oxygen concentrator (available for use) in room 13. - A broken window blind slat in the bathroom of room 10.</li> <li>- The floor in room 11 was dirty with debris and dust.</li> <li>- A heavy buildup of stains and matted debris covered the carpet in room 4.</li> <li>- The floors in room 7 had dried dark brown debris near the door and all base boards were missing.</li> </ul> <p>B. Observations in room 8 revealed:</p> <ul style="list-style-type: none"> <li>- A stand up portable fan had a heavy buildup of dust and debris on the blades.</li> <li>- Dried food spills, dirt and debris on the floor by the window and in front of the bed.</li> <li>- The oxygen concentrator (available for use but not in use at the time of observation) was covered with dust and debris.</li> <li>- Several glass bowls, plates, knives, spoons and forks were draining on a paper towel under the sink on the bathroom floor.</li> <li>- A bag full of trash, with debris on the outside of the bag, sitting on top of a full can of trash beside the closet.</li> <li>- Paper plates with dried food debris, paper napkins and towels with stained food particles/debris scattered on the floor.</li> <li>- Oxygen tubing, electrical cords and electronic device cords and chargers on the floor by the bed.</li> </ul> <p>C. Observations in the only common shower/bath room revealed:</p> <ul style="list-style-type: none"> <li>- Missing sheet rock on the entire door frame of the shower stall, exposing the 2x4s.</li> <li>- An 8 inch section of the window blinds were broken about halfway up the center of the window.</li> </ul>	<p>D 079</p> <p>Co-Director to audit for linen/bedspreads in random weekly room audits to ensure overall cleanliness and order, for minimum of 4 consecutive weeks. Will address any issues as they arise.</p> <p>New furniture for dayroom purchased and put into place – was previously ordered.</p> <p>Administrator, co-director, and outside volunteer completed “deep cleaning” after hours to improve overall cleanliness of the building.</p> <p>Daily after 9pm through Midnight staff are available to do more than incidental, occasional tasks such as emptying trash, laundry, etc.</p> <p>On unscheduled specific housekeeping staffing days, the co-director/maintenance supervisor is available to complete more than non-incidental and occasional housekeeping duties, so that care staff are in compliance with the state reg (such as a liquid spill or urine spill to prevent falls).</p> <p>Resident rooms in transition (move out and move in process) will be shut off so that any debris or clutter is limited to the actual room – ensuring less debris exposure. This process will be managed by the Co-Director. For example: Over flow storage is currently assigned Room 17 but is subject to change as other room’s transition.</p> <p>Co-Director and Admin will conduct weekly x 4 weeks planning/prepping audit (walk-throughs) for future Health Inspection Score surveys – physical plant. Current score is 95. Will use an internal checklist and provide documentation.</p>
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D 079	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- The cover of the working base board heater was detached and hung off the heater exposing sharp metal edges of the heating element. One end of the cover was protruding out approximately 6 inches and was laying on the floor.</li> </ul> <p>D. Observations in the common living area revealed:</p> <ul style="list-style-type: none"> <li>- The screen in the door of the common living area had an approximate 12 inch tear and was pulled away from the frame exposing sharp pieces of wire/screen.</li> <li>- A standup fan in the common living area had a heavy build-up of dust and debris on the blades.</li> </ul> <p>E. Observations in the dining room revealed:- All six ceiling fans had a heavy build-up of dust and debris on the blades.</p> <p>F. Observations of the lid and sides of the plastic water pitcher used on the medication cart was covered with a dark, sticky, gummy build-up residue.</p> <p>Observation on November 18, 2014 at 9:00am revealed all the above areas remained the same.</p> <p>Confidential interviews with alert and oriented residents revealed:</p> <ul style="list-style-type: none"> <li>- The floor was dirty.</li> <li>- The facility had not had a "housekeeper in quite a while".</li> <li>- Residents did not remember when the floor was mopped.</li> <li>- "Have thought about getting a mop and cleaning the floor myself".</li> <li>- "I take out my own trash".</li> <li>- Floors are seldom mopped, maybe every other month.</li> <li>- Sometimes the floors are cleaned once a week.</li> </ul>	D 079		

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D 079	Continued From page 3  - My floor gets mopped "maybe one time a week".  Confidential staff interviews revealed a personal care staff was assigned to housekeeping duties one day a week (instead of personal care duties). The facility did not have a specific "housekeeper".  Interview with the Administrator and Co-director on 11/20/14 at 10:10am revealed: - They were in the process of remodeling each individual room as rooms became available/vacant. - It had not been long since the common shower room had been remodeled but a resident had recently (unsure how long) knocked the door frames down when bumped by a wheel chair. - A different resident had torn the base board heater cover off with when running into the heater with a power wheel chair, unsure of exactly when (this resident had been discharged October 23, 2014). - Each room that had carpet was supposed to be vacuumed each week. - It had been "a while" since any carpet had been cleaned. - The designated housekeeping staff should be cleaning the rooms each week. - Personal care staff were supposed to take trash out daily and clean any "incidentals" as they occurred. - They did not have a designated "housekeeper" but a personal care staff was assigned housekeeping duties twice weekly. - There was no staff assigned housekeeping duties 5 days per week.	D 079		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	<p>Continued From page 4</p> <p>10A NCAC 13F .0407. Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interview and record review, the facility failed to assure 2 of 4 sampled staff (Staff D and J) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR).</p> <p>The findings are:</p> <p>A. Review of Staff D's personnel file revealed: -Staff D was hired as a medication aide on 10/27/14. -No documentation of a HCPR check.</p> <p>Review of the HCPR check obtained by the facility on 11/20/14, during the survey, revealed no substantial findings for Staff D.</p> <p>Refer to interview with the Administrator on 11/20/14 at 3:00pm.</p> <p>B. Review of Staff J's personnel file revealed: -Staff J was hired as a medication aide on 3/25/12, but was currently the Resident Care Coordinator. -No documentation of a HCPR check.</p> <p>Review of the HCPR check obtained by the facility on 11/20/14 during the survey revealed no substantial findings for Staff J.</p>	D 137	<p><i>do however prefer to take out their own trash as well as light housekeeping but this does not exclude them from weekly housekeeping schedule.</i></p> <p><i>After review of all 14 employee files. Only staff D &amp; J were without HCPR check in file and these were placed in file before survey completion.</i></p>	

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HAL087005

B. WING

R-C  
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D 137	<p>Continued From page 5</p> <p>Refer to interview with the Administrator on 11/20/14 at 3:00pm.</p> <p>-----</p> <p>Interview with the Administrator on 11/20/14 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The Co-Director was responsible for assuring HCPR checks were completed on all new employees.</li> <li>-The Co-Director had either overlooked these employees for a HCPR check or had misplaced the documentation.</li> </ul> <p>-----</p> <p>Plan of Correction provided by the facility revealed:</p> <ul style="list-style-type: none"> <li>-All new prospective hires will be checked and page printed from the Health Care Personnel Registry (HCPR).</li> <li>-All current staff have now been checked. - HCPR will be checked for any new prospective hires before offer of employment considered.</li> </ul> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2015.</p>	D 137		
D 167	<p>10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation</p> <p>10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation</p> <p>Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver,</p>	D 167	<p><i>Per telephone call to Connie Sealy, Ad on 2-10-15, she stated she would assure a staff person with a current CPR cert. is always scheduled for each shift. Brenda Rogers 2-10-15.</i></p> <p>House Rules updated to reflect that CPR certification/training is added to the new hire checklist – New Hires will receive CPR class within 90 days of employment – this will be tracked by the Administrator. Also, annual CPR training will be offered simultaneously per quarter, for staff in need of renewal.</p> <p>Admin also has the addition of a "tickler File" to prevent lapses in staff certification. Will be monitored "in-house" quarterly for review.</p>	1-9-15

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D 167	<p>Continued From page 6</p> <p>provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.</p> <p>This Rule is not met as evidenced by: <b>TYPE B VIOLATION</b></p> <p>Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 4 of 21 days on third shift from 11/1/14 to 11/21/14.</p> <p>The findings are:</p> <p>Review of the staff work schedule for 11/1/14 through 11/21/14 revealed Staff H, a supervisor/medication aide and Staff E, a personal care aide were the only 2 staff scheduled to work third shift on November 1, 4, 13, and 21.</p> <p>A. Review of Staff H's personnel file revealed: -Staff H was hired as a medication aide on 4/2/13. -No documentation of CPR training.</p> <p>Refer to interview with the Administrator on 11/25/14 at 4:00pm.</p> <p>B. Review of Staff E's personnel file revealed: -Staff E was hired as a personal care aide on</p>	D 167		
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D 167	<p>Continued From page 7</p> <p>6/24/14.</p> <p>-No documentation of CPR training.</p> <p>Refer to interview with the Administrator on 11/25/14 at 4:00pm.</p> <hr/> <p>Telephone interview with the Administrator on 11/25/14 at 4:00pm revealed:</p> <p>-She had no information that any other staff worked on third shift those 4 nights.</p> <p>-She had changed the schedule to assure there was always a staff in the building who had CPR training within in the past 24 months.</p> <hr/> <p>Plan of Protection provided by the facility revealed:</p> <p>-At least one staff with CPR training will always be scheduled to work each shift.</p> <p>-Staff who require CPR training will be trained as soon as possible.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2015.</p>	D 167		
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D 176	<p>10A NCAC 13F .0601 Management Of Facilities</p> <p>10A NCAC 13F .0601 Management Of Facilites</p> <p>(a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Facility Services and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the</p>	D 176		
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D 176	<p>Continued From page 8</p> <p>operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview and record review, the Administrator failed to assure responsibility for the total operation of the facility to maintain compliance in the rule areas regarding resident rights, housekeeping, staff qualifications, training on cardio-pulmonary resuscitation, personal care and other staffing, medication administration, health care implementation, health care referral and follow-up, and adult care home infection prevention requirements.</p> <p>The findings are:</p> <p>Interview with the Administrator on 11/20/14 at 3:40pm revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for the overall operation of the facility.</li> <li>-She had placed responsibility for medications, health care, and oversight on a former Resident Care Coordinator (RCC).</li> <li>-After the former RCC left employment of the facility, the Administrator said she found problems in the areas of medications and health care the former RCC was supposed to have done.</li> <li>-She had staff turnover and they were in the process of hiring new staff.</li> </ul> <p>Areas of non-compliance identified during the survey were as follows:</p>	D 176	<p><i>It is with due respect that in response to overall operation of the facility, may I first state that in 31 years of long term care experience and management I have an exemplary record of compliance in all areas of facility management and adhering to the NC rules, regulations and general statutes. Cornerstone Living Center has been recently deficiency free and last survey with minimal issues that were given immediate attention, action and resolution.</i></p> <p><i>Each of the violations/Deficiencies in this survey →</i></p>	
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D 176	<p>Continued From page 9</p> <p>A. Based on observations and interviews the facility failed to maintain the environment in a clean, orderly manner and free from hazards in 7 resident rooms, the common living area, dining room and the only common bath and shower room. [Refer to Tag 79 10A NCAC 13F .0306 (a).]</p> <p>B. Based on interview and record review, the facility failed to assure 2 of 4 sampled staff (Staff D and J) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR). [Refer to Tag 137 10A NCAC 13F .0407(a) (Type B Violation).]</p> <p>C. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 4 of 21 days on third shift from 11/1/14 to 11/21/14. [Refer to Tag 167 10A NCAC 13F .0507 (Type B Violation).]</p> <p>D. Based on observations, interviews and record review, the facility failed to assure there was staff available to perform laundry and housekeeping duties in addition to the staff on duty to attend to the residents personal care needs. [Refer to Tag 189 10A NCAC 13F .0604.]</p> <p>E. Based on observation, interview, and record review, the facility failed to assure referral and follow up to meet the acute health care needs for 3 of 3 residents (#1, #3 &amp; #6) sampled related to medications not available for days, medication refusals, and mental health referral for behavior changes. [Refer to Tag 273 10A NCAC 13F .0902(b) (Type A2 Violation).]</p>	D 176	<p><i>have been thoroughly reviewed and taken seriously to action to ensure safety, well being and compliance with all rules and regulations. As stated in response to this survey actions include</i></p> <ul style="list-style-type: none"> <li><i>• Nursing Oversight 3 days per week to work with med aid staff</i></li> <li><i>• Change to multidose packaging medication in 7 day quantities to reduce med errors and in preparation for EMAR system</i></li> <li><i>• Hiring of new staff</i></li> <li><i>• posted policies for aid vs housekeeping staff</i></li> <li><i>• Daily check system for maintenance &amp; repair</i></li> </ul> <p><i>As well as others stated in this response.</i></p>	
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D 176	Continued From page 10  F. Based on observation, interview, and record review, the facility failed to assure implementation of fingerstick blood sugars as ordered for 1 of 4 sampled residents (#3). [Refer to Tag 276 10A NCAC 13F .0902(c) (Type B Violation).]  G. Based on observation, interview, and record review, the facility failed to assure medications, which included Warfarin, Enablex, Spironolactone, Nucynta, Metformin, Glimepiride and Coreg, were administered as ordered for 5 of 5 sampled residents. (Residents #3, #4, #6, #8 and #10) [Refer to Tag 358 10A NCAC 13F .1004(a). (Type A2 Violation).]  H. Based on observations, record review and interviews, the facility failed to assure the documentation regarding the administration and availability of medications was recorded on the medication administration records for 3 of 4 sampled residents (Residents #3, #4, and #6). [Refer to Tag 367 10A NCAC 13F .1004(j).]  I. Based on interview, observation, and record review, the facility failed to assure 1 of 1 resident's (#3) medication, Nucynta, was not borrowed for another resident (#9) and failed to assure the borrowing and replacement of the medication was documented. [Refer to Tag 372 10A NCAC 13F .1004(o).]  J. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucometers and lancet devices without adequate disinfection of the glucometer when used for different residents for 3 of 4 sampled residents with orders for finger stick blood	D 176	<i>Finger sticks &amp; blood sugars This is being closely monitored and followed up in facility nurse.  with the change over to multidose packaging 12-29-14 as well as PCP consult and nursing oversight this has been resolved see notes at tag 358</i>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
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D 176	<p>Continued From page 11</p> <p>samples (FSBS). (Residents #4, 7, and 11.) [Refer to Tag 932 G.S. 131D-4.4A (Type A2 Violation).]</p> <p>K. Based on interview, and record review, the facility failed to provide mandatory annual infection prevention training for 2 of 2 sampled medication aides (Staff H and Staff J) and employed for more than one year. [Refer to Tag 934 G.S. 131D-4.5B(a) (Type B Violation).]</p> <p>Plan of Protection provided by the facility revealed: -A nursing assistant will be put into place to support maintaining rules of licensing for medication staff.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2015.</p>	D 176		
D 189	<p>10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing</p> <p>10A NCAC 13F .0604 Personal Care And Other Staffing</p> <p>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents.</p>	D 189		

JAN - 9 2015

PRINTED: 12/11/2014  
FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL087005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 11/25/2014
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D 189	<p>Continued From page 12</p> <p>(B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty.</p> <p>(C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks.</p> <p>(D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty.</p> <p>(E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure there was staff available to perform laundry and housekeeping duties in addition to the staff on duty to attend to the residents personal care needs.</p> <p>The findings are:</p>	D 189	<p><i>a regular housekeeper is scheduled 3x per week in addition to full time maintenance person.</i></p> <p><i>all laundry with the exception of incidentals is performed after 9pm 12-1-14 with a posted schedule</i></p>	12-29-14
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Division of Health Service Regulation

FEB - 4 2015

HAL087005

B. WING

R-C  
11/25/2014

NAME OF PROVIDER OR SUPPLIER  
**CORNERSTONE LIVING CENTER OF BRYSON CITY**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**314 HUGHES BRANCH ROAD  
BRYSON CITY, NC 28713**

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D 176	<p>Continued From page 11</p> <p>samples (FSBS). (Residents #4, 7, and 11) [Refer to Tag 932 G.S. 131D-4.4A (Type A2 Violation).]</p> <p>K. Based on interview, and record review, the facility failed to provide mandatory annual infection prevention training for 2 of 2 sampled medication aides (Staff H and Staff J) and employed for more than one year. [Refer to Tag 934 G.S. 131D-4.5B(a) (Type B Violation).]</p> <hr/> <p>Plan of Protection provided by the facility revealed: -A nursing assistant will be put into place to support maintaining rules of licensing for medication staff.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2015.</p>	D 176		
D 189	<p>10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing</p> <p>10A NCAC 13F .0604 Personal Care And Other Staffing</p> <p>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.</p> <p>(2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents.</p>	D 189	<p>Laundry procedures updated and posted and will be monitored weekly by Maintenance manager and/or Administrator for the next 4 weeks to ensure compliance. Laundry being done after 9pm per reg.</p>	1-5-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____	(X3) DATE SURVEY COMPLETED
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D 189	<p>Continued From page 13</p> <p>Review of resident census provided by the facility for 11/18/14 revealed 28 residents.</p> <p>Review of staffing schedule for all three shifts for month of November 14 revealed: -One supervisor/medication aide and 1 personal care staff scheduled for each shift. - A housekeeper was scheduled 6 days in the month, the 5th, 6th, 14th, 19th, 24th and 28th.</p> <p>Two staff for first and second shift is the staffing requirement for a census of 28.</p> <p>Confidential interviews with 2 personal care aides and 2 medication aides revealed: -Personal care aides (PCA) do all the resident laundry on all three shifts. -The medication aides help if they have time. -PCAs do five to six loads of laundry per day. -One staff said time spent doing laundry, "All day." -PCAs give 4 to 5 showers per shift on first and second shift in addition to emptying garbage, vacuuming and sweeping if time permits.</p> <p>Confidential interviews with two staff revealed: -They thought personal care like incontinent care and showers were sometimes not completed because of laundry duties. -It was difficult to answer call bells timely if two staff were busy assisting other residents, giving medications, showers, or doing laundry. -We usually have a housekeeper one day per week. -We have at least 5 residents who require routine incontinent care.</p> <p>Confidential interviews with 4 residents during the survey revealed: -Staff do the best they can.</p>	D 189		

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HAL087005

B. WING

R-C  
11/25/2014

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D 189	<p>Continued From page 14</p> <p>-The time it takes staff to answer the call bells varies depending on how busy the staff are.</p> <p>Interview with the Administrator on 11/20/14 at 2:30pm revealed:</p> <p>-Personal care aides (PCA) and medication aides (MA) only do "incidental" cleaning.</p> <p>-She was not aware PCAs and MAs were not supposed to do laundry from 7:00am to 9:00pm.</p> <p>-The November, 2014 schedule with a housekeeper scheduled for 6 days was not accurate because she has a housekeeper come in 2 days per week.</p>	D 189		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to assure referral and follow up to meet the acute health care needs for 3 of 3 residents (#1, #3 &amp; #6) sampled related to medications not available for days, medication refusals, and mental health referrals for behavior changes.</p> <p>The findings are:</p> <p>A. Review of Resident #6's record revealed an FL2 dated 06/03/14 with diagnoses that included: - High blood pressure.</p>	D 273	<p>RN contracted for a minimum of 4 weeks - from Jan 3<sup>rd</sup>, 2015 through January 30<sup>th</sup> to audit, follow up, and monitor weekly health care needs. Included but not limited to: LPHS tasks, training, supervision of Medication Administration, Personal Care Services, and all clinical aspects as related to resident care. RN will report weekly to the Administrator, either in writing or verbally or both during this time.</p> <p><i>Per telephone call to Connie Seely, Ad. on 2-10-15, she stated the date for POC for Tag 273 was 12-25-14. B. Boyce 2-10-15</i></p>	<p>12-25-14 <i>bb</i> <del>1-9-15</del></p>

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D 273	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>- Congestive heart failure</li> <li>- Pulmonary embolism (blood clot in the lungs).</li> <li>- Diabetes mellitus Type II.</li> <li>- Gastro esophageal reflux disease.</li> </ul> <p>Review of Resident #6's current Physician Order sheet dated 9/26/14 revealed orders that included:</p> <ul style="list-style-type: none"> <li>- Coreg 3.125mg twice a day (used to treat heart failure and high blood pressure.)</li> <li>- Glimepiride 4mg twice a day (used to lower blood sugar.)</li> <li>- Ranitidine 150mg once a day (used to reduce stomach acid).</li> <li>- Aspirin 81mg one time a day (used to prevent heart attacks and strokes).</li> <li>- Zolpidem 5mg every night (used to treat insomnia.)</li> <li>- Metformin 1000mg twice a day (used to treat high blood sugar).</li> <li>- Gabapentin 900mg every night (used to treat nerve pain).</li> <li>- Warfarin 7.5mg daily (used to prevent blood clots).</li> </ul> <p>Interview with Resident #6 on 11/18/14 at 11am and 3:45pm revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented to time, place and person.</li> <li>- The resident had been out of several medications for "a week or more", due to the "pharmacy bill got too high".</li> <li>-The resident was unsure of the names of all the medications, but stated he had not had his Metformin and Coreg as ordered.</li> <li>- The resident was not sure of his FSBS results and was not able to report negative consequences from missing medications.</li> </ul> <p>Observations of Resident #6's medications on</p>	D 273		

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D 273	<p>Continued From page 16</p> <p>hand on 11/18/14 at 2pm revealed none of the following medications were available for administration:</p> <ul style="list-style-type: none"> <li>- Coreg 3.125mg: review of the empty bubble pack revealed 60 pills were last dispensed on 09/30/14.</li> <li>- Glimepiride 4mg: review of the empty bubble pack revealed 60 pills were dispensed on 09/30/14.</li> <li>- Ranitidine 150mg: review of the empty empty bubble pack revealed 30 pills were dispensed 09/30/14.</li> <li>- No aspirin or container was found.</li> <li>- Zolpidem 5mg: review of the empty bubble pack revealed 30 pills were dispensed 09/23/14.</li> <li>- Metformin 1000mg: review of the empty bubble pack revealed 60 pills were dispensed 09/30/14.</li> <li>- Gabapentin 900mg: Review of the empty bubble pack revealed 90, 300mg capsules, were dispensed on 09/30/14.</li> <li>- Warfarin 10mg not available.</li> </ul> <p>Review of Resident #6's November 2014 Medication Administration Record (MAR) on November 18th revealed staffs' initials circled for the following administrations:</p> <ul style="list-style-type: none"> <li>- Coreg - 8:00am from November 15th through 18th.</li> <li>- Ranitidine - 8:00am from November 5th through 18th.</li> <li>- Glimepiride - 8:00am from November 15th through the 18th.</li> <li>- Aspirin - 8:00am from November 3rd through 18th.</li> <li>- Zolpidem - 12:00am from November 7th through 18th.</li> <li>- Metformin - 8:00am from November 7th through November 18th and in 8:00pm from November 7, 14 and 17.</li> </ul>	D 273		

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D 273	<p>Continued From page 17</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/18/14 at 1:45pm revealed:</p> <ul style="list-style-type: none"> <li>- Staffs' circled initials on the MAR meant no medications were available for administration on that specific date and time.</li> <li>- Resident #6 had been out of several medications for "up to 2 weeks" due to non-payment.</li> <li>- The RCC did not know if the resident's physician had been notified.</li> </ul> <p>A telephone interview with Resident #6's PCP (Primary Care Provider) on 10/19/14 at 4:00pm revealed:</p> <ul style="list-style-type: none"> <li>- He had not been made aware that Resident #6 was out of medications until "this morning".</li> <li>- Any missed medication would be significant for Resident #6 due to the diagnoses of heart disease, diabetes, blood clots, etc.</li> <li>- He would have expected the facility to let him know any issues regarding a resident's medications "before this morning."</li> </ul> <p>A follow-up telephone interview with Resident #6's PCP (Primary Care Provider) 11/21/14 at 9:15am revealed:</p> <ul style="list-style-type: none"> <li>- The last order for Warfarin was on October 17, 2014 for 10mg two days a week and 7.5 all other days due to a recent change in INR (blood clotting times) , the PCP was unsure of exact results. No dose changes had been since that time.</li> <li>- The resident had regular INR test since the change on October 17, had been stable on that dose and no changes had been made.</li> <li>- The PCP thought Resident #6 had been on 10mg of Warfarin two days a week and 7.5 all other days since 10/17/14.</li> </ul> <p>Review of INR coagulation tests (a blood test to</p>	D 273		

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D 273	<p>Continued From page 18</p> <p>determine blood clotting time with reference range 0.8-1.2) revealed:</p> <ul style="list-style-type: none"> <li>- No results of an INR for 10/17/14 was found in the resident's record.</li> <li>- 10/23/14 with results of 1.8; no new orders.</li> <li>- 11/06/14 with results of 1.8; no new orders.</li> <li>- 11/13/14 with results of 1.5; no new orders.</li> </ul> <p>The RCC took Resident #6's blood pressure on 11/20/14 with results of 126/76.</p> <p>Review of the November 2014 FSBS log for Resident #6 revealed daily results at 8:00am that ranged from 124-207.</p> <p>B. Review of current FL2 for Resident #3, dated 8/10/14 revealed the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Hypertension</li> <li>-Chronic obstructive pulmonary disease</li> <li>-Seizure disorder</li> <li>-Alcohol abuse</li> <li>-Lumbago</li> </ul> <p>Review of Resident #3's Resident Register revealed he was admitted to the facility on 6/24/14.</p> <p>1. Review of documentation of an Emergency Room visit for Resident #3 on 10/28/14 revealed:</p> <ul style="list-style-type: none"> <li>-Was evaluated for chronic back pain, bilateral pedal edema secondary to chronic venous insufficiency, and tinea cruris.</li> <li>-An order for Lasix 20 mg take 1 every 12 hours. ( A diuretic). Directions for use included, "If you were told to take this medicine every day, do not skip doses or suddenly stop taking this medicine."</li> </ul> <p>Review of Resident #3's October 2014 MAR revealed no entry and no documentation of administration for Lasix.</p>	D 273		

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D 273	<p>Continued From page 19</p> <p>Review of the November 2014 MAR revealed for 33 opportunities to administer Lasix at 8:00am and 8:00pm, staff had initialed and circled 13 doses, failed to document anything for 5 doses, and documented the administration of 15 doses as follows:</p> <ul style="list-style-type: none"> <li>-11/1: refused in pm</li> <li>-11/2: refused in am and pm</li> <li>-11/3: administered in am</li> <li>-11/3: no documentation in pm</li> <li>-11/4: administered in am</li> <li>-11/4: administered in am</li> <li>-11/4: refused in pm</li> <li>-11/5: administered in am</li> <li>-11/5: refused in pm</li> <li>-11/6: administered in am and pm</li> <li>-11/7: administered in am and pm</li> <li>-11/8: administered in am and pm</li> <li>-11/9: administered in am and pm</li> <li>-11/10: no documentation in am</li> <li>-11/10: refused in pm</li> <li>-11/11: no documentation in am</li> <li>-11/11: refused in pm</li> <li>-11/12: no documentation in am</li> <li>-11/12: refused in pm</li> <li>-11/13: no documentaion in am</li> <li>-11/14: administered in am and pm</li> <li>-11/15: refused in am and pm</li> <li>-11/16: refused in am and pm</li> <li>-11/17: administered in am</li> <li>-11/17: refused in pm</li> </ul> <p>Review of Resident #3's November 2014 MAR revealed:</p> <ul style="list-style-type: none"> <li>-Documentation on the back of the MAR noted Resident #3 had refused 6 doses.</li> <li>-No documentation the other 7 circled initials meant Resident #3 had refused the Lasix.</li> <li>-No documentation Resident #3's physician had</li> </ul>	D 273		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>
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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 273	<p>Continued From page 20</p> <p>been contacted.</p> <p>On 11/18/14 at 2:40pm, observation of medications on hand for Resident #3 revealed a bubble pack of Lasix 20 mg labeled that 17 doses that had been dispensed on 11/13/14. Twelve tablets of Lasix remained.</p> <p>Interview with the RCC on 11/18/14 at 2:40pm revealed:</p> <ul style="list-style-type: none"> <li>-The circled initials meant Resident #3 had refused the medication.</li> <li>-The medication aides and he were supposed to contact the physician after a resident refused medication three consecutive days.</li> <li>-Staff were supposed to document on back of the MAR if they contacted the physician.</li> <li>-He was not aware any staff had contacted the physician.</li> </ul> <p>On 11/21/14 at 1:55pm, telephone interview with staff at Resident #3's primary care physician revealed facility staff had not informed them that Resident #3 was refusing his Lasix and he needed to know this information.</p> <p>Interview with the Administrator on 11/25/14 at 4:00pm revealed staff were supposed to contact the physician after a resident refused 3 doses of medication.</p> <p>Review of the November 2014 MAR as stated above revealed Resident #3 refused 3 doses of Lasix in a row twice in the month.</p> <p>Review of an Urologist office visit, dated 11/6/14, revealed:</p> <ul style="list-style-type: none"> <li>-"Pt wants to have catheter placed so that he may have diuretics to get swelling down in feet and lower legs, but with his incontinence he feels he</li> </ul>	D 273		

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D 273	<p>Continued From page 21</p> <p>would be wet constantly if he does not have a catheter." -A catheter was inserted.</p> <p>Interview with Resident #3 on 11//14 at 5:15pm revealed: -His ankles had been swollen "some." -He had refused the 8:00pm Lasix because it would make him have to go to the bathroom at night. -He did have a catheter in but he had a Urinary Tract Infection (UTI) and the catheter was taken out, date unknown. -The physician ordered an antibiotic for the UTI when the catheter was removed.</p> <p>Review of records revealed no documentation when the catheter was removed but physician orders were given for Ciproflaxin 500 mg 1 every 12 hours (an antibiotic) on 11/13/14.</p> <p>Resident #3's weight was taken by staff on 11/20/14 at 5:30pm and reported as 253 pounds. Review of record revealed previous weights were documented as 209.5 pounds on 6/24/14 pounds, 210 pounds on 9/16/14, and 235 pounds on 11/6/14.</p> <p>2. Review of records for Resident #3 revealed Spironolactone 25 mg twice per day was ordered on 9/16/14 (a potassium sparing diuretic used for the removal of excess fluid from the body in congestive heart failure, cirrhosis of the liver, kidney disease and also to prevent hypokalemia).</p> <p>Observation of the medications on hand for Resident #3 on 11/18/14 at 2:40pm and on 11/21/14 at 11:30am revealed no Spironolactone available for administration.</p>	D 273		

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D 273	<p>Continued From page 22</p> <p>Review of the September, October, and November 2014 Medication Administration Records (MARs) documentation for Spironolactone 25 mg at 8:00am and 8:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Administered from 9/16 to 9/30 in the am and pm (28 tablets).</li> <li>-Administered from 10/1 to 10/20 in the am (20 tablets).</li> <li>-Administered in the pm from 10/1 to 10/15 (15 tablets).</li> <li>-Administered twice daily in the am on 10/30 and 10/31 (4 tablets).</li> <li>-Circled initials from 10/21 through 10/29 in the am.</li> <li>-Circled initials from 10/16 through 10/29 in the pm.</li> <li>-Administered from 11/1 through 11/18 in the am (18 tablets).</li> <li>-Administered from 11/1/through 11/17 in the pm (17 tablets).</li> <li>-A total of 102 tablets were documented from 9/16 to 11/18.</li> </ul> <p>On 11/19/14 at 5:18pm, a telephone call to the local pharmacy who dispensed the Spironolactone 25 mg revealed:</p> <ul style="list-style-type: none"> <li>-They dispensed 60 Spironolactone tablets (a 30 day supply) on 9/16/14.</li> <li>-They had not received any requests for refills since 9/16/14 for Spironolactone 25 mg for Resident #3.</li> <li>-They dispensed 6 tablets on 6/24/14 when the order for Spironolactone 25 mg was three times per week.</li> </ul> <p>Based on the quantity of Spironalactone dispensed (60 tablets) and the quantity of tablets documented as administered (102 tablets) from 9/16 to 10/17/14, the Spironalactone was not</p>	D 273		

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D 273	<p>Continued From page 23 administered as ordered.</p> <p>Review of record revealed no documentation Spironolactone was dispensed for Resident #3 after 9/16/14.</p> <p>On 11/18/14 at 2:40pm, interview with the Resident Care Coordinator (RCC), who was also the first shift medication aide revealed:</p> <ul style="list-style-type: none"> <li>-There was no Spironolactone currently on hand available for administration for Resident #3.</li> <li>-He was not sure why there was no Spironolactone.</li> <li>-He was not sure how 102 tablets were documented if only 60 tablets were dispensed.</li> <li>-The circled initials in October meant "no medication available."</li> <li>-He was not aware of any documentation which verified that 102 tablets of Spironolactone would have been available for administration.</li> <li>-The RCC and the medication aides write on the pharmacy medication order sheet when refills are requested.</li> <li>-He did not have any documentation on the medication order sheet that Spironolactone had been requested in the past 3 months.</li> </ul> <p>On 11/21/14 at 1:55pm, telephone interview with staff at Resident #3's primary care physician revealed:</p> <ul style="list-style-type: none"> <li>-The facility had not notified them Resident #3 was out of Spironolactone.</li> <li>-The administration of Spironolactone was very significant for Resident #3 because the medication was prescribed to prevent further liver damage.</li> </ul> <p>Interview with Resident #3 on 11/21/14 at 11:30am revealed</p> <ul style="list-style-type: none"> <li>-He knew he used to take Spironolactone, but</li> </ul>	D 273		

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D 273	<p>Continued From page 24</p> <p>staff had not told him he was out of the medication. -He took so many medications he would not recognize if any were missing.</p> <p>Review of Resident #3's labs, dated 5/29/14, revealed: -ALT/GPT level 34 with reference range as 8 to 35 U/L. ( a lab used to diagnosis for liver damage.) -AST/GOT level 30 with reference range as 10-42 U/L. ( AST/GOT [aspartate aminotransferase] is a lab used in diagnosing and monitoring liver disease.)</p> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed: -She did not know if Spironolactone for Resident #3 had yet been dispensed to the facility. -The RCC and the medication aides were responsible for calling the physician if medications were not available.</p> <p>4. Review of records for Resident #3 revealed an order, dated 9/17/14 for Nucynta 75 mg, 1 every 8 hours as needed for pain. (A medication for neuropathic pain associated with diabetic peripheral neuropathy in adults severe enough to require daily, around the clock, long-term opioid treatment and for which alternative treatment options are inadequate.)</p> <p>Observation of medications on hand on 11/18/14 at 2:40pm revealed no Nucynta available for administration.</p> <p>Review of the Controlled Drug Disposition Form for Nucynta 75 mg for Resident #3 revealed: -90 tablets were available for administration on 9/17/14.</p>	D 273		
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D 273	<p>Continued From page 25</p> <p>-Administration of 81 tablets were documented from 9/17/14 through 10/29/14.</p> <p>-Nine tablets of Resident #3's Nucynta was documented as administered to another resident.</p> <p>Interview with the RCC on 11/21/14 at 10:30am revealed:</p> <p>-He had documentation he had requested a refill for Nucynta on 10/29/14. (This would have been the day the last Nucynta was documented as administered on the Controlled Drug Disposition Form.)</p> <p>-Nucynta was not refilled due to pharmacy needed "prior authorization."</p> <p>Telephone interview with staff at the local pharmacy on 11/19/14 at 5:18pm revealed they had dispensed 90 Nucynta 75 mg, on 9/17/14 with directions for administering one every 8 hours for pain.</p> <p>Telephone interview with the facility provider pharmacy on 11/24/14 at 11:30am revealed:</p> <p>-According to their records, the facility sent in a request for Nucynta on 10/14/14 and 10/29/14, but the insurance declined payment.</p> <p>-This pharmacy never dispensed any Nucynta for Resident #3.</p> <p>Interview with Resident #3 on 11/19/14 at 5:15pm revealed:</p> <p>-He had been in severe pain and when he asked for medication recently, the medication aides told him the only thing available for pain was "Tylenol."</p> <p>-When he asked for something stronger than Tylenol, the medication aides told him they did not know why it was not available.</p> <p>-Tylenol did not decrease his pain.</p> <p>-He had asked "several weeks ago" to go to a pain clinic.</p>	D 273		
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D 273	<p>Continued From page 26</p> <p>-Facility staff would always tell him they were still working on getting an appointment at the pain clinic.</p> <p>Review of a Urologist office visit, dated 11/6/14, for Resident #3 revealed, "[Resident #3] has been referred to pain management in [name of another town]."</p> <p>Review of record revealed no documentation when the physician first made a referral to the pain clinic and no documentation the facility had scheduled or attempted to schedule an appointment to a pain clinic.</p> <p>On 11/24/14 at 2:45pm a telephone call to the pain clinic revealed Resident #3 was not in their system and they had no appointment scheduled for Resident #3.</p> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed: -It was the responsibility of the RCC to assure all medications were available for administration, but there had been payment issues with obtaining Resident #3's Nucynta. -She did not know if Nucynta had yet been dispensed to the facility. -The facility staff had made attempts to get Resident #3 an appointment for a local pain clinic, but had no success. They would try to schedule an appointment in another town.</p> <p>4. Review of records for Resident #3 revealed: -On 7/24/14, an order to start Enablex 7.5 mg oral tablet extended release 24 hour, 1 daily, "Enablex Samples" (no number documented). (Enablex is a medication to reduce leaking of urine, feelings of needing to urinate right away, and frequent trips to the bathroom.)</p>	D 273		

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D 273	<p>Continued From page 27</p> <p>-On 8/25/14, review of the urologist report revealed Resident #3 here with complaints of urinary frequency. "Associated symptoms include urinary urgency, urinary incontinence and nocturia." Increase Enablex to 15 mg daily.</p> <p>- On 10/2/14, an order for Enablex 15 mg per day was sent to the providing pharmacy and 29 doses were dispensed</p> <p>On 11/18/14 at 2:40pm, observations of Resident #3's medications on hand revealed no Enablex available for administration.</p> <p>Telephone interview with a pharmacist at the facility pharmacy provider on 11/24/14 at 10:45am revealed:</p> <p>-The only previous order for Enablex was for 7.5 mg per day, which was received and dispensed on 8/6/14 for 26 doses.</p> <p>-They had no order for Enablex 15 mg before 10/2/14.</p> <p>-On 10/2/14, 29 tablets of Enablex 15 mg were dispensed to the facility.</p> <p>-No Enablex 15 mg was dispensed for Resident #3 after 10/2/14.</p> <p>-Prior Authorization for the medication was faxed on 11/3/14 to Resident #3's physician.</p> <p>-The physician responded on 11/15/14 to discontinue the Enablex 15 mg and ordered Toviaz 4 mg per day (because insurance would not pay for the Enablex).</p> <p>Review of October and November, 2014 MAR revealed documentation of Enablex 15 mg administered daily from 10/3 to 11/18 (40 tablets were documented, but only 29 tablets were dispensed on 10/2/14).</p> <p>Review of August and September 2014 MAR revealed documentation of Enablex 7.5 mg</p>	D 273		

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D 273	<p>Continued From page 28</p> <p>administered daily from 7/24 through 9/30.</p> <p>Based on record for the quantity of Enablex 15 mg dispensed (29 tablets) and the quantity of medication documented as administered (40 tablets), Enablex 15 mg could not have been administered as ordered.</p> <p>Review of resident record revealed the facility had no documentation Enablex 15 mg was available for administration from 11/1/14 to day of survey, 11/21/14 at 11:30am.</p> <p>Interview with the RCC on 11/21/14 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-He was not sure how 40 tablets of Enablex was administered if only 29 tablets were dispensed.</li> <li>-He had documentation he requested a refill for Enablex 15 mg on 11/6/14 to the pharmacy. (All 29 tablets Enablex should have all been administered by 11/1/14, and should have been reordered before 11/1/14 according to facility policy.)</li> <li>-The medication aides and the RCC were supposed to order medication refills before all the doses were administered, specifically, when medications were down to the "blue strip" on the bubble pack.</li> <li>-He was not aware of any documentation available which would account for 40 tablets of Enablex available for administration after 11/1/14.</li> </ul> <p>Enablex should have been requested before 11/1/14 according to the facility policy that medications should be reordered when doses to be administered are in the blue zone on the bubble pack.</p> <p>Review of resident record revealed no documentation that facility staff contacted the</p>	D 273		

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D 273	<p>Continued From page 29</p> <p>physician to determine why Enablex was delayed in being dispensed.</p> <p>Interview with Resident #3 on 11/19/14 at 4:35pm revealed:</p> <ul style="list-style-type: none"> <li>-He knew he used to take medication to decrease urinary incontinence.</li> <li>-He had a lot of urinary incontinence recently which has been very stressful.</li> <li>-The urinary incontinence was so bad he went to the urologist and had a catheter inserted sometime "recently."</li> <li>-While the catheter was in, he got a urinary tract infection and had to have the catheter removed.</li> <li>-He was on antibiotics for a urinary tract infection.</li> <li>-The catheter was only in for "a few days."</li> </ul> <p>Review of resident records revealed Resident #3 had a catheter inserted on 11/6/14.</p> <p>Review of resident records revealed no documentation when the catheter was removed but physician orders were given for an antibiotic on 11/13/14, Ciproflaxin 500 mg 1 every 12 hours.</p> <p>On 11/21/14 at 1:55pm, telephone interview with staff at Resident #3's primary care physician revealed:</p> <ul style="list-style-type: none"> <li>-The Enablex was prescribed to reduce urinary incontinence for Resident #3.</li> <li>-Since insurance would not pay for Enablex, Toviaz 4 mg once daily was prescribed on 11/15/14.</li> <li>-They sent the order for Toviaz 4 mg to the pharmacy, not to the facility.</li> </ul> <p>On 11/18/14 at 2:40pm and on 11/21/14 at 11:45am, observation of medications on hand for Resident #3 revealed:</p> <ul style="list-style-type: none"> <li>-A bubble pack of Toviaz 4 mg extended release,</li> </ul>	D 273		
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D 273	<p>Continued From page 30</p> <p>one daily, which was dispensed on 11/15/14 with 15 doses. (A medication used for urinary incontinence.) -All 15 doses of Toviaz 4 mg remained in the bubble pack.</p> <p>Review of the November 2014 MAR on 11/18 at 2:40pm and 11/21 at 11:45am revealed the Tovias 4 mg had not been transcribed on the MAR. This was 6 days after the Tovias was dispensed.</p> <p>Interview with the RCC on 11/21/14 at 11:45am revealed: -He had not seen an order for the Toviaz and he could not enter it on the MAR. -He had not called Resident #3's primary care physician nor the pharmacy for an order or clarification.</p> <p>Review of record revealed no documentation staff had contacted the physician nor the pharmacy for a Toviaz order.</p> <p>Telephone interview with staff at the facility pharmacy provider on 11/24/14 at 10:45am revealed: -Resident #3's physician was faxed on 11/3/14 to obtain Prior Authorization for another urinary incontinence medication, Enablex. -The physician responded on 11/15/14 to discontinue the Enablex 15 mg and ordered Toviaz 4 mg per day (because insurance would not pay for the Enablex). -The pharmacy dispensed 15 doses Toviaz 4mg daily to the facility on 11/15/14.</p> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed: -The RCC was accurate in that a medication</p>	D 273		

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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>
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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 273	<p>Continued From page 31</p> <p>could not be placed on the MAR without an order. -The RCC should have contacted the primary care physician to see if it had been ordered. -She did not know if Toviaz had yet been administered to Resident #3.</p> <p>Interview with the Administrator on 11/20/14 at 11:30am revealed: -The medication aides had been trained to contact the physician for orders if medications were dispensed with no order in the facility. -She had considered acquiring a computerized MAR system to increase the accuracy of medication administration and documentation and to make medication aides more accountable.</p> <p>Refer to interview with the Administrator on 11/24/14 at 3:30pm.</p> <p>C. Review of current FL2, dated 2/6/14, for Resident #1 revealed diagnoses included: -Cerebral palsy -Seizure disorder -Cardiovascular accident</p> <p>Review of Resident Register revealed Resident #1 was admitted to the facility on 8/19/08.</p> <p>Review of resident record revealed Resident #1 was admitted to the hospital on 10/23/14 and did not return to the facility.</p> <p>Review of record revealed Resident #1's behavior changed in September 2014, continued into October 2014, with the following episodes documented: -9/13/14: Local Emergency Room Visit documented Resident #1 had "altered mental status and acting differently. Facility report says "he is not acting himself." Patient "swung at staff</p>	D 273		

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D 273	<p>Continued From page 32</p> <p>member."</p> <p>-10/5/14: Progress note stated, "Resident refused to be changed."</p> <p>-10/6/14: Progress note stated, "Resident refused to be changed."</p> <p>-10/10/14: Resident was "cussing and screaming,"</p> <p>-10/18/14: Resident "got in altercation today with another male resident. Verbally abusive and threw a coffee cup at him."</p> <p>-10/20/14: "I attempted to give resident his am meds today and he slapped the cup out of my hands and cursed at me while beating on his room door."</p> <p>-10/23/14: Resident #1 got in an altercation with another resident. When staff tried to intervene, Resident #1 assaulted staff. The police and Emergency Medical Services were called and Resident #1 was taken to the Emergency Room (ER).</p> <p>Review of Resident #1's ER report, dated 10/23/14 revealed Chief Complaint was "Aggressive behavior and violent behavior."</p> <p>Confidential interviews with 3 staff revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's behavior changed in September, 2014.</li> <li>-Resident #1 became more aggressive.</li> <li>-Resident #1 became more physically abusive with residents and staff.</li> <li>-Resident #1 had a "change in personality."</li> <li>-Resident #1 "acted out."</li> <li>-Resident #1 had anger issues.</li> <li>-The Administrator was informed of Resident #1's behavior changes.</li> </ul> <p>Review of record revealed no documentation Resident #1 was referred for mental health services.</p>	D 273		

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D 273	<p>Continued From page 33</p> <p>Interview with the Administrator on 11/21/14 at 11:30am revealed: -When Resident #1's primary care physician saw Resident #1, "he felt like" the behavior was med related. -There was no need for Mental Health Services until Resident #1's behavior started. -[Named] Mental Health Services was called but they did not have anyone available to see Resident #1.</p> <p>Telephone call to Resident #1's primary care physician office on 11/19/14 at 8:00am revealed they only saw Resident #1 once which was 9/16/14.</p> <p>Telephone call to [Named] Mental Health Services on 12/25/14 at 10:15am revealed they could not find any record that Resident #1 was referred to their services.</p> <p>Telephone interview with Resident #1's contact person on 11/25/14 at 10:30am revealed: -"I think [Resident #1] needed counseling and an evaluation." -Resident #1 had "pent up anger." -Resident #1 lost 2 close relatives in the past two years.</p> <p>Refer to interview with the Administrator on 11/24/14 at 3:30pm.</p> <hr/> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed: -The former Resident Care Coordinator (RCC) had left employment at that facility 10/25/14. -They currently had a medication aide filling in as RCC.</p>	D 273		

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D 273	<p>Continued From page 34</p> <p>-The RCC was responsible for completing a weekly "random" checking of the MARS to assure medications were administered as ordered. -She was not aware if the RCC was reconciling medications on hand with the medications listed on the MARS.</p> <p>-Medication aides should contact the pharmacy if residents' medications are not available.</p> <hr/> <p>Plan of Protection provided by the facility revealed:</p> <p>-Re-training through nursing oversight to medication aide staff or through immediate inservice to assure that medication refusal policies are followed.</p> <p>-The facility will provide ongoing training and oversight.</p> <p>-The primary care physician will be notified immediately when residents are out of medication and or refuses medication.</p> <p>-If medications are refused by resident, state regulations and protocol will be followed.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2015.</p>	D 273		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care</p> <p>(c) The facility shall assure documentation of the following in the resident's record:</p> <p>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</p> <p>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p>	D 276	<p>(5) RN is monitoring medication aids and resident records at least 3x per week to assure documentation for written procedures, treatments or orders from a physician or other licensed health professional; and implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. Including accuracy of MAR and FSBS</p>	12/3/2014

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*Janice Seely Administrator*

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D 276	<p>Continued From page 35</p> <p>This Rule is not met as evidenced by: Type B Violation</p> <p>Based on observation, interview, and record review, the facility failed to assure implementation of fingerstick blood sugars as ordered for 1 of 4 sampled residents (#3).</p> <p>The findings are:</p> <p>Review of current FL2 for Resident #3, dated 8/10/14 revealed the following diagnoses: -Hypertension -Chronic obstructive pulmonary disease -Cirrhosis</p> <p>Review of "Health Summary" submitted by Resident #3's primary care physician revealed diagnoses of "Type 2 diabetes, diagnosed in 2011."</p> <p>Review of Resident #3's Resident Register revealed he was admitted to the facility on 6/24/14.</p> <p>Review of resident record revealed a physician order (a hard script), dated 10/14/14, for fingerstick blood sugars (FSBS) am and pm with a diagnosis of diabetes mellitus type II.</p> <p>Review of the facility medication cart on 11/19/14 at 12:00pm revealed no glucometer available for Resident #3.</p> <p>Review of the October and November 2014 Medication Administration Record (MAR) revealed no entry and no documentation of</p>	D 276		
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D 276	<p>Continued From page 36</p> <p>FSBSs.</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/19/14 at 12:00pm revealed:</p> <ul style="list-style-type: none"> <li>-He had requested a glucometer from the local pharmacy (date unknown), but they had never sent one.</li> <li>-He did not know why the pharmacy had not sent a glucometer.</li> <li>-The facility policy was for the RCC and the medication aides to transcribe orders on the MAR when they came in the office, but he did not know why the FSBS order had not been transcribed on the MAR.</li> </ul> <p>Telephone interview with a pharmacist at the local pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-The facility had called to request a glucometer but never sent a "hard script," which was required.</li> <li>-The pharmacist said they told staff at the facility they would have to have a hard script.</li> </ul> <p>Review of resident records revealed no documentation of communication with pharmacy staff that a glucometer had been ordered, nor why it had never been sent by the pharmacist.</p> <p>Telephone interview with Resident #3's primary care physician staff on 11/19/14 at 8:00am revealed:</p> <ul style="list-style-type: none"> <li>-The physician ordered the FSBSs because Resident #3's blood glucose level was "high," 214, on the last lab.</li> <li>-Delay in obtaining the glucometer and taking the FSBSs was "significant" for this resident.</li> </ul> <p>Review of labs, dated 5/28/14, revealed the HgA1C was 7.1 with reference range of 4.4-5.6.</p>	D 276		
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D 276	<p>Continued From page 37</p> <p>Observation of the medication cart on 11/20/14 at 11:30am revealed a glucometer was available and labeled with Resident #3's name.</p> <p>Documentation of the FSBS readings faxed to the surveyor on 11/25/14 revealed: -Hand written entry on the MAR for FSBS twice daily. -One FSBS documented in the am for 21st through 24th as follows: 189, 176, 230, and 273. -One FSBS documented in the pm was 286 on the 24th. -Staff had not documented any FSBSs twice daily from 11/21/14 through 11/23/14 (3 days).</p> <p>Interview with the Adminsitrator on 11/25/14 at 4:00pm revealed: -She was not aware staff delayed in sending an order for the glucometer to the pharmacy. -She did not know why staff had not taken the FSBS twice per day as ordered after the glucometer was obtained. -She did not know why staff delayed taking the first FSBS from the time the glucometer was delivered on the 11/19 to the 11/21.</p> <hr/> <p>The Plan of Protection provided by the facility revealed: -Resident #3 obtained a glucometer today. -An immediate inventory was completed of all resident medications. -Any needed orders were executed by contacting the primary care physician for any needed new orders or faxing reorders to pharmacy for delivery. -With the termination of our recent Resident Care Coordinator, we will delegate responsibilities for medication orders to our medication aides with follow up overseen by contracted physician and</p>	D 276		

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D 276	Continued From page 38  administrator. -Fingerstick blood sugars will be overseen by Administrator or Registered Nurse.  THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2015	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration  10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.  This Rule is not met as evidenced by: TYPE A2 VIOLATION  Based on observation, interview, and record review, the facility failed to assure medications, which included Warfarin, Enblex, Spironolactone, Nucynta, Metformin, Glimepiride and Coreg, were administered as ordered for 5 of 5 sampled residents. (Residents #3, #4, #6, #8 and #10)  The findings are:  On 11/18/14 at 2:40pm, interview with the Resident Care Coordinator (RCC), who was also the first shift medication aide revealed: -He had been the RCC for about 1 month. -The residents' medications were not	D 358		

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D 358	<p>Continued From page 39</p> <p>automatically refilled by the dispensing pharmacy. -Staff had to request the pharmacy to send medication refills. -Medication aides and the RCC were supposed to request refills when the medications on hand were down to the blue zone on the bubble pack. -The number of medications in the blue zone was different for each medication based on the frequency of administration. -If medications were reordered when beginning on the blue zone, they should be dispensed in time so the residents would not miss a medication.</p> <p>A. Review of current FL2 for Resident #3, dated 8/10/14 revealed the following diagnoses: -Hypertension -Chronic obstructive pulmonary disease -Seizure disorder -Alcohol abuse -Lumbago -Cirrhosis</p> <p>Review of an Emergency Room Report, dated 11/20/14, revealed: -Diagnoses included hypokalemia, chronic anxiety, and depression. -Resident #3 complaining of chronic pain and having frequent urination.</p> <p>Review of "Health Summary" submitted by Resident #3's primary care physician revealed diagnoses of "Type 2 diabetes, diagnosed in 2011."</p> <p>Review of Urologist notes on 10/2/14 revealed "Active Problems" which included urge incontinence of urine and urinary incontinence.</p> <p>Review of Resident #3's Resident Register</p>	D 358		

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D 358	<p>Continued From page 40</p> <p>revealed he was admitted to the facility on 6/24/14.</p> <p>1. Review of resident records for Resident #3 revealed Spironolactone 25 mg twice per day ordered on 9/16/14 (a potassium sparing diuretic used for the removal of excess fluid from the body in congestive heart failure, cirrhosis of the liver, kidney disease and also to prevent hypokalemia).</p> <p>Observation of the medications on hand for Resident #3 on 11/18/14 at 2:40pm and on 11/21/14 at 11:30am revealed no Spironolactone available for administration.</p> <p>Review of the September, October, and November 2014 Medication Administration Records (MARs) documentation for the 8am and 8pm administration of Spironolactone 25 mg revealed:</p> <ul style="list-style-type: none"> <li>-Administered from 9/16 to 9/30 in the am and pm (28 tablets).</li> <li>-Administered from 10/1 to 10/20 in the am (20 tablets).</li> <li>-Administered in the pm from 10/1 to 10/15 (15 tablets).</li> <li>-Administered twice daily in the am on 10/30 and 10/31 (4 tablets).</li> <li>-Circled initials from 10/21 through 10/29 in the am.</li> <li>-Circled initials from 10/16 through 10/29 in the pm.</li> <li>-Administered from 11/1 through 11/18 in the am (18 tablets).</li> <li>-Administered from 11/1/through 11/17 in the pm (17 tablets).</li> <li>-A total of 102 tablets were documented from 9/16 to 11/18.</li> </ul>	D 358	<p><i>Facility Administrator has contacted PCP for resident #3 to ensure that orders for all medications prescribed are on file in resident medical chart. The referral to medication "Spironolactone" was ordered to pharmacy by PCP, but no order was sent to facility to place in medical chart. This has been a struggle with resident #3's PCP who is not our preferred "in house" physician and with no disrespect to #3's</i></p>	<p><i>Continued</i></p>
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D 358	<p>Continued From page 41</p> <p>On 11/19/14 at 5:18pm, a telephone call to the local pharmacy who dispensed the Spironolactone 25 mg revealed:</p> <ul style="list-style-type: none"> <li>-They dispensed 60 Spironolactone tablets (a 30 day supply) on 9/16/14.</li> <li>-They had not received any requests for refills since 9/16/14 for Spironolactone 25 mg for Resident #3.</li> <li>-They dispensed 6 tablets on 6/24/14 when the order was Spironolactone 25 mg was three times per week.</li> </ul> <p>Based on the quantity of Spironolactone dispensed (60 tablets) and the quantity of tablets documented as administered (102 tablets) from 9/16 to 11/18/14, the Spironolactone was not administered as ordered.</p> <p>Review of record revealed no documentation Spironolactone was dispensed for Resident #3 after 9/16/14.</p> <p>On 11/18/14 at 2:40pm, interview with the Resident Care Coordinator (RCC), who was also the first shift medication aide revealed:</p> <ul style="list-style-type: none"> <li>-There was no Spironolactone currently on hand available for administration for Resident #3.</li> <li>-He was not sure why there was no Spironolactone.</li> <li>-He was not sure how 102 tablets were documented if only 60 tablets were dispensed.</li> <li>-The circled initials in October meant "no medication available."</li> <li>-He was not aware of any documentation which verified that 102 tablets of Spironolactone would have been available for administration.</li> <li>-The RCC and the medication aides write on the pharmacy medication order sheet when refills are requested.</li> <li>-He did not have any documentation on the</li> </ul>	D 358	<p>PCP as he is not fluent with some protocols of Long Term Care. I (Administrator) have scheduled a face to face consultation with resident #3, PCP to clarify Long Term Care protocol and to include Medication Policies &amp; Procedures from NC State Rules &amp; Regulations Section 1000 - Medications. Earliest available date for consult is set for</p> <p>12-29-14 @ 2:40pm</p>	

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D 358	<p>Continued From page 42</p> <p>medication order sheet that Spironolactone had been requested in the past 3 months.</p> <p>On 11/21/14 at 1:55pm, telephone interview with staff at Resident #3's primary care physician revealed:</p> <ul style="list-style-type: none"> <li>-The facility had not notified them Resident #3 was out of Spironolactone.</li> <li>-The administration of Spironolactone was very significant for Resident #3 because the medication was prescribed to prevent further liver damage.</li> </ul> <p>Interview with Resident #3 on 11/21/14 revealed</p> <ul style="list-style-type: none"> <li>-He knew he used to take Spironolactone, but staff had not told him he was out of the medication.</li> <li>-He took so many medications he would not recognize if any were missing.</li> </ul> <p>Review of Resident #3's labs, dated 5/29/14, revealed:</p> <ul style="list-style-type: none"> <li>-ALT/GPT level 34 with reference range as 8 to 35 U/L. ( a lab used to diagnosis for liver damage.)</li> <li>-AST/GOT level 30 with reference range as 10-42 U/L. ( AST/GOT [aspartate aminotransferase] is a lab used in diagnosing and monitoring liver disease.)</li> </ul> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed she did not know if Spironolactone for Resident #3 had yet been dispensed to the facility.</p> <p>2. Review of records for Resident #3 revealed:</p> <ul style="list-style-type: none"> <li>-On 7/24/14, an order to start Enablex 7.5 mg oral tablet extended release 24 hour, 1 daily, "Enablex Samples" (no number documented). (Enablex is a medication to reduce leaking of urine, feelings</li> </ul>	D 358	<p><i>Re-education for medication order protocol was put in place beginning 12-3-14 through contracted nursing oversight, cart audits are being conducted to ensure that all residents have an adequate supply of all medications prescribed by their PCP.</i></p> <p><i>MAR is being closely monitored to ensure accuracy for all residents</i></p>	12-3-14

DEC 23 2014

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL087005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C 11/25/2014
NAME OF PROVIDER OR SUPPLIER  CORNERSTONE LIVING CENTER OF BRYSON CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 43</p> <p>of needing to urinate right away, and frequent trips to the bathroom.) -On 8/25/14, review of the urologist report revealed Resident #3 here with complaints of urinary frequency. "Associated symptoms include urinary urgency, urinary incontinence and nocturia." Increase Enblex to 15 mg daily. - On 10/2/14, an order for Enblex 15 mg per day was sent to the providing pharmacy and 29 doses were dispensed</p> <p>On 11/18/14 at 2:40pm, observation of Resident #3's medications on hand revealed no Enblex available for administration.</p> <p>Telephone interview with staff at the facility pharmacy provider on 11/24/14 at 10:45am revealed: -The only previous order for Enblex was for 7.5 mg per day, which was received and dispensed on 8/6/14 for 26 doses. -They had no order for Enblex 15 mg before 10/2/14. -On 10/2/14, 29 tablets of Enblex 15 mg was dispensed to the facility. -No Enblex 15 mg was dispensed for Resident #3 after 10/2/14. -Prior Authorization for the medication was faxed on 11/3/14 to Resident #3's physician. -The physician responded on 11/15/14 to discontinue the Enblex 15 mg and ordered Toviaz 4 mg per day (because insurance would not pay for the Enblex).</p> <p>Review of October and November 2014 MARs revealed documentation of Enblex 15 mg administered daily from 10/3 to 11/18 (40 doses were documented, but only 29 doses were dispensed on 10/2/14).</p>	D 358	<p>Beginning upon phone exit review on 11-24-14 this includes medication inventory, documentation and order verification.</p> <p>To further ensure that medical/medication needs are being met for all residents, another full "cart and chart audit" has been scheduled for 11-29-14</p> <p>Going forward, accuracy reviews of each resident</p>	11-24-14

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D 358	<p>Continued From page 44</p> <p>Review of August and September 2014 MAR revealed documentation of Enablex 7.5 mg administered daily from 7/24 through 9/30.</p> <p>Based on record for the quantity of Enablex 15 mg dispensed (29 tablets) and the quantity of medication documented as administered (40 tablets), Enablex 15 mg could not have been administered as ordered.</p> <p>From 11/1/14 to day of survey 11/21/14, the facility had no documentation Enablex 15 mg was available for administration.</p> <p>Interview with the RCC on 11/21/14 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-He was not sure how 40 tablets of Enablex was administered if only 29 tablets were dispensed.</li> <li>-He had documentation he had requested a refill for Enablex 15 mg on 11/6/14 to the pharmacy. (All 29 doses Enablex should have all been administered by 11/1/14, and should have been reordered before 11/1/14 according to facility policy.)</li> <li>-The medication aides and the RCC were supposed to order medication refills before all the doses were administered, specifically, when medications were down to the "blue strip" on the bubble pack.</li> <li>-He was not aware of any documentation available which would account for 40 doses of Enablex available for administration after 11/1/14.</li> </ul> <p>Enablex should have been requested before 11/1/14 according to the facility policy that medications should be reordered when doses to be administered are in the blue zone on the bubble pack.</p> <p>Review of resident record revealed no</p>	D 358	<p><del>REVISED</del></p> <p>MAR is being conducted at minimum of 3x per week through Nursing oversight.</p>	

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D 358	<p>Continued From page 45</p> <p>documentation that facility staff contacted the physician to determine why Enablex was delayed in being refilled.</p> <p>Interview with Resident #3 on 11/19/14 at 4:35pm revealed:</p> <ul style="list-style-type: none"> <li>-He knew he used to take medication to decrease urinary incontinence.</li> <li>-He had a lot of urinary incontinence recently which has been very stressful.</li> <li>-The urinary incontinence was so bad he went to the urologist and had a catheter inserted sometime "recently."</li> <li>-While the catheter was in, he got a urinary tract infection and had to have the catheter removed.</li> <li>-He was on antibiotics for a urinary tract infection.</li> <li>-The catheter was only in for "a few days."</li> </ul> <p>Review of resident records revealed Resident #3 had a catheter inserted on 11/6/14.</p> <p>Review of resident records revealed no documentation when the catheter was removed but physician orders were given for an antibiotic on 11/13/14. (Ciproflaxin 500 mg 1 every 12 hours).</p> <p>On 11/21/14 at 1:55pm, telephone interview with staff at Resident #3's primary care physician revealed:</p> <ul style="list-style-type: none"> <li>-The Enablex was prescribed to reduce urinary incontinence for Resident #3 and failure to administer it was significant because the resident would "urinate all over himself."</li> <li>-Since insurance would not pay for Enablex, Toviaz 4 mg once daily was prescribed on 11/15/14.</li> <li>-They sent the order for Toviaz 4 mg to the pharmacy, not to the facility.</li> </ul>	D 358		

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D 358	<p>Continued From page 46</p> <p>On 11/18/14 at 2:40pm and on 11/21/14 at 11:45am, observation of medications on hand for Resident #3 revealed: -A bubble pack of Toviaz 4 mg extended release, one daily, which was dispensed on 11/15/14 with 15 doses. (A medication used for urinary incontinence.) -All 15 doses of Toviaz 4 mg remained in the bubble pack.</p> <p>Review of the November 2014 MAR on 11/18 at 2:40pm and 11/21 at 11:45am revealed the Toviaz 4 mg had not been transcribed on the MAR. This was 6 days after the Toviaz was dispensed.</p> <p>Interview with the RCC on 11/21/14 at 11:45am revealed: -He had not seen an order for the Toviaz and he could not enter it on the MAR without an order. -He had not called Resident #3's primary care physician nor the pharmacy for an order or clarification.</p> <p>Review of resident record revealed no documentation staff had contacted the physician regarding the Toviaz when it was received from the pharmacy for Resident #3.</p> <p>On 11/21/14 at 1:55pm, telephone interview with staff at Resident #3's primary care physician revealed: -Administering Toviaz was significant for Resident #3 to prevent him from "wetting all over himself." -They had no documentation the facility had called to ask about an order for Toviaz.</p> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed: -The RCC was accurate in that a medication could not be placed on the MAR without an order.</p>	D 358		

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D 358	<p>Continued From page 47</p> <p>-The RCC should have contacted the primary care physician to see if there was an order. -She did not know if Toviaz had yet been administered to Resident #3.</p> <p>3. Review of records for Resident #3 revealed an order, dated 9/17/14 for Nucynta 75 mg, 1 every 8 hours as needed for pain. (A medication for neuropathic pain associated with diabetic peripheral neuropathy in adults severe enough to require daily, around the clock, long-term opioid treatment and for which alternative treatment options are inadequate.)</p> <p>Observation of medications on hand on 11/18/14 at 2:40pm revealed no Nucynta available for administration.</p> <p>Review of the Controlled Drug Disposition Form for Nucynta 75 mg revealed: -90 tablets were available for administration on 9/17/14. -Administration was documented from 9/17/14 through 10/29/14 with 81 tablets administered to Resident #3. -Nine tablets were documented on the Controlled Drug Form as administered to another Resident (#9) "on consent" dates of October 26, 27, 28, and 29.</p> <p>Review of September, October, and November, 2014 MARs revealed only 51 tablets Nucynta were documented on front of the MARs as administered to Resident #3 from 9/17 through 11/3/14 (although the last one of the Controlled Drug Disposition Form was documented as administered on 10/29/14.)</p> <p>Interview with the RCC on 11/21/14 at 10:30am revealed:</p>	D 358		

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D 358	<p>Continued From page 48</p> <p>-He had documentation he requested a refill for Nucynta on 10/29/14. (This would have been the day the last Nucynta was documented as administered on the Controlled Drug Disposition Form.)</p> <p>-Nucynta was not refilled due to pharmacy needed "prior authorization."</p> <p>Telephone interview with the local pharmacy on 11/19/14 at 5:18pm revealed they had dispensed 90 Nucynta 75 mg on 9/17/14 with directions to administer one every 8 hours for pain.</p> <p>Telephone interview with staff at the pharmacy provider on 11/24/14 at 11:30am revealed:</p> <p>-According to their records, the facility sent in a request for Nucynta on 10/14/14 and 10/29/14, but the insurance declined payment.</p> <p>-This pharmacy never dispensed any Nucynta for Resident #3.</p> <p>Interview with Resident #3 on 11/19/14 5:15pm revealed:</p> <p>-He had been in severe pain and when he asked for medication recently, the medication aides told him the only thing available for pain was "Tylenol."</p> <p>-When he asked for something stronger than Tylenol, the medication aides told him they did not know why no other pain medications were not available.</p> <p>-Tylenol did not decrease his pain.</p> <p>-He had asked "several weeks ago" to go to a pain clinic.</p> <p>-Facility staff would always tell him they were still working on getting an appointment at the pain clinic.</p> <p>Review of a Urologist office visit, dated 11/6/14, for Resident #3 revealed, "[Resident #3] has been referred to pain management in [name of another</p>	D 358		
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D 358	<p>Continued From page 49</p> <p>town]."</p> <p>Review of record revealed no documentation when the physician first made a referral to the pain clinic and no documentation the facility had scheduled or attempted to schedule an appointment to a pain clinic.</p> <p>Review of resident record revealed no documentation the facility had scheduled an appointment to a pain clinic.</p> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed: -If staff did not circle their initials on the MAR, she would not have been aware the medications were not available for administration. -It was the responsibility of the RCC to assure all medications were available for administration. -She did not know if Nucynta had yet been dispensed to the facility.</p> <p>4. Review of record revealed an order, dated 7/28/14, for Thiamine 100 mg per day. (Thiamine is a nutritional supplement.)</p> <p>Observation of medications on hand on 11/18/14 at 2:40pm revealed no Thiamine available for administration.</p> <p>Review of the August, September, October, and November 2014 MARs revealed: -Thiamine was documented as administered 8/1 through 9/17. -There was no explanation why Thiamine was not documented from 9/18 to 9/30. -Thiamine was documented as administered 10/1 through 10/31. -Thiamine was documented as administered 11/1 through 11/18 (day of survey.)</p>	D 358		

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D 358	<p>Continued From page 50</p> <p>Telephone interview with staff at the facility pharmacy provider on 11/24/14 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-On 7/28/14, they dispensed Thiamine 100mg (5 tablets).</li> <li>-On 8/1/14, they dispensed 30 tablets Thiamine 100 mg 1 daily.</li> <li>-They had not dispensed any Thiamine since 8/1/14.</li> <li>-The order before 8/1/14 was for Thiamine 1000 mg per day for which they had dispensed a 10 day supply on 6/25/14, again on 7/5/14, and again on 7/15/14.</li> <li>-Over the counter medications were not dispensed to Resident #3 because of a payment issue. The pharmacy did not send over the counter medications if a resident owed a pharmacy bill.</li> <li>-The order was clarified on 7/28/14 for Thiamine 100 mg per day.</li> <li>-They did not have a discontinue order for the Thiamine.</li> </ul> <p>Thiamine was was documented as administered 96 times (for 96 tablets) after 8/1/14 when 30 tablets were dispensed.</p> <p>The facility could provide no documentation an additional 66 tablets of Thiamine had been dispensed.</p> <p>On 11/18/14 at 2:40pm, interview with the Resident Care Coordinator revealed:</p> <ul style="list-style-type: none"> <li>-He did not know how 96 tablets of Thiamine could have been documented if only 30 tablets were dispensed.</li> <li>-He said the circled initials meant no Thiamine was available to administer.</li> </ul>	D 358		

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D 358	<p>Continued From page 51</p> <p>Observation of medications on hand on 11/20/14 at 11:30am revealed Thiamine had been dispensed on 11/18/14 and was available for administration.</p> <p>5. Review of record revealed an order, dated 8/10/14, for Folic Acid 1 mg daily (a nutritional supplement).</p> <p>Observation of medications on hand on 11/18/14 at 2:40pm revealed no Folic Acid available for administration.</p> <p>Review of the August, September, October, and November 2014 MARs revealed:                      -Folic Acid was documented as administered daily from 8/1 through 9/7.                      -Staff circled their initials 9/8 through 9/30 with the exception of 9/21 when nothing was documented.                      -Folic Acid was documented as administered daily 10/1 through 10/27.                      -Staff circled their initials 10/28 through 10/31.                      -Folic Acid was documented as administered daily 11/1 through 11/18 (day of survey).</p> <p>Telephone interview with staff at the facility pharmacy provider on 11/24/14 at 11:30am revealed:                      -They dispensed 30 tablets on 8/1/14, 30 tablets on 7/2/14 and 9 tablets on 6/24/14.                      -They had not dispensed any Folic Acid since 8/1/14 and none had been requested since then.                      -Over the counter medications were not dispensed to Resident #3 because of a payment issue. The pharmacy did not send over the counter medications if a resident owed a pharmacy bill.                      -They did not have a discontinue order for the Folic Acid.</p>	D 358		

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D 358	<p>Continued From page 52</p> <p>Folic Acid was documented as administered 82 times (for 82 doses) after 8/1/14 when 30 tablets were dispensed.</p> <p>On 11/18/14 at 2:40pm, interview with the Resident Care Coordinator revealed: -He did not know how 82 tablets of Folic Acid were administered if only 30 tablets were dispensed. -He said the circled initials meant no Folic Acid was available to administer.</p> <p>The facility could provide no documentation 52 additional tablets of Folic Acid had been dispensed.</p> <p>Observation of medications on hand on 11/20/14 at 11:30am revealed Folic Acid had been dispensed on 11/18/14 and was available for administration.</p> <p>6. Review of record revealed an order, dated 6/24/14, for Thera Beta Carotene, 1 daily (a nutritional supplement).</p> <p>Observations of medications on hand on 11/18/14 at 2:40pm revealed no Thera Beta Carotene available for administration.</p> <p>Review of the August, September, October, and November 2014 MARs revealed: -Thera Beta Carotene was documented as administered 8/1 through 9/7. -Staff circled their initials 9/8 through 9/30. -Thera Beta Carotene was documented as administered 10/1 through 10/27. -Staff circled their initials 10/28 through 10/31. -Thera Beta Carotene was documented as administered 11/1 through 11/18.</p>	D 358		

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D 358	<p>Continued From page 53</p> <p>Telephone interview with staff at the facility pharmacy provider on 11/24/14 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-They dispensed 30 tablets on 8/1/14, 30 tablets on 7/2/14 and 9 tablets on 6/24/14.</li> <li>-They had not dispensed any Thera Beta Carotene since 8/1/14 and none had been requested since then.</li> <li>-Over the counter medications were not dispensed to Resident #3 because of a payment issue. The pharmacy did not send over the counter medications if a resident owed a pharmacy bill.</li> <li>-They did not have a discontinue order for the Thera Beta Carotene.</li> </ul> <p>Thera Beta Carotene was documented as administered 94 times (94 tablets) after 30 tablets were dispensed on 8/1/14.</p> <p>The facility could provide no documentation 64 additional tablets of Thera Beta Carotene had been dispensed.</p> <p>On 11/18/14 at 2:40pm, interview with the Resident Care Coordinator revealed:</p> <ul style="list-style-type: none"> <li>-He did not know how 94 tablets of Thera Beta Carotene could have been documented if only 30 tablets were dispensed.</li> <li>-He said the circled initials meant no Thera Beta Carotene was available to administer.</li> </ul> <p>Observation of medications on hand on 11/20/14 at 11:30am revealed Thera Beta Carotene was dispensed on 11/18/14 and available for administration.</p> <p>Refer to interview with the Administrator on 11/24/14 at 3:30pm.</p>	D 358		
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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 358	<p>Continued From page 54</p> <p>B. Review of Resident #6's record revealed an FL2 dated 06/03/14 with diagnoses that included:</p> <ul style="list-style-type: none"> <li>- High blood pressure.</li> <li>- Congestive heart failure</li> <li>- Pulmonary embolism (blood clot in the lungs).</li> <li>- Diabetes mellitus Type II.</li> <li>- Gastro esophageal reflux disease.</li> <li>- Pulmonary embolism (blood clot in the lungs).</li> </ul> <p>Review of Resident #6's current Physician Order sheet dated 9/26/14 revealed orders that included:</p> <ul style="list-style-type: none"> <li>- Coreg 3.125mg twice a day (used to treat heart failure and high blood pressure.)</li> <li>- Glimepiride 4mg twice a day (used to lower blood sugar.)</li> <li>- Ranitidine 150mg once a day (used to reduce stomach acid).</li> <li>- Aspirin 81mg one time a day (used to prevent heart attacks and strokes).</li> <li>- Zolpidem 5mg every night (used to treat insomnia.)</li> <li>- Metformin 1000mg twice a day (used to treat high blood sugar).</li> <li>- Gabapentin 900mg every night (used to treat nerve pain).</li> <li>- Warfarin 7.5mg daily (used to prevent blood clots).</li> </ul> <p>Review of a Physician order for Resident #6 dated 10/17/14 revealed:</p> <ul style="list-style-type: none"> <li>- Warfarin 10mg to be given Saturday the 18th and Monday the 20th.</li> <li>- Warfarin 7.5 mg to be given all other days.</li> </ul> <p>1. Interview with Resident #6 on 11/18/14 at 11am and 3:45pm revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented to time, place and person.</li> <li>- The resident had been out of several</li> </ul>	D 358		

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D 358	<p>Continued From page 55</p> <p>medications for "a week or more", due to the "pharmacy bill got too high".</p> <ul style="list-style-type: none"> <li>-The resident was unsure of the names of all his medications, but stated he had not had his Metformin and Coreg as ordered.</li> <li>- The resident was not sure of his FSBS results and was not able to report negative consequences from missing medications.</li> </ul> <p>Observations of Resident #6's medications on hand on 11/18/14 at 2pm revealed none of the following medications were available for administration:</p> <ul style="list-style-type: none"> <li>- Coreg 3.125mg: review of the empty container revealed 60 pills were last dispensed on 09/30/14.</li> <li>- Glimepiride 4mg: review of the empty container revealed 60 pills were dispensed on 09/30/14.</li> <li>- Ranitidine 150mg: review of the empty container revealed 30 pills were dispensed 09/30/14.</li> <li>- No aspirin or container was found.</li> <li>- Zolpidem 5mg: review of the empty container revealed 30 pills were dispensed 09/23/14.</li> <li>- Metformin 1000mg: review of the empty container revealed 60 pills were dispensed 09/30/14.</li> <li>- Gabapentin 900mg: Review of the empty container revealed 90, 300mg capsules, were dispensed on 09/30/14.</li> <li>- Warfarin 10mg not available.</li> </ul> <p>Interview with staff at the facility's pharmacy provider on 11/18/14 at 3:15pm revealed:</p> <ul style="list-style-type: none"> <li>- A "cut off letter" had been sent to the facility on 9/13/14 informing them no prescriptions would be filled for Resident #6 after October 13th.</li> <li>- The last prescriptions filled for Resident #6 were dispensed on September 30, 2014.</li> </ul> <p>Review of Resident #6's November 2014</p>	D 358		

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D 358	<p>Continued From page 56</p> <p>Medication Administration Record (MAR) on 11/18/14 revealed staff's initials circled for the following administrations:</p> <ul style="list-style-type: none"> <li>- Coreg - 8:00am from November 15th through 18th.</li> <li>- Ranitidine - 8:00am from November 5th through 18th.</li> <li>- Glimepiride - 8:00am from November 15 through the 18th.</li> <li>- Aspirin - 8:00am from November 3rd through 18th.</li> <li>- Zolpidem - 12:00am from November 7th through 18th.</li> <li>- Metformin - 8:00am from November 7th through November 18th and 8:00pm on November 7, 14 and 17.</li> </ul> <p>An interview with the RCC on 11/18/14 at 1:45pm revealed:</p> <ul style="list-style-type: none"> <li>- Staffs' circled initials on the MAR meant no medications were available for administration on that specific date and time.</li> <li>- Resident #6 had been out of several medications for "up to 2 weeks" due to non-payment.</li> <li>- The RCC did not know when or if medications had been ordered for Resident #6.</li> </ul> <p>A telephone interview with Resident #6's PCP (Primary Care Provider) on 10/19/14 at 4pm revealed:</p> <ul style="list-style-type: none"> <li>- He had not been made aware that Resident #6 was out of medications until "this morning".</li> <li>- Any missed medication would be significant due to Resident #6's diagnoses of heart disease, diabetes, blood clots, etc.</li> </ul> <p>Interviews with the Administrator and Co-director on 11/18/14 at 4:20pm revealed:</p> <ul style="list-style-type: none"> <li>- The Administrator was not aware Resident #6</li> </ul>	D 358		

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D 358	<p>Continued From page 57</p> <p>"was out of that many medications." - Pharmacy A had cut off the resident's medications due to Resident #6's refusal to make the co-pay. The Co-director stated they had become aware about "two weeks ago" regarding Pharmacy A not sending anymore medications for the Resident #6. - The Co-director had gone to Pharmacy B (another local pharmacy) and thought they were going to contact Pharmacy A to get the orders transferred for Resident #6's medications. - The Co-director stated he was unsure why this never happened and no follow up had been done.</p> <p>A follow-up interview with the Administrator on 11/24/14 at 3:30pm revealed: - The former RCC was responsible for making sure all medications were available and ordered per physician orders. - The former RCC was also responsible for reviewing MARS weekly. - The Administrator was not aware these duties were not being performed until "recently."</p> <p>The RCC took Resident #6's blood pressure on 11/20/14 with results of 126/76.</p> <p>Review of the November 2014 FSBS log for Resident #6 revealed daily results at 8:00am that ranged from 124-207.</p> <p>2. Review of a Physician order for Resident #6 dated 10/17/14 revealed: - Warfarin 10mg to be given Saturday the 18th and Monday the 20th. - Warfarin 7.5 mg to be given all other days.</p> <p>Review of the October 2014 MAR revealed: - Warfarin 7.5mg administered at 5pm October</p>	D 358		

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D 358	<p>Continued From page 58</p> <p>1st through 17th.</p> <ul style="list-style-type: none"> <li>- A line drawn at the 18th entry date and a hand written entry with the symbol to "change" 10/17/14.</li> <li>- No further or other entries on the October MAR documented Warfarin had been given in any amount after 10/17/14.</li> </ul> <p>Review of the November 2014 MAR revealed:</p> <ul style="list-style-type: none"> <li>- Warfarin 7.5mg documented as given at 5pm November 1st through 17th.</li> </ul> <p>Interview with staff at the facility's pharmacy provider on 11/18/14 at 3:15pm revealed they had never received an order for Warfarin 10mg.</p> <p>Interview with staff at another local pharmacy on 11/21/14 at 8:45am revealed:</p> <ul style="list-style-type: none"> <li>- They had never received an order for Warfarin 10mg.</li> <li>- Only one order (transferred from a different pharmacy) for Warfarin had ever been filled for Resident #6 and this was for 7.5mg, last filled 11/10/14.</li> </ul> <p>Interview with the RCC (Resident Care Coordinator) on 11/18/14 at 1:45pm revealed:</p> <ul style="list-style-type: none"> <li>- He had worked at the facility for over 2 years but just became the RCC over the last month.</li> <li>- The RCC also was a Medication Aide and administered medications usually on day shift.</li> <li>- Resident #6 had been out of several medications for "up to 2 weeks" due to non-payment.</li> <li>- The RCC did not know when or if Resident #6 had ever had 10mg of Warfarin, all he knew of was 7.5mg.</li> <li>- He "could not say" whether the Warfarin 10mg had ever been ordered.</li> </ul>	D 358		
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D 358	<p>Continued From page 59</p> <p>Telephone interview with Resident #6's PCP (Primary Care Provider) on 11/19/14 at 4pm and 11/21/14 at 9:15am revealed:</p> <ul style="list-style-type: none"> <li>- He had not been made aware that Resident #6 was out of medications until this morning (11/19/14).</li> <li>- Any missed medication would be significant due to Resident #6's diagnoses of heart disease, diabetes, blood clots, etc.</li> <li>- The last order for Warfarin was on October 17, 2014 for 10mg two days a week and 7.5 all other days due to a recent change in INR (blood clotting times), the PCP was unsure of exact results. No dose changes had been made since that time.</li> <li>- The resident had regular INR test since the change on October 17, had been stable on that dose and no changes had been made.</li> <li>- The PCP thought Resident #6 had been on 10mg of Warfarin two days a week and 7.5 all other days since 10/17/14.</li> </ul> <p>Review of INR coagulation tests (INR is a test used to determine the effectiveness of Warfarin and the therapeutic range is 2 to 3) revealed:</p> <ul style="list-style-type: none"> <li>- No results of an INR for 10/17/14 was found in the resident's record.</li> <li>- 10/23/14 with results of 1.8; no new orders.</li> <li>- 11/06/14 with results of 1.8; no new orders.</li> <li>- 11/13/14 with results of 1.5; no new orders.</li> </ul> <p>Refer to interview with the Administrator on 11/24/14 at 3:30pm.</p> <p>C. Review of Resident #8's current FL2, dated 01/9/14 revealed diagnoses that included:</p> <ul style="list-style-type: none"> <li>- Bipolar disorder.</li> <li>- Anxiety</li> <li>- Chronic lower back pain.</li> </ul>	D 358		

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D 358	<p>Continued From page 60</p> <p>Review of the current Physician Order sheet signed 9/26/14 included orders for:</p> <ul style="list-style-type: none"> <li>- Seroquel 200mg twice a day (used to treat bipolar disorders).</li> <li>- Lamotrigine 25mg twice a day (used to treat mood disorders).</li> <li>- Trazodone 50mg at bedtime (used to treat anxiety orders).</li> <li>- Docusate sodium 100mg at bedtime (used for constipation).</li> <li>- Hydrocodone/Apap 5-325mg three times a day (used for pain).</li> <li>- Gabapentin 100mg at 5pm (used as an analgesic/pain reliever).</li> <li>- Lyrica 50mg twice a day ( used to treat fibromyalgia and nerve pain).</li> <li>- Zantac 150mg twice a day (used to reduce stomach acid).</li> </ul> <p>Review of the Standing Order Sheet dated 11/07/14 revealed orders for Tylenol 325mg, 2 tablets every 4 hours as needed for headache, fever and minor discomfort.</p> <p>1. Observation on 11/19/14 at 8:45am revealed:</p> <ul style="list-style-type: none"> <li>- Resident #8 approached RCC at medication cart and requested Tylenol due to a "splitting head ache."</li> <li>-The RCC looked in the drawer and pulled out an empty house stock bottle of Acetaminophen (generic name for Tylenol) 325mg.</li> <li>-The RCC said he did not have any 325mg available, just 500mg of house stock Tylenol but did not have an order for 500mg.</li> <li>-The Resident just turned and walked away.</li> </ul> <p>At this time, the RCC said he did not know how long the facility had been out of the 325mg tablets.</p>	D 358		
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D 358	<p>Continued From page 61</p> <p>2. Observation on 11/19/14 at 3:15pm revealed Resident #8 was being transferred out of the facility via ambulance due to a fall. The resident was taken to the local ED (Emergency Department) for evaluation.</p> <p>An interview with Resident #8 the following morning on 11/20/14 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented to person, place and time.</li> <li>- She did not know why the facility could not give her some Tylenol yesterday morning.</li> <li>- She had a headache almost everyday.</li> <li>- Yesterday the headache eventually "eased off".</li> <li>- She usually did not have any problems receiving medications as ordered.</li> <li>- She had returned from the ED last night around 9:20pm but was not "allowed" any of her evening medications because "it was after 9 o'clock".</li> <li>- "I could not sleep all night", kept having "pain and strange thoughts in the night."</li> </ul> <p>Review of the November 2014 MAR on revealed the following medications circled as not given between 5pm and 8pm on 11/19/14 because "out of facility at 5 and 8 med pass" (per documentation the back of the MAR):</p> <ul style="list-style-type: none"> <li>- Seroquel 200mg, 8pm dose.</li> <li>- Lamotrigine 25mg, 8pm dose.</li> <li>- Trazodone 50mg , 8pm dose.</li> <li>- Docusate sodium 100mg, 8pm dose.</li> <li>- Hydrocodone/Apap 5-325mg, 8pm dose.</li> <li>- Gabapentin 100mg, 5pm dose.</li> <li>- Lyrica 50mg, 8pm dose.</li> <li>- Zantac 150mg, 8pm dose.</li> </ul> <p>An interview with the RCC on 11/20/14 at 11am revealed:</p> <ul style="list-style-type: none"> <li>- We have a one hour window to give medications.</li> </ul>	D 358		

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D 358	<p>Continued From page 62</p> <ul style="list-style-type: none"> <li>- After the one hour window has passed we are supposed to call the doctor to check if it is OK to give the medications.</li> </ul> <p>An interview with Staff D (Medication Aide) on 11/21/14 at 8am revealed:</p> <ul style="list-style-type: none"> <li>- She had worked the evening Resident #8 returned from the ED (11/19/14).</li> <li>- She thought it was between 9 and 9:30pm when the resident came back.</li> <li>- Staff D thought she could not administer Resident #8's medications because it was "past the 1 hour" time designated on the MAR.</li> <li>- She did not know what else to do and did not know anything about calling anyone to get permission to "go against the rule."</li> </ul> <p>Refer to interview with the Administrator on 11/24/14 at 3:30pm.</p> <p>D. Record review of Resident #10's FL2 dated 02/06/14 revealed diagnoses that included uncontrolled DM II (type II diabetes) and gastroparesis.</p> <p>Review of Resident #10's current Physician Order sheet signed 09/26/14 included orders for:</p> <ul style="list-style-type: none"> <li>- Metoclopramide 5mg before meals and at bedtime (used for gastroesophageal reflux.)</li> <li>- FSBS (finger stick blood samples) before meals and at bedtime.</li> <li>- Humalog 20 units and per sliding scale (SS) subcutaneously before meals (a fast acting insulin used to treat diabetes).</li> <li>- Lantus 45 units subcutaneously twice (long acting insulin used to treat diabetes).</li> </ul> <p>Observations during medication administration pass on 11/19/14 revealed:</p> <ul style="list-style-type: none"> <li>- 7:45am, Resident #10 left the dining room,</li> </ul>	D 358		
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D 358	<p>Continued From page 63</p> <p>came to the medication cart. The resident had already eaten breakfast.</p> <ul style="list-style-type: none"> <li>- The RCC/MA (Resident Care Coordinator/Medication Aide) proceeded to obtain Resident #10's FSBS, which required 6 units of SSI.</li> <li>- The RCC prepared the routine dose of Humalog of 20 units (plus an additional 6 units to cover the SS) and the Lantus 45 units.</li> <li>- Resident #10 refused the Humalog but accepted the Lantus.</li> <li>- The RCC prepared the resident's oral medications that included Metoclopramide 5mg and administered the medication at 8:05am.</li> <li>- Interview at this time with the RCC revealed the resident had gone into the dining room before the RCC was able to administer the medications as ordered.</li> </ul> <p>Interview with Resident #10 on 11/19/14 at 11:00am revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert to time, person and place.</li> <li>- The resident was not sure about exact times medications were usually given.</li> <li>- The resident denied having any gastrointestinal problems.</li> </ul> <p>Refer to interview with the Administrator on 11/24/14 at 3:30pm.</p> <p>E. Review of Resident #4's FL2 dated 02/07/14 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses that included constipation.</li> <li>- Orders for MOM (Milk of Magnesia) 30cc every other day.</li> </ul> <p>Review of an emergency department note dated 01/13/14 revealed diagnoses of lower extremity pain and osteoarthritis in left knee.</p>	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 64</p> <p>Review of Physician Order Sheet dated 9/26/14 revealed orders to apply Biofreeze (a topical cream to relieve arthritis pain) to knee three times a day.</p> <p>Observations during the morning medication administration pass on 11/19/14 revealed:</p> <ul style="list-style-type: none"> <li>- The RCC prepared Resident #4's oral medications at 8:30am.</li> <li>- No MOM was available for administration.</li> <li>- The RCC stated he had used the last of the MOM the day before yesterday but could not say when or if anymore had been ordered.</li> <li>- The RCC stated there was no Biofreeze available for administration and did not know when or if it had been ordered.</li> </ul> <p>Interview with Resident #4 on 11/19/14 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented to person, time and place.</li> <li>- Staff had never used any ointment, gel or cream on his knee.</li> <li>- His knee hurt "everyday" and was able to get medication as needed for pain.</li> <li>- The resident was unsure how often he received the MOM and could not remember exactly when the last dose was given.</li> </ul> <p>Refer to interview with the Administrator on 11/24/14 at 3:30pm.</p> <p>-----</p> <p>Telephone interview with Administrator on 11/24/14 at 3:30pm revealed:</p> <ul style="list-style-type: none"> <li>-After the former Resident Coordinator (RCC) left the last of October, 2014, the administrator became aware there were medications missing.</li> <li>-After the former RCC left it was also discovered the RCC had not provided the appropriate</li> </ul>	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 11/25/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON CITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 65</p> <p>oversight for assuring medications were administered as ordered, -After the former RCC left, she had been reported her to the local authorities to determine if any drug diversion had occurred, but the local authorities have not concluded their investigation.</p> <p>Plan of Protection provided by the facility revealed: -The facility will provide an alternate pharmacy with prescriptions to fill medications for Resident #3 and #6. -The facility will conduct an immediate review of resident Medication Administration Records to assure that all residents are receiving prescribed medications. -Medications on hand will be compared to current physician orders. -The medication reviews will be conducted by the interim Resident Care Coordinator and the Administrator.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2014.</p>	D 358		
D 367	<p>10A NCAC 13F .1004(j) Medication Administration</p> <p>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;</p>	D 367	<p>The contracted RN will audit and assess for 4 weeks overall competency of each Med Tech and provide 1:1 training as needed for each individual if/when needs are identified. Findings will be reported to the Administrator weekly. Clerical Med Tech responsibilities will be assigned according to Strengths and Weaknesses in conjunction with minimum state requirements.</p> <p>RN will conduct a weekly Med Tech team meeting for 4 weeks to receive and provide feedback, and to review general statutes of med administration included but not limited to the 6 Rights of Med Administration. Feedback will be given to the Administrator and/or Co-Director for overview as well.</p> <p>RN is communicating with employees/Med Techs no less than 3 times per week, when she is conducting on site supervision.</p>	1-9-15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 11/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON CITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>		
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D 367	<p>Continued From page 66</p> <p>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;</p> <p>(6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,</p> <p>(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).</p> <p>This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure the documentation regarding the administration and availability of medications was recorded on the medication administration records for 3 of 4 sampled residents (Residents #3, #4, and #6).</p> <p>The findings are:</p> <p>A. Review of Resident #6's record revealed an FL2 dated 06/03/14 with diagnoses that included:</p> <ul style="list-style-type: none"> <li>- High blood pressure.</li> <li>- Congestive heart failure- Diabetes mellitus Type II.</li> </ul> <p>Review of Resident #6's current Physician Order sheet dated 9/26/14 revealed orders that included:</p> <ul style="list-style-type: none"> <li>- Coreg 3.125mg twice a day (used to treat heart failure and high blood pressure.)</li> <li>- Glimepiride 4mg twice a day (used to lower blood sugar.)</li> <li>- Metformin 1000mg twice a day (used to treat high blood sugar).</li> </ul>	D 367	<p>All resident LHPS, FL-2s, and Care Plans were audited and completed as needed under the supervision of the RN and Administrator accordingly. All clinical charts were audited for general overview and state compliance.</p> <p>Weekly med cart audits will be completed for no less than 4 weeks to ensure adequate supply of meds on hand. This process will be supervised by the RN and supporting documentation will be turned in to the Administrator for review, which will ensure that proper protocols are being followed, and that residents will not be without prescribed meds.</p> <p>RN will provide additional training for Med Techs including but not limited to: Diabetes Mellitus, Insulin protocols, Infection Control, and the 6 Rights of Medication Administration within the 15 hours of Med Aide Training for those staff for whom it applies.</p> <p>Moving forward, Administrator and/or Co-Director will ensure each Med Tech receives annual diabetic training, ensuring baseline knowledge and safe practices.</p>	<p>1-09-15</p> <p>1-9-15</p> <p>1-9-15</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>
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D 367	<p>Continued From page 66</p> <p>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</p> <p>This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure the documentation regarding the administration and availability of medications was recorded on the medication administration records for 3 of 4 sampled residents (Residents #3, #4, and #6).</p> <p>The findings are:</p> <p>A. Review of Resident #6's record revealed an FL2 dated 06/03/14 with diagnoses that included: - High blood pressure. - Congestive heart failure - Diabetes mellitus Type II.</p> <p>Review of Resident #6's current Physician Order sheet dated 9/26/14 revealed orders that included: - Coreg 3.125mg twice a day (used to treat heart failure and high blood pressure.) - Glinpiperide 4mg twice a day (used to lower blood sugar.) - Metformin 1000mg twice a day (used to treat high blood sugar).</p> <p>Resident #6 was interviewed on 11/18/14 at 11am</p>	D 367		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
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D 367	<p>Continued From page 67</p> <p>and 3:45pm. The resident was alert and oriented to time, place and person. Resident #6 revealed:</p> <ul style="list-style-type: none"> <li>- He had been out of several medications for "a week or more", due to the "pharmacy bill got too high".</li> <li>-The resident was unsure of the names of all his medications, but reported Metformin and Coreg as two medications he had been out of.</li> <li>- The resident was not sure of his FSBS results and was not able to report negative consequences from missing medications.</li> </ul> <p>Observation of Resident #6's medications on hand on 11/18/14 at 2pm included:</p> <ul style="list-style-type: none"> <li>- Coreg 3.125mg: review of the empty container revealed 60 pills were last dispensed on 09/30/14 (a one month supply).</li> <li>- Glimepiride 4mg: review of the empty container revealed 60 pills were dispensed on 09/30/14 (a one month supply).</li> <li>- Metformin 1000mg: review of the empty container revealed 60 pills were dispensed 09/30/14 (a one month supply).</li> </ul> <p>Interview with staff at the facility's pharmacy provider on 11/18/14 at 3:15pm revealed the medications above were last filled for Resident #6, dispensed on September 30, 2014.</p> <p>The November 2014 MAR for Resident #6 was reviewed on November 18th and revealed:</p> <ul style="list-style-type: none"> <li>- An entry for Coreg 3.125mg, take one tablet twice a day with scheduled administrations times at 8am and 8pm. The 8am dose was initialed as given November 1st through 14th and and circled as not given November 15th through the 18th. The 8pm dose was initialed as given November 1st through the 17th except circled as not given on the 14th.</li> <li>- An entry for Glimepiride 4mg, take one tablet</li> </ul>	D 367		

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D 367	<p>Continued From page 68</p> <p>twice a day with scheduled administration times at 8am and 8pm. The 8am dose was initialed as given November 1st through 14th and circled as not given November 15th through 18th. The 8pm dose was initialed as given November 1st through November 17th.</p> <ul style="list-style-type: none"> <li>- An entry for Metformin 1000mg, take one tablet twice a day with scheduled times at 8am and 8pm. The 8am dose was initialed as given November 1st through November 6th and circled as not given November 7th through 18th. The 8pm dose was initialed as given November 1st through 6th, November 8th through November 13th, November 15th and 16th. The 8pm dose was circled as not given on November 7th, 14th and 17th.</li> </ul> <p>An interview with the RCC on 11/18/14 at 1:45pm and 4pm revealed:</p> <ul style="list-style-type: none"> <li>- Resident #6 had run out of several medications.</li> <li>- The RCC was also a medication aide and mostly worked first shift.</li> <li>- When medications were not available, he circled his initials in the date and administration time slot on the MAR.</li> <li>- He did not know how the 8pm doses could have been given when the medications were not available.</li> </ul> <p>B. Review of an emergency department note for Resident #4 dated 01/13/14 revealed diagnoses of lower extremity pain and osteoarthritis in left knee.</p> <p>Review of Physician Order Sheet dated 9/26/14 revealed orders to apply Biofreeze (a topical gel to relieve arthritis pain) to knee, coccyx and rectum three times a day.</p> <p>Observations during the morning medication</p>	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
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D 367	<p>Continued From page 69</p> <p>administration pass on 11/19/14 revealed:</p> <ul style="list-style-type: none"> <li>- At 8:30am, the RCC prepared Resident #4's 8:00am medications for administration.</li> <li>- The RCC searched the medication cart drawer and stated there was no Biofreeze available for administration.</li> </ul> <p>Review of the November 2014 MAR for Resident #4 on November 19th revealed:</p> <ul style="list-style-type: none"> <li>- An entry for Biofreeze, apply to knee, coccyx and rectum three times a day with scheduled times at 8am, 2pm and 8pm.</li> <li>- The Biofreeze was initialed as given: at 8am on November 1 through November 18th; at 2pm November 1st through 18th (except November 16 was left blank); and at 8pm November 1st through 18th.</li> </ul> <p>An interview with Resident #4 on 11/19/14 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented to time, place and person.</li> <li>- He was not aware of an order for a pain reliever gel.</li> <li>- Staff had never used any ointment, cream, or gel on him anywhere.</li> <li>- His knee hurt "everyday" and was able to get medication as needed for pain.</li> </ul> <p>Interview with the RCC on 11/19/14 at 1:45pm revealed:</p> <ul style="list-style-type: none"> <li>- He thought he might have used the last of the Biofreeze the day before but was not sure.</li> <li>- He did not know why the doses were initialed on the MAR as given if there was none available.</li> </ul> <p>C. Review of current FL2 for Resident #3, dated 8/10/14 revealed the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Chronic obstructive pulmonary disease</li> <li>-Lumbago</li> </ul>	D 367		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/25/2014</b>
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D 367	<p>Continued From page 70</p> <p>-Cirrhosis</p> <p>Review of an Emergency Room Report for Resident #3, dated 11/20/14, revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included hypokalemia, chronic anxiety, and depression.</li> <li>-Resident #3 complaining of chronic pain and having frequent urination.</li> </ul> <p>Review of Resident #3's Resident Register revealed he was admitted to the facility on 6/24/14.</p> <p>Review of records for Resident #3 revealed an order, dated 9/17/14 for Nucynta 75 mg, 1 every 8 hours as needed for pain. (A medication for neuropathic pain associated with diabetic peripheral neuropathy in adults severe enough to require daily, around the clock, long-term opioid treatment and for which alternative treatment options are inadequate.)</p> <p>Observations of medications on hand on 11/18/14 at 2:40pm revealed no Nucynta available for administration.</p> <p>Review of the Nucynta 75 mg Controlled Drug Disposition Form revealed:</p> <ul style="list-style-type: none"> <li>-90 tablets were available to administer on 9/17/14.</li> <li>-Administration was documented from 9/17/14 through 10/29 with 81 tablets administered to Resident #3.</li> </ul> <p>Review of September, October, and November 2014 MARs revealed only 51 tablets of Nucynta were documented on front of the MARs as administered to Resident #3 from 9/17/14 through 11/3/14 (although the last one of the Controlled Drug Disposition Form was documented as</p>	D 367		

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D 367	<p>Continued From page 71 administered on 10/29/14.)</p> <p>When the documentation of Nucynta on the Controlled Drug Disposition Form for Resident #3 was compared to the back of the October 2104 MAR, it revealed staff failed to document the administration, reason for administering, and effectiveness of the Nucynta at the following times:</p> <p>10/1: 6:01pm 10/2: 5:25pm 10/3: 6:00pm 10/5: 7:15pm 10/6: 8:10pm 10/7: 8:15pm 10/9: 8am 10/10: 7:26am and 5:30pm 10/11: 7:34am and 4:25pm 10/12: 12:30am 10/13: 8:03am 10/14: 7:38am and 8pm 10/15: 8:17am and 5:31pm 10/16: 7:33am 10/17: 8pm 10/19: 8pm 10/20: 5:30pm 10/21: 3am 10/22: 8am and 8pm 10/28: 4pm 10/29: 7:58am</p> <p>When the documentation of Nucynta on the Controlled Drug Disposition Form for Nucynta for Resident #3 was compared to the back of the November 2104 MAR, it revealed staff failed to document the administration, reason for administering, and effectiveness of the Nucynta at the following times:</p> <p>9/18: 6:30pm</p>	D 367		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
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D 367	<p>Continued From page 72</p> <p>9/19: 4:30pm 9/20: 3:30pm and 11:46pm 9/21: 8:30am 9/22: 2:30pm 9/23: 12:08am 9/24: 3:45am 9/25: 4:06pm 9/27: 8pm 9/29: 8am and 7:30pm</p> <p>Confidential interviews with two medication aides during the survey revealed they had forgotten to document on the back of the MAR, but they knew they were supposed to.</p> <p>Interview with the Administrator on 11/24/14 at 3:30pm revealed: -Medication aides had been trained to document the administration on the back of the MAR the reason and effectiveness of prn medications. -She had depended on the former Resident Care Coordinator (RCC) to provide oversight for medications but the RCC left employment of the facility on 10/25/14.</p>	D 367		
D 372	<p>10A NCAC 13F .1004 (o) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration</p> <p>(o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented.</p>	D 372		

JAN - 9 2015

PRINTED: 12/11/2014  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL087005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C 11/25/2014
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NAME OF PROVIDER OR SUPPLIER  CORNERSTONE LIVING CENTER OF BRYSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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D 372	<p>Continued From page 73</p> <p>This Rule is not met as evidenced by: Based on interview, observation, and record review, the facility failed to assure 1 of 1 resident's (#3) medication, Nucynta, was not borrowed for another resident (#9) and failed to assure the borrowing and replacement of the medication was documented.</p> <p>The findings are:</p> <p>Review of records for Resident #3 revealed an order, dated 9/17/14, for Nucynta 75mg, 1 every 8 hours as needed for pain.</p> <p>Observations of medications on hand on 11/18/14 at 2:40pm revealed no Nucynta available for administration for Resident #3.</p> <p>Review of the Nucynta 75 mg Controlled Drug Disposition Form for Resident #3 revealed: -90 tablets were available to administer on 9/17/14. -Administration was documented from 9/17/14 through 10/29 with 81 doses administered to Resident #3. -Administration of 9 doses were documented on the Controlled Drug Disposition Form as administered to another Resident #9 "on consent" dates of October 26, 27, 28, and 29.</p> <p>Review of record for Resident #9 revealed no documentation the Nucynta that had been borrowed from Resident #3 and administered to Resident #9 had been replaced.</p> <p>Interview with the RCC on 11/21/14 at 10:30am revealed: -He had documentation he had requested a refill for Nucynta for Resident #3 on 10/29/14. (This would have been the day the last Nucynta was</p>	D 372	<p><i>In regards to sharing of medications. All med aid staff has been addressed and re-educated and understands that medication sharing is not an option and the consequences of violation of this rule.</i></p>	12-3-14

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D 372	<p>Continued From page 74</p> <p>documented as administered on the Controlled Drug Disposition Form.) -Nucynta had not been refilled due to pharmacy needed "prior authorization." -He had been trained that medications for one resident could be borrowed from another resident.</p> <p>Telephone interview with staff the local pharmacy on 11/19/14 at 5:18pm revealed on 9/17/14, they had dispensed 90 tablets Nucynta 75 mg, one every 8 hours for pain for Resident #3.</p> <p>Interview with Resident #3 on 11/19/14 5:15pm revealed: -He had been in severe pain and when he asked for medication recently, the medication aides tell him the only thing available is "Tylenol." -When he asked for something stronger than Tylenol, the medication aides told he they don't know why it is not available. -Tylenol did not decrease his pain. -He had asked "several weeks ago" to go to a pain clinic.</p> <p>Review of current FL2 for Resident #9, dated 5/21/14, revealed the following diagnoses: -Past hip anthroplasty. -Chronic obstructive pulmonary disease. -Cirrhosis.</p> <p>Review of record revealed a physician order for Resident #9, dated 10/16/14, for Nucynta 75 mg, 1 every 6 hours as needed for pain. (A narcotic medication for moderate to severe pain.)</p> <p>Telephone interview with staff at the facility pharmacy provider on 11/24/14 at 11:30am revealed: -On 10/16/14, they dispensed 30 tablets, a 7 day</p>	D 372		

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D 372	<p>Continued From page 75</p> <p>supply of Nucynta 75 mg, with direction to administer 1 every 6 hours as needed for Resident #9.</p> <p>-The facility did not request any refills until 10/27/14, one day after the last Nucynta was documented as administered to Resident #9.</p> <p>-The pharmacy dispensed 30 tablets of Nucynta 100mg, 1 every six hours as needed for pain, on 10/28/14 and the facility received them on 10/29/14.</p> <p>Review of Resident #9's Controlled Drug Disposition Form for the Nucynta 75 mg revealed:</p> <p>-Thirty tablets were received at the facility on 10/18/14.</p> <p>-The first tablet was administered on 10/18/14 at 8:30pm and the last tablet was administered on 10/26/14 at 9:30am.</p> <p>Review of the Controlled Drug Disposition Form Nucynta 75 mg for Resident #3 revealed 9 doses were documented as administered to Resident #9 "on consent" dates of October 26, 27, 28, and 29 as follows.</p> <p>-10/26: 1 dose at 3:30pm and at 9:30pm.</p> <p>-10/27: 1 dose at 10:00am, 4:00pm, and 10:00pm.</p> <p>-10/28: 1 dose at 4:00am, 10:00am, and 9:00pm.</p> <p>-10/29: 1 dose at 7:50am.</p> <p>Review of Resident #9's October 2014 Medication Administration Record (MAR) revealed:</p> <p>-No documentation on the front of the MAR that any Nucynta was administered on 10/27 and 10/28.</p> <p>-No documentation that 9 tablets of Nucynta were borrowed from Resident #3 and administered to Resident #9 from 10/26 to 10/29.</p> <p>-Documentation of one dose Nucynta</p>	D 372		

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D 372	<p>Continued From page 76</p> <p>administered on the 29th.</p> <ul style="list-style-type: none"> <li>-No documentation the Nucynta borrowed for Resident #9 was returned to Resident #3.</li> <li>-No documentation Resident #9's physician was contacted to inform him Resident #9 was out of Nucynta and would it be acceptable to borrow medication from Resident #3.</li> <li>-Documentation of the back of the MAR revealed the 9:30pm dose on 10/26, and 3 doses on 10/27.</li> <li>-Five borrowed doses were not accounted for on the front nor the back of the October MAR for Resident #9.</li> </ul> <p>Interview with the Administrator on 11/24/13 at 3:30pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff should only borrow medications from other residents after the physician has been called for a resident requiring a borrowed medication.</li> <li>-Staff should order refills for medications before they administer the last dose, when the medications in the bubble pack are down to the blue zone.</li> </ul> <p>Confidential interview with one medication aide during the survey revealed she had been trained they could borrow medications, but could not think of any current examples.</p> <p>Telephone interview with the Administrator on 11/24/14 at 3:30pm revealed:</p> <ul style="list-style-type: none"> <li>-If staff did not circle their initials on the MAR, she would not have been aware the medications were not available for administration.</li> <li>-It was the responsibility of the RCC to assure all medications were available for administration.</li> </ul>	D 372		
D912	G.S. 131D-21(2) Declaration of Residents' Rights  G.S. 131D-21 Declaration of Residents' Rights	D912		

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D912	<p>Continued From page 77</p> <p>Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to North Carolina Health Care Personnel Registry, cardio-pulmonary resuscitation, health care referral and implementation, medication administration, infection control, annual infection control training, and management.</p> <p>The findings are:</p> <p>A. Based on interview and record review, the facility failed to assure 2 of 4 sampled staff (Staff D and J) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR). [Refer to Tag 137 10A NCAC 13F .0407(a) (Type B Violation).]</p> <p>B. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 4 of 21 days on third shift in November 2014. [Refer to Tag 167 10A NCAC 13F .0507 (Type B Violation).]</p> <p>C. Based on observation, interview, and record review, the facility failed to assure referral and follow up to meet the acute health care needs for</p>	D912	<p>New Hire protocols reviewed by Admin – New Hire Checklist Developed and implemented. In addition to all other state requirements, All new employees will be screened on the Health Registry per the reg. and checklist will be used on each person. Overseen by Admin and Co-Director as needed ongoing.</p>	1-9-15

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D912	<p>Continued From page 78</p> <p>3 of 3 residents (#1, #3 &amp; #6) sampled related to medications not available for days, medication refusals, and mental health referral for behavior changes. [Refer to Tag 273 10A NCAC 13F .0902(b) (Type A2 Violation).]</p> <p>D. Based on observation, interview, and record review, the facility failed to assure implementation of fingerstick blood sugars as ordered for 1 of 4 sampled residents (#3). [Refer to Tag 276 10A NCAC 13F .0902(c) (Type B Violation).]</p> <p>E. Based on observation, interview, and record review, the facility failed to assure medications, which included Warfarin, Enablex, Spironolactone, Nucynta, Metformin, Glimepiride and Coreg, were administered as ordered for 5 of 5 sampled residents. [Refer to Tag 358 10A NCAC 13F .1004(a). (Type A2 Violation).]</p> <p>F. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucometers without disinfection of the glucometer and sharing lancing devices when used for different residents for 3 of 4 sampled residents with orders for finger stick blood samples (FSBS). (Residents #4, 7, and 11.) [Refer to Tag 932 G.S. 131D-4.4A (Type A2 Violation).]</p> <p>G. Based on interview, and record review, the facility failed to provide mandatory annual infection prevention training for 2 of 2 sampled medication aides (Staff H and Staff J) and employed for more than one year. [Refer to Tag 934 G.S. 131D-4.5B(a) (Type B Violation).]</p> <p>H. Based on observation, interview and record</p>	D912		

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D912	Continued From page 79  review, the Administrator failed to assure responsibility for the total operation of the facility to maintain compliance in the rule areas regarding resident rights, housekeeping, staff qualifications, training on cardio-pulmonary resuscitation, personal care and other staffing, medication administration, health care implementation, health care referral and follow-up, and adult care home infection prevention requirements. [Refer to Tag 176 10A NCAC 13F .0601(a) (Type B Violation).]	D912		
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	D932		

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D932	<p>Continued From page 80</p> <p>significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.</p> <p>f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.</p> <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucometers without disinfection of the glucometer and sharing lancing devices when used for different residents for 3 of 4 sampled residents with orders for finger stick blood samples (FSBS). (Residents #4, 7, and 11.)</p> <p>The findings are:</p> <p>Interview with the RCC (Resident Care Coordinator) on 11/18/14 at 12:30pm revealed:</p> <ul style="list-style-type: none"> <li>- There were several residents in the facility currently receiving FSBS.</li> <li>- Each resident had their own glucometer.</li> </ul>	D932		

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D932	<p>Continued From page 81</p> <ul style="list-style-type: none"> <li>- The RCC proceeded to show the surveyor numerous glucometers stored in the top drawer of the medication cart. Initial observation at this time revealed the cases were labeled with names or initials of residents.</li> </ul> <p>Interview with Staff D (Medication Aide) on 11/19/14 at 10:55am revealed:</p> <ul style="list-style-type: none"> <li>- She had worked on 11/15/14 and had used one resident's (#7) glucometer and lancing device to obtain all residents' FSBS for 11/15/14.</li> <li>- Whenever she performed fingersticks, she used the first available glucometer and lancing device (whichever one was in the front of the medication cart drawer) when she obtained FSBS for all residents because it was "easier that way." This was how she had been trained by a medication aide on third shift.</li> <li>- She always changed the lancet between residents and cleaned the lancing device with alcohol before putting in a new lancet.</li> <li>- She had infection control training but really did not "remember much about it."</li> </ul> <p>Interview with Staff C (Medication Aide) on 11/20/14 at 5:20pm revealed:</p> <ul style="list-style-type: none"> <li>- She did not share glucometers.</li> <li>- She did share lancing devices but always cleaned the device "real good with alcohol" before inserting a new lancet.</li> <li>- Today she used one resident's (#7) lancing device to obtain 2 other residents' (#4 and #11) fingersticks at 4pm today because they did not have their own lancing device.</li> </ul> <p>Review of residents' records, medication administration records and glucometer history for 3 residents, who staff identified as sharing glucometers and lancing devices revealed the following:</p>	D932	<p>Re: GS. 131D-4.4 Interview with staff D on 11-23-14 revealed: she stated that she did in fact use the same glucometer for more than one resident, but never the same lancet. also stated that glucometers were cleaned after each use.</p> <p>Staff D has received written notice for training required for infection control and diabetic training. With completion date 12-19-14 (Training tools provided by facility).</p> <p>Facility has provided an onsite nurse as of 12-3-14 as a plan of action for immediate oversight of medication staff, <del>the</del> immediate review of diabetic procedures and infection control as well as on going oversight in all areas of medication administration.</p>	
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D932	<p>Continued From page 82</p> <p>A. Review of Resident #4's record revealed:</p> <ul style="list-style-type: none"> <li>- An FL2 dated 02/07/14 with diagnoses that included type II diabetes.</li> <li>- A Physician Order Sheet for September 2014, signed by the physician but not dated, for FSBS to be obtained twice a day.</li> <li>- The November 2014 MAR (Medication Administration Record) with documentation the FSBS had been done at 8am and 8pm but no results were documented.</li> <li>- There was no documentation of a FSBS log for Resident #4.</li> </ul> <p>Observations of the Medication Administration pass on 11/19/14 at 8:40am revealed:</p> <ul style="list-style-type: none"> <li>- RCC/MA (Resident Care Coordinator/Medication Aide) took a glucometer case from the medication cart drawer that was labeled with Resident #4's initials.</li> <li>- The actual glucometer was labeled with Resident #7's name.</li> <li>- When questioned about names/initials, the RCC replaced the glucometer back in the drawer and retrieved another case from the drawer labeled with Resident #4's name.</li> <li>- The actual glucometer in this case was not labeled but the RCC stated this was Resident #4's newest glucometer and proceeded to obtain the FSBS from Resident #4.</li> </ul> <p>Observations of the second glucometer case with Resident #4's name revealed an unlabeled glucometer and unlabeled lancing device that was used to obtain Resident #4's FSBS on 11/19/14 at 8:40am with results of 268.</p> <p>Review of this unlabeled glucometer history revealed the following readings</p> <ul style="list-style-type: none"> <li>- 11/11/14 at 8:18am, results of 208.</li> </ul>	D932	<p>FSBS Logs for all residents diagnosed with diabetes are now in place as well as review of FSBS documentation daily but not less than 3x weekly by nurse oversight and/or administrator.</p> <p>RCC/Med Aid Staff member was required to attend the annual <del>completion</del> diabetic training; completion date 12-12-14</p> <p>"RCC" Med Aid has gone under review for job performance in the areas cited in this survey and placed on a 30 day corrective action. Said staff member will work under close supervision of nurse and administrative staff and reviewed again per 30 days of corrective action to insure that safe and accurate practices are in place.</p>	<p>12-15-14</p> <p>12-12-14</p>
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D932	<p>Continued From page 83</p> <ul style="list-style-type: none"> <li>- 11/2/14 at 5:04pm results of 166.</li> <li>- 11/2/14 at 9:45pm results of 195.</li> <li>- 11/5/14 at 9:29pm results of 178.</li> <li>- 11/6/14 at 8:41pm results of 161.</li> <li>- 11/8/14 at 8:30pm results of 195.</li> <li>- 11/9/14 at 9:38pm results of 181.</li> <li>- 11/10/14 at 8:59pm results of 187.</li> <li>- 11/12/14 at 9:33pm results of 199.</li> <li>- 11/13/14 at 9:20pm results of 181.</li> <li>- 11/15/14 at 8:34pm results of 160.</li> <li>- 11/16/14 at 8:49pm results of 190.</li> <li>- 11/17/14 at 9:09pm results of 140.</li> </ul> <p>Interview with Staff C (Medication Aide) on 11/20/14 at 5:20pm revealed:</p> <ul style="list-style-type: none"> <li>- Today she used one resident's (#7) lancing device to obtain Resident #4's fingersticks at 4pm today because Resident #4 did not have a lancing device.</li> </ul> <p>Refer to interview with the RCC on 11/19/14 at 9:00am.</p> <p>Refer to the interviews with the Administrator on 11/19/14 at 4:00pm and 11/21/14 at 10am.</p> <p>B. Review of Resident #7's record revealed:</p> <ul style="list-style-type: none"> <li>- The current FL2 dated 05/23/13 revealed a diagnosis of diabetes and orders to obtain FSBS one time a week.</li> <li>- A physician order dated 08/07/14 to obtain FSBS biweekly.</li> <li>- Review of the November 2014 MAR revealed FSBS documented at 7:30am twice a week.</li> </ul> <p>Observation of a glucometer case labeled with Resident #7's name revealed an unlabeled glucometer inside.</p> <p>Review of the unlabeled glucometer history</p>	D932		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	<p>Continued From page 84</p> <p>revealed 5 glucose readings ranging from 68 to 189 were obtained within 54 minutes. The readings were:</p> <ul style="list-style-type: none"> <li>- 10/27/14 at 7:19pm, results of 189.</li> <li>- 10/27/14 at 7:31pm, results of 126.</li> <li>- 10/27/14 at 7:51pm, results of 68.</li> <li>- 10/27/14 at 7:52pm, results of 72.</li> <li>- 10/27/14 at 8:13pm, results of 168.</li> </ul> <p>Review of a glucometer case with Resident #4's initials revealed a glucometer inside with Resident #7's name on the back of the glucometer.</p> <p>Review of the history of the glucometer labeled with Resident #7's name revealed multiple readings obtained on 11/15/14. The readings were:</p> <ul style="list-style-type: none"> <li>- 11/15/14 at 7:29am, results of 156.</li> <li>- 11/15/14 at 8:14am, results of 222.</li> <li>- 11/15/14 at 8:29 am, results of 287.</li> <li>- 11/15/14 at 8:52am, results of 195.</li> <li>- 11/15/14 at 9:56am results of 207.</li> <li>- 11/15/14 at 11:54am, results of 394.</li> <li>- 11/15/14 at 12:05pm, results of 226.</li> <li>- 11/15/14 at 8:45pm, results of 135.</li> </ul> <p>Refer to interview with the RCC on 11/19/14 at 9:00am.</p> <p>Refer to the interviews with the Administrator on 11/19/14 at 4:00pm and 11/21/14 at 10am.</p> <p>C. Review of Resident #11's record revealed:</p> <ul style="list-style-type: none"> <li>- The resident's current FL2 dated 10/01/14 with diagnoses that included Diabetes Mellitus and an order to obtain FSBS daily and to vary times.</li> <li>- A Physician's order dated 10/03/14 to obtain FSBS twice a day.</li> <li>- The November 2014 MAR had Resident #11's FSBS documented twice a day at 8am and 8pm</li> </ul>	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	<p>Continued From page 85</p> <p>but no results were on the MAR, however, a FSBS log for November revealed results of the FSBS documented twice some days and once some days.</p> <p>Review of the history for Resident # 11's glucometer was unable to be done due to the resident's original glucometer had been removed the morning of 11/20/14 when the facility replaced all glucometers.</p> <p>Interview with Staff C (Medication Aide) on 11/20/14 at 5:20pm revealed:</p> <ul style="list-style-type: none"> <li>- Today she used one resident's (#7) lancing device to obtain Resident #11's fingersticks at 4pm today because Resident #11 did not have a lancing device.</li> </ul> <p>Refer to interview with the RCC on 11/19/14 at 9:00am.</p> <p>Refer to the interviews with the Administrator on 11/19/14 at 4:00pm and 11/21/14 at 10am.</p> <p>During an interview with the RCC on 11/19/14 at 9am the RCC stated:</p> <ul style="list-style-type: none"> <li>- Glucometers were never shared.</li> <li>- He could not say why some glucometers in the cases did not match the name on the case and did not know why some glucometers were not labeled with resident names.</li> <li>- He could not say why there was no documented results for Resident #4's twice a day FSBS results.</li> </ul> <p>During an interview on 11/19/14 at 4pm and 11/21/14 at 10:00am the Administrator stated:</p> <ul style="list-style-type: none"> <li>- Every resident had their own glucometer.</li> <li>- Each glucometer and case should be labeled with the resident's name.</li> </ul>	D932		

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON CITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>
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D932	Continued From page 86  - Glucometers should never be shared. - Sharing of glucometers and lancing devices was "not acceptable." - Staff knew better than to share glucometers or lancing devices.  A Plan of Protection was submitted by the facility on 11/19/14 that included: - All existing glucometers will be sent back to the pharmacy immediately and new glucometers will be purchased today for all residents that require diabetic supplies. - Glucometer infection control will be written and verbally shared at shift change beginning immediately. - Infection control and diabetic training will be done by registered nurse or contracted pharmacy going forward for all medication aides.  THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2014.	D932		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements  G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements  (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount	D934	<i>RN to supervise and conduct appropriate state approved Infection Control training. To meet infection control requirements all medication aid staff will complete the mandatory, annual in-service training program developed by the Division of Health Service Regulation for adult care homes. RN will ensure documentation for employees is kept in the business file upon completion. Administrator will track annual training with a "tickler" file.</i>	1-09-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 11/25/2014</b>
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL087005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>11/25/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>
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D934	<p>Continued From page 87</p> <p>determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interview, and record review, the facility failed to provide mandatory annual infection prevention training for 2 of 2 sampled medication aides (Staff H and Staff J) and employed for more than one year.</p> <p>The findings are:</p> <p>A. Review of Staff H's personnel file revealed: -Staff H was hired as a medication aide on 4/2/13. -Medication aide clinical skills checklist was completed 7/26/13. -Staff H passed the written medication exam on 12/18/13. -No documentation the annual state approved infection control training had been completed.</p> <p>Refer to interview with the Administrator on 11/25/14 at 4:00pm.</p> <p>B. Review of Staff J's personnel file revealed: -Staff J was hired as a personal care aide on 3/25/12, but was currently a medication aide and the Resident Care Coordinator. -Medication aide clinical skills checklist was completed on 5/3/12. -Staff J passed the written medication exam on</p>	D934		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE LIVING CENTER OF BRYSON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713</b>		
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D934	<p>Continued From page 88</p> <p>12/19/12.</p> <p>-No documentation the annual state approved infection control training had been completed.</p> <p>Refer to interview with the Administrator on 11/25/14 at 4:00pm</p> <hr/> <p>Telephone interview with the Administrator on 11/25/14 at 4:00pm revealed:</p> <ul style="list-style-type: none"> <li>-She was not aware of the required annual state approved infection control training.</li> <li>-She had hired a nurse to begin working on 12/1/14 and had already discussed an infection control training to be completed.</li> </ul> <p>Plan of Correction provided by the facility revealed:</p> <ul style="list-style-type: none"> <li>-The facility will provide in-service training for infection control to all mediation aides.</li> <li>-The pharmacy will be contacted immediately for a scheduled training as well as an immediate in house training session.</li> <li>-The facility will develop written policies and procedures for the required training and will assure the training is conducted within 30 days of hire.</li> </ul> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2015.</p>	D934			



FEB - 4 2015

**Cornerstone Living Center of Bryson City**  
PO Box 1429, 314 Hughes Branch Road  
Bryson City, NC 28713  
828-488-2780

To: *Adult Care Licensure Section*  
*NCDHHS*  
*12 Barbetta Drive*  
*Asheville, NC 28806*

*In response to our facility survey completed on November 25, 2014, please see the enclosed "revised" Plan of Correction for deficiency items not acceptable on our previous response; these items include Tag #079 Housekeeping and Furnishings, #137 Other Staff Qualifications, #167 Training on Cardio-Pulmonary Resuscitation, #189 Personal Care and Other Staffing, #273 Health Care, #367 Medication Administration, #372 Medication Administration and #934 ACH Infection Prevention Requirements.*

*I hope that you find these responses for the plan of Correction acceptable, as we have taken each of these very seriously to ensure the health, safety and wellbeing of those we serve. Please contact me for any additional information or supporting documentation.*

*Sincerely,*

*Connie Seely*  
*Administrator*  
*Cornerstone Living Center*  
*P.O. Box 1429*  
*314 Hughes Branch Rd.*  
*Bryson City NC 28713*  
*Ph. # 828-488-2780*  
*cornerstone-connie@outlook.com*

## Shook, Linda

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**From:** Shook, Linda  
**Sent:** Friday, February 13, 2015 2:17 PM  
**To:** Carole Maennle (carole.maennle@swaindss.org)  
**Cc:** Boggs, Brenda; Penland, Beverly D  
**Subject:** CORNERSTONE LIVING CENTER of BRYSON CITY - SWAIN COUNTY  
**Attachments:** Cornerstone Living Center 2015-02-04 POCA-QR0U11.pdf

Please find attached copy of the approved "Amended" Plan of Correction (POC) for the above referenced facility.

Thank you.

Linda Y. Shook, Processing Assistant  
Adult Care Licensure Section  
NC Department of Health and Human Services  
Division of Health Service Regulation  
12 Barbetta Drive, Asheville, NC 28806  
Phone: (828) 670-3391 x 149  
Fax: (828) 670-5040  
[Linda.Shook@dhhs.nc.gov](mailto:Linda.Shook@dhhs.nc.gov)  
[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr)

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