

MAR 16 2015

PRINTED: 02/13/2015
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ <i>ls</i>	(X3) DATE SURVEY COMPLETED 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE FAMILY CARE HOME # 5	STREET ADDRESS, CITY, STATE, ZIP CODE 18 ELLA LANE ALEXANDER, NC 28701 <i>County: Buncombe</i>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a biennial survey on February 5, 2015 and February 6, 2015.	C 000		
C 342	<p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ol style="list-style-type: none"> (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). <p>This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to assure staff accurately documented the administration of (Fosamax) on the medication administration records (MAR) for 1 of 3 residents (Resident #3).</p> <p>The findings are:</p>	C 342	<p>Administrator will assure MAR's are accurate following all physician orders.</p> <p>Administrator will assure MAR's are documented with staff's initials and signatures.</p> <p>Administrator will monitor MAR's weekly for accuracy.</p> <p>Administrator will monitor medication refills are ordered in a timely manner</p> <p>Administrator will monitor Medication cart twice a week to assure all medications are in compliance with correct Administration and refills.</p>	3/3/15

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

3/3/15

STATE FORM

8899

BNRJ11

If continuation sheet 1 of 4

Approved 3/9/15 *Casey Fitzgerald*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE FAMILY CARE HOME # 5	STREET ADDRESS, CITY, STATE, ZIP CODE 18 ELLA LANE ALEXANDER, NC 28701
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 342	<p>Continued From page 1</p> <p>Review of Resident #3's current FL2 dated 2/28/14 revealed diagnoses of diabetes mellitus type 2, memory disturbance / loss, gastroesophageal reflux disease, hypertension, major depressive disorder, alcoholism and tobacco dependence.</p> <p>Medication orders on the current FL2 dated 2/28/14 revealed Boniva (used to prevent and treat bone loss) 150mg once every month.</p> <p>Review of Resident #3's record on 2/5/15 revealed: -A written note from the facility to Resident #3's physician on 6/10/2014 stated "insurance will not pay for Boniva ...please discontinue or change." -A copy of a prescription dated 6/11/14 for Fosamax 70mg once per week.</p> <p>Review of Resident #3's November 2014 MAR on 2/5/15 at 10:30am revealed documentation of Fosamax being administered on 11/5/14, 11/12/14 and 11/19/14.</p> <p>Review of Resident #3's December 2014 and January 2015 MAR on 2/5/15 at 10:30am revealed there was no documentation of Fosamax being administered.</p> <p>Review of Resident #3's February 2015 MAR on 2/5/15 at 10:30am revealed documentation of Fosamax being administered on 2/4/15.</p> <p>Interview with Resident #3 on 2/5/15 at 9:40am while on the initial tour revealed no medication administration issues or concerns.</p> <p>Interview with Supervisor in Charge (SIC) on 2/5/15 at 12:35pm revealed Resident #3 was in</p>	C 342		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE FAMILY CARE HOME # 5	STREET ADDRESS, CITY, STATE, ZIP CODE 18 ELLA LANE ALEXANDER, NC 28701
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	<p>Continued From page 2</p> <p>and out of the facility multiple times in November 2014, December 2014 and January 2015.</p> <p>Review of Resident #3's record revealed documentation of her being out of the facility from:</p> <ul style="list-style-type: none"> -11/25/14 until 12/2/14. -12/19/14 until 1/13/15. <p>Interview with SIC on 2/5/15 at 1:50pm revealed:</p> <ul style="list-style-type: none"> -She administers medications for all 3 facilities. -She strives for accuracy of the MAR's. -"I always check my MAR's and honestly feel this was a documentation mistake." -"I would have given the medication, I just didn't sign the MAR." <p>Interview with Resident #3 on 2/5/15 at 1:55pm revealed:</p> <ul style="list-style-type: none"> -She knows her pills and medications. -She self-administers her medications when away from the facility. -She is a "fanatic about taking my pills" when away from the facility and would have taken the medications that the facility sent home with her. <p>Interview with a representative from the facility's contracted pharmacy on 2/5/15 at 2:00pm revealed:</p> <ul style="list-style-type: none"> -A four week supply of Fosamax was delivered to the facility on 11/26/14. -A four week supply of Fosamax was delivered to the facility on 2/2/15. <p>Interview with Administrator and SIC on 2/6/15 at 9:30am revealed:</p> <ul style="list-style-type: none"> -Fosamax was not on the list of medications given to Resident #3 when she left the facility on 12/19/15. -Resident #3 was scheduled to receive Fosamax 	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2015
--	---	---	--

NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE FAMILY CARE HOME # 5	STREET ADDRESS, CITY, STATE, ZIP CODE 18 ELLA LANE ALEXANDER, NC 28701
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	<p>Continued From page 3</p> <p>on Wednesday, 12/24/14.</p> <p>-Resident #3 was scheduled to return to the facility before 12/24/14.</p> <p>-When Resident #3 did not return to the facility as scheduled there was one pill remaining in the 11/26/14 bubble pack.</p> <p>-Administrator stated Resident #3 would have been administered the 12/24/14 dose of Fosamax on 1/14/15.</p> <p>-Resident #3 would have missed 5 doses of Fosamax (12/24/14, 12/31/14, 1/7/15, 1/21/15, and 1/28/15).</p> <p>-SIC stated it was "her error" for not documenting on the MAR and not reordering the Fosamax until 1/26/15.</p> <p>Observation on 2/6/15 at 9:30am of list of medications sent home with Resident #3 revealed Fosamax was not on the list.</p> <p>Interview with the Administrator on 2/6/15 at 9:50am revealed:</p> <p>-Checking the MAR for accuracy is the Administrator's responsibility.</p> <p>-At her last chart audit she did only checked the December 2014 or January 2015 MARs, checked only the February 2015 MAR.</p> <p>Observation of Resident #3's medications on hand at the facility on 2/6/15 at 10:00am revealed 3 of 4 Fosamax 70mg tablets were available.</p> <p>Phone interview with staff at Resident #3's physician's on 2/6/15 at 1:30pm revealed the missed doses of Fosamax would have had "no adverse effects and the patient is doing well."</p>	C 342		

Shook, Linda

From: Shook, Linda
Sent: Monday, March 23, 2015 3:31 PM
To: Cathie Beatty (Cathie.Beatty@buncombecounty.org)
Cc: Fitzgerald, Casey E; Penland, Beverly D
Subject: WOODLAND TERRACE FAMILY CARE HOME #5 - BUNCOMBE COUNTY
Attachments: Woodland Terrace #5 2015-03-03 POC-BNRJ11.pdf

Please find attached copy of the approved 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
www.ncdhhs.gov/dhsr

Email correspondence to and from this address is subject to the North Carolina Public Records Law and may be disclosed to third parties by an authorized State official. Unauthorized disclosure of juvenile, health, legally privileged, or otherwise confidential information, including confidential information relating to an ongoing State procurement effort, is prohibited by law. If you have received this e-mail in error, please notify the sender immediately and delete all records of this e-mail.
