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PRINTED: 02/03/2015
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL029009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/23/2015
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NAME OF PROVIDER OR SUPPLIER THE PERRYMAN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 902 KENREED DR THOMASVILLE, NC 27380	County: Davidson
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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
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C 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-up survey on 1/22/15 to 1/23/15.	C 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
C 265	10A NCAC 13G .0904(c)(2) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day and cycle for any given day for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure menus were maintained in the kitchen and identified as the current menu day and cycle for any given day for guidance for food service staff. The findings are: Observation of the kitchen menu on 1/22/15 at 9:00 am revealed: -A single handwritten menu undated and posted on the side of the refrigerator. -No additional menus were observed to be posted in the kitchen area. Interview on 1/22/15 at 9:05 am with the Supervisor in Charge/ Medication Aide (SIC/MA) revealed: -Weekly menus were available for guidance for food service staff.	C 265	Tag C265 10A NCAC 13G.0904(c)(2) Nutrition and Food Service (c) Menus in Family Care Homes -The deficiencies identified for all residents will be corrected by posting the menus on the refrigerator in the kitchen for staff to use as a guide for preparing meals. -The posting of the menu in the kitchen will eliminate the possibility of other residents having the potential to be affected by the same deficiency practice. -To make sure the deficient practice will not recur, the Administrator will ensure that the menus are posted by the first day of each month and at all times. -The administrator will also monitor the corrective actions to ensure the deficient practice does not recur. Addendum: per telephone conversation with Ms. Kathy Hatfield, Adm on 2/25/15 at 11:45 am - the facility will be in compliance on correction date on 2/17/15, with the exception of a scheduled Residents' Rights in-service scheduled for facility staff on 3/15/15 by the local Ombudsman. (Carlyn Hanson Pres/BSN)	1-24-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathryn Hatfield	TITLE owner / administrator	DATE 2-20-15
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POC approved by Carlyn Hanson, RN, BSN accompanied addendum on 2/25/15

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NAME OF PROVIDER OR SUPPLIER THE PERRYMAN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 902 KENREED DR THOMASVILLE, NC 27380
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C 285	<p>Continued From page 1</p> <ul style="list-style-type: none"> -She kept them in a filing cabinet in her office and the menus were supposed to be posted in the kitchen. -She did not know why and was not aware the menus were not posted in the kitchen. -All of the residents residing in the facility were ordered regular diets. <p>Observation of the breakfast meal service from 9:10 am to 9:40 am revealed:</p> <ul style="list-style-type: none"> -There were 2 residents present for the breakfast meal. -There were 2 residents asleep in their rooms. -One resident was served scrambled eggs, one slice of bacon, one slice of toast, one 4 oz. glass of orange juice and one 4 oz. glass of water. -A second resident was served one waffle, one slice of bacon, one 4 oz. glass of water, one 4 oz. glass of milk, and one 8 oz. cup of coffee. <p>Review of the week-at-a-glance menus stored in the filing cabinet in the SIC/MA's office revealed:</p> <ul style="list-style-type: none"> -Residents on a regular diet were to be served for the breakfast meal on 1/22/15 as follows: -Four ounces of orange juice, 1 cup of cereal, 8 ounces of milk and 1 banana. <p>Interview on 1/22/15 at 9:20 am and 2:30 pm with a staff member revealed:</p> <ul style="list-style-type: none"> -She prepared a waffle for one resident because she did not like eggs. -She had not noticed a menu posted in the kitchen. -She could not recall the last time she saw a menu posted in the kitchen. -She did not use menus for guidance when preparing breakfast. -Sometimes the staff asked the residents what they wanted for breakfast. -Breakfast daily usually consisted of scrambled 	C 285	<p>Tag C265</p> <p>10A NCAC 13G.0904(c)(2) Nutrition and Food Service (2) Menus shall be maintained in the kitchen and identified as to the current menu day and cycle for any given day for guidance of food service staff.</p> <ul style="list-style-type: none"> -The deficiencies identified for all residents will be corrected by posting the menus on the refrigerator in the kitchen for staff to use as a guide for preparing meals. If the resident prefers an alternate meal, the substitution will be noted in the MENU SUBSTITUTION notebook in the kitchen. -The MENU SUBSTITUTION notebook will keep track of all meals served, thereby eliminating the possibility of other residents having the potential to be affected by the same deficiency practice. -To make sure the deficient practice will not recur, the Administrator will ensure that the MENU SUBSTITUTION notebook is located in the kitchen at all times. -The administrator will also train the staff to correctly follow the menu and/or report substituted meals in the MENU SUBSTITUTION notebook and monitor the corrective actions to ensure the deficient practice does not recur. 	2-17-15

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NAME OF PROVIDER OR SUPPLIER: THE PERRYMAN HOUSE
STREET ADDRESS, CITY, STATE, ZIP CODE: 902 KENREED DR THOMASVILLE, NC 27380

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C 265	<p>Continued From page 2</p> <p>eggs, bacon and toast for the residents. -If a resident requests an alternative, we accommodate their request for meal time.</p> <p>Interview on 1/22/15 at 10:00 am with the Administrator revealed: -The menus were not posted in the kitchen because they were being used to go grocery shopping. -The menus were in the process of being revised.</p> <p>Interview on 1/23/15 with a resident revealed: -Most of the time, "we are served whatever we ask for" at meal times. - "We eat whenever we get ready to eat", there was no set meal times.</p>	C 265	<p>Tag C330</p> <p>NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration</p> <p>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p>	2-2-15
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 1 of 4 sampled residents (Residents #3) with physician's orders for anti-fungal, and allergy medications, and 2 of 2 residents (Resident #1</p>	C 330	<p>The deficiencies identified for Resident #3 will be corrected by placing physician orders discontinued by the prescribing doctor in the resident's chart, as the foot condition was healed and the allergies were no longer an issue upon the resident's admission to the facility.</p> <p>The facility will identify other residents having the potential to be affected by the same deficiency practice by having the RN and Nurse Practitioner provide an audit to be sure that all medication that is discontinued has a corresponding doctor's D/C order in the resident's chart.</p> <p>Measures will be taken to make sure the deficient practice will not recur will be evidenced by the RN Med Cart/MAR audit which is conducted monthly.</p> <p>The facility is monitoring its corrective actions to ensure the deficient practice does not recur by keeping a log of the RN's Med Cart/MAR audits.</p>	

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C-330	<p>Continued From page 3</p> <p>and #4) observed during medication pass with physician's orders for potassium supplement, pain relief, and laxative medications.</p> <p>The findings are:</p> <p>A. Observation of the 9:00 am medication pass on 1/22/15 revealed:</p> <ul style="list-style-type: none"> -At 9:30 am, Staff B, Medication Aide (MA) poured a potassium elixir for Resident #1. -The potassium elixir was observed to have been poured by Staff B, MA to the 10 ml mark on the plastic medication cup (should have poured 7.5 ml of potassium elixir, and did not confirm measurement at eye level). -Staff B prepared 6 oral tablets to give to Resident #1. -Staff B mixed the potassium elixir in 4 ounces of water and administered along with the oral medications to Resident #1. <p>Review of Resident #1's current FL2 dated 7/17/14 revealed diagnoses included chronic obstructive pulmonary disease, hypertension, dementia, and intable bowel syndrome with diaphragmatic hernia.</p> <p>Record review revealed:</p> <ul style="list-style-type: none"> -A physician's order dated 1/9/15 for potassium 40 meq per 15 ml and give 7.5 ml daily (used to treat low potassium blood levels). -A potassium laboratory result dated 11/5/13 of 3.6 (normal reference range on laboratory result sheet was 3.5 to 5.1). -A potassium laboratory result dated 1/9/14 of 4.3 (normal reference range on laboratory result sheet was 3.5 to 5.1). <p>Review of Resident #1's January 2015 Medication Administration Record (MAR)</p>	C-330	<p>Tag 330</p> <ul style="list-style-type: none"> • The deficiencies identified for residents #1 and #4 were corrected by the re-training on Medication Administration for Staff B. Special attention was paid to EXACT measuring of liquid and powder medication. • The facility has identified other residents having the potential to be affected by the same deficiency practice and the RN has and re-certified ALL medication aides in the facility. Special attention was paid to EXACT measuring of liquid and powder medication. • Measures taken to make sure the deficient practice will not recur are twofold. First, the RN will certify each medication aide at least quarterly and when significant resident medication changes are made. If a medication aide is out on leave for over a period of (9) months, she will be re-trained after her re-hire date as if she were a new employee. Special attention was paid to EXACT measuring of liquid and powder medication. • The Nurse Practitioner in collaboration with the RN will monitor the facility's corrective actions to ensure the deficient practice does not recur. 	2-2-15

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NAME OF PROVIDER OR SUPPLIER THE PERRYMAN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 592 KENREED DR THOMASVILLE, NC 27360
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C-330	<p>Continued From page 4</p> <p>revealed:</p> <ul style="list-style-type: none"> -An entry for potassium 40 meq per 15 ml, give 7.5 ml once daily and scheduled for administration at 9:00 am. -Documented as administered at 9:00 am on 1/22/15 by Staff B. <p>Interview on 1/22/15 at 1:10 pm with a representative from the contract pharmacy revealed:</p> <ul style="list-style-type: none"> -An increased dose of potassium would cause potassium levels to "go high" over a period of time. -For this reason, the potassium should be administered as ordered by the physician. <p>Interview on 1/22/15 at 2:30 pm with Staff B, MA revealed:</p> <ul style="list-style-type: none"> -She had recently been rehired at the sister facility next door after an extended leave of absence. -She was working at this facility today (1/22/15) because a staff person had called out of work. -She was unaware she had measured the potassium incorrectly. -She had been taught how to prepare liquid medications by another MA at the facility, but could not recall who the MA was. -She had completed new employee orientation training at the facility in October 2014 when she returned to work. -The last training she attended at the facility was in December 2014. -She could not recall who conducted the training and what the training consisted of. <p>Interview on 1/23/15 at 3:00 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She thought Staff B had been properly trained in measuring liquid medications. 	C-330		

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C 330	<p>Continued From page 5</p> <ul style="list-style-type: none"> -She was not aware Staff B had not measured the potassium correctly prior to administering to Resident #1. -She would schedule additional MA training for Staff B as soon as possible. <p>Interview on 1/23/15 at 3:50 pm with Resident #1 revealed:</p> <ul style="list-style-type: none"> -She relied on the staff to administer her medications. -She was unsure of the medications she took. -She did take potassium because it had been low at one time when checked at the physician's office. -The physician kept a close eye on her potassium levels. <p>Refer to interview on 1/22/15 at 1:05 pm with the pharmacy Nurse Consultant.</p> <p>Refer to interview on 1/23/15 at 2:10 pm with Medical Record Staff.</p> <p>B. Observation of the 9:00 am medication pass on 1/22/15 revealed:</p> <ul style="list-style-type: none"> -At 8:45 am, Staff B, medication aide (MA) poured Tylenol elixir for Resident #4. -Staff B poured Tylenol past the 30 cc mark up to the brim of the plastic medication cup. -It could not be determined how much Tylenol elixir was measured by Staff B to be administered to the resident. -Staff B poured Miralax powder 17 gm in the containers' cap and the powder measured less than the 17 gm measurement line in the container cap. -Staff B prepared 5 oral tablets to give to Resident #4. -Staff B poured the Miralax powder into a cup of coffee for the resident to drink. 	C 330		

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NAME OF PROVIDER OR SUPPLIER THE PERRYMAN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 502 KENREED DR THOMASVILLE, NC 27380
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C 330	<p>Continued From page 6</p> <p>-Staff B mixed the Tylenol elixir into 1 ounce of cranberry juice and administered to the resident along with the other 9:00 am oral medications.</p> <p>Review of Resident #4's current FL2 dated 3/11/14 revealed diagnoses included dementia, degenerative disc disease, and gastroesophageal reflux disease.</p> <p>Record review revealed:</p> <ul style="list-style-type: none"> -A physician's order dated 1/20/15 for Tylenol elixir 160 mg per 5ml take 31.25 ml 4 times daily for chronic back pain. -A physician's order dated 1/20/15 for Miralax mix 17 gm (as indicated on inside of cap) in 8 ounces of water or coffee once daily (used to treat constipation) <p>Review of Resident # 4's January 2015 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> -An entry for Tylenol 160 mg per 5ml take 31.25 ml (1000 mg) 4 times daily for chronic back pain and scheduled for administration at 9:00 am, 3:00 pm, 9:00 pm, and 3:00 am (Do not exceed 4000 mg in 24 hours). -An entry for Miralax 17 gm (as indicated on inside of cap) in 8 ounces of water or coffee once daily and scheduled for administration at 9:00 am. -Documented as administered at 9:00 am by Staff B. <p>Interview on 1/22/15 at 1:10 pm with a representative from the contract pharmacy revealed:</p> <ul style="list-style-type: none"> -Increased dosing of Tylenol would not be "good" for the resident's liver. -That was the reason for the note "not to exceed 4000 mg in 24 hours" printed on the MARs. -The maximum dosing of Tylenol was 4000 mg 	C 330		

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C 330	<p>Continued From page 7</p> <p>within a 24 hour period.</p> <p>Interview on 1/22/15 at 2:30 pm with Staff B, MA revealed:</p> <ul style="list-style-type: none"> -She had recently been rehired at the sister facility next door after an extended leave of absence. -She was working at this facility today (1/22/15) because a staff person had called out of work. -She was unaware she had measured the Tylenol and Miralax incorrectly. -She had been taught how to prepare liquid and powder medications by another MA at the facility, but could not recall who the MA was. -She had completed new employee orientation training at the facility in October 2014 when she returned to work. -The last training she attended was at the facility in December 2014. -She could not recall who conducted the training and what the training consisted of. <p>Based on observation, record review and staff interviews, it was determined Resident #4 was not interviewable.</p> <p>Interview on 1/23/15 at 3:00 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She thought Staff B had been properly trained in measuring liquid medications. -She was not aware Staff B had not measured Tylenol and Miralax correctly prior to administering to Resident #4. -She would schedule additional MA training for Staff B as soon as possible. <p>Refer to interview on 1/22/15 at 1:05 pm with the pharmacy Nurse Consultant.</p> <p>Refer to interview on 1/23/15 at 2:10 pm with</p>	C 330		
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C 330	<p>Continued From page 8</p> <p>Medical Record staff.</p> <p>C. Review of Resident # 3 current FL-2 dated 5/6/14 revealed diagnoses included hypertension, thyroid disease, seasonal depression, hypothyroidism, and advanced Alzheimer disease.</p> <p>1. Further review of the current FL-2 dated 5/6/14 revealed a physician's order for Diflucan 150 mg at bedtime.</p> <p>Review of the May, June, July, and August 2014 Medication Administration Records (MARs) revealed no entry on the MARs for Diflucan 150 mg at bedtime.</p> <p>Review of the September, October, November, and December 2014 MARs revealed no entry on the MARs for Diflucan 150 mg at bedtime.</p> <p>Review of the January 2015 MAR revealed no entry on the MAR for Diflucan 150 mg at bedtime.</p> <p>Based on observation and record review, it was determined Resident #3 was not interviewable.</p> <p>On 1/23/15 at 10:05 am, attempted telephone interview with primary care physician was unsuccessful.</p> <p>Interview on 1/23/15 at 2:05 pm with a representative from the contract pharmacy revealed:</p> <ul style="list-style-type: none"> -They had not received an order for Diflucan 150 mg at bedtime. -They could not find an order for Diflucan for Resident #3 on file. <p>Interview on 1/23/15 at 2:30 pm with the</p>	C 330	<p>10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration</p> <p>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:</p> <ul style="list-style-type: none"> (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. <p>The deficiencies identified for Resident #3 have been corrected by placing physician orders discontinued by the prescribing doctor in the resident's chart, as the chronic urinary tract infections were treated by pushing fluids and instituting a successful continence plan upon the resident's admission to the facility.</p>	2-2-15

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C 330	<p>Continued From page 9</p> <p>Administrator revealed: -The Diflucan was ordered because Resident #3 had chronic urinary tract infections -She was not sure what happened with the Diflucan order. -The SIC/MA was responsible for transcribing orders to the MAR and faxing the order to the pharmacy.</p> <p>Refer to interview on 1/22/15 at 1:05 pm with the pharmacy Nurse Consultant.</p> <p>Refer to interview on 1/23/15 at 2:10 pm with Medical Record staff.</p> <p>2. Review of Resident #3 record revealed: -A verbal physician's order dated 5/15/14 transcribed by the SIC/MA for Zyrtec 10 mg tablets once a day for allergies. -A signed physician's order dated 5/20/14 for Zyrtec one tablet daily as needed.</p> <p>Review of the May, June, July, and August 2014 Medication Administration Records (MARs) revealed no entry on the MARs for Zyrtec 10 mg daily as needed.</p> <p>Review of the September, October, November, and December 2014 MARs revealed no entry on the MARs for Zyrtec 10 mg daily as needed.</p> <p>Review of the January 2015 MAR revealed no entry on the MAR for Zyrtec 10 mg daily as needed.</p> <p>Based on observation and record review, it was determined Resident #3 was not interviewable.</p> <p>On 1/22/15 at 10:05 am, attempted telephone interview with primary care physician was</p>	C 330	<p>10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>-The deficiencies identified for Resident #3 will be corrected by placing all physician orders which are discontinued by the prescribing doctor in the resident's chart. As for the ZYRTEC specifically, [redacted] reported upon admission that [redacted] was put on ZYRTEC at [redacted] previous facility and had never suffered from allergies. The medication was discontinued upon the resident's admission to the facility.</p>	2-2-15

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NAME OF PROVIDER OR SUPPLIER THE PERRYMAN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 802 KENREED DR THOMASVILLE, NC 27380
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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
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C 330	<p>Continued From page 10</p> <p>unsuccessful.</p> <p>Interview on 1/23/15 at 2:05 pm with a representative from the contract pharmacy revealed:</p> <ul style="list-style-type: none"> -They had not received an order for Zyrtec 10 mg daily as needed. -They could not find an order for Zyrtec 10 mg daily as needed. <p>Interview on 1/23/15 at 2:30 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She was not sure what happened with the Zyrtec order. -The SIC/MA was responsible for transcribing orders to the MAR and faxing the order to the pharmacy. <p>Refer to interview on 1/22/15 at 1:05 pm with the pharmacy Nurse Consultant.</p> <p>Refer to interview on 1/23/15 at 2:10 pm with Medical Record staff.</p> <p>Interview on 1/22/15 at 1:05 pm with the pharmacy Nurse Consultant revealed:</p> <ul style="list-style-type: none"> -He had conducted a medication administration training at the facility about 9 months ago, but could not recall the exact date. -The training included the administration of eye drops, oral medications, as needed medications, controlled drugs, preparation of liquid and powder medications. -The training also included instructions if correct measurements of liquid medications were not clearly marked, then the medication would have to be measured using a syringe. <p>Interview on 1/23/15 at 2:10 pm with Medical Record staff revealed:</p>	C 330		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL029009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/23/2015
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NAME OF PROVIDER OR SUPPLIER THE PERRYMAN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 902 KENREED DR THOMASVILLE, NC 27360
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C 330	<p>Continued From page 11</p> <ul style="list-style-type: none"> -The process was for all medications to be faxed to the pharmacy. -She and the Supervisor in Charge/Medication Aide (SIC/MA) were responsible for MAR audits each month. -Her last MAR audit was October 2014. -The SIC/MA had been doing the monthly MAR audits since October 2014. -The SIC/MA was responsible for making sure all medication orders were faxed to the pharmacy. <p>The facility provided a Plan of Protection on 1/23/15 as follows: Immediately, the Facility Nurse will be responsible to observe and critique all medication aides during medication pass. An in-service will be scheduled immediately for dosage training and administration. The contract pharmacy will be contacted to provide more accurate dosing equipment. The Facility Nurse will be responsible for verifying all incoming orders and transcription of orders to the MARs.</p> <p>The Facility Nurse will be responsible for MAR audits, physician orders and control sheet accuracy, weekly and ongoing. The Facility Nurse will perform random medication pass observations for all medication aides, ongoing and document results in the Nurse's medication book.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED: March 9, 2015.</p>	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights	C 912		
	G.S. 131D-21 Declaration of Resident's Rights			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL029009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/23/2015
NAME OF PROVIDER OR SUPPLIER THE PERRYMAN HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 902 KENREED DR THOMASVILLE, NC 27380		
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C 912	Continued From page 12 Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations regarding medication administration, and medication aides training and competency. The findings are: 1. Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 1 of 4 sampled residents (Residents #3) with physician's orders for anti-fungal, and allergy medications, and 2 of 2 residents (Resident #1 and #4) observed during medication pass with physician's orders for potassium supplement, pain relief, and laxative medications. [Refer to Tag 330 10A NCAC 13G .1004(a) (Type B Violation)] 2. Based on interviews and record reviews, the facility failed to ensure staff performing medication aide duties met the requirements to administer medications as evidenced by 1 of 3 sampled staff (Staff B) was not competency validated or completed any of the state approved medication aide training. [Refer to Tag 935 G.S. 131D-4.5(B)(b) (Type B Violation)]	C 912	Davidson County Ombudsman, [REDACTED] will provide training to facility staff within thirty (30) days which will explain Residents' Rights in detail. • The deficiencies identified for residents were corrected by the re-training on Medication Administration for all medication aides in the facility. Special attention was paid to EXACT measuring of liquid and powder medication. • The facility has identified other residents having the potential to be affected by the same deficiency practice and the RN has and repeating competency evaluation for ALL medication aides in the facility. Special attention was paid to EXACT measuring of liquid and powder medication. • Measures taken to make sure the deficient practice will not recur are twofold. First, the RN will certify each medication aide at least quarterly and when significant resident medication changes are made. Random medication pass evaluations will be performed and documented on Form 1005B (CMS). • The Nurse Practitioner in collaboration with the RN will monitor the facility's corrective actions to ensure the deficient practice does not recur.	Projected 3-15-15 2-2-15

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER
THE PERRYMAN HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
**902 KENREED DR
THOMASVILLE, NC 27360**

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C935	Continued From page 13	C935		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides Training and Competency	C935		
	G.S. § 131D-4.5B (b) Adult Care Home Medication Aides Training and Competency Evaluation Requirements.			
	(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding		All medication aides in the facility have been re-evaluated and documented on the medication skills checklist since February 5th. The 10-15 hour training has been completed for all medication aides in the facility. All aides have completed the State Approved Infection Control Training. Immediately, all medication aides will have medication administration competency evaluation re-checked by the Facility Nurse are completed. The Facility Nurse will validate medication aides quarterly and will perform random medication pass evaluation forms for each medication aide over the next 90 days and every 90 days ongoing.	2-5-15 2-5-15 2-11-15

Division of Health Service Regulation

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C935	<p>Continued From page 14</p> <p>exists.</p> <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to ensure staff performing medication aide duties met the requirements to administer medications as evidenced by 1 of 3 sampled staff (Staff B) was not competency validated or completed any of the state approved medication aide training.</p> <p>The findings are:</p> <p>Review of Staff B's personnel file revealed</p> <ul style="list-style-type: none"> -An original hire date of 6/13/13 as a Certified Nursing Assistant/Medication Aide. -A rehire date of 10/4/14. -Staff B passed the written Medication Aide test on 8/28/13. -No documentation a medication clinical skills validation checklist had been completed. <p>Observation of the 9:30 am to 9:45 am medication pass on 1/22/15 revealed.</p> <ul style="list-style-type: none"> -At 9:30 am, Staff B, Medication Aide (MA) poured a potassium elixir for a resident. -The potassium was measured by the MA to the 10 ml mark on the plastic medication cup (did not confirm measurement at eye level). -At 9:45 am, Staff B, MA poured Tylenol elixir for a resident. -The MA poured Tylenol past the 30 cc mark up 	C935		

Division of Health Service Regulation

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C935	<p>Continued From page 15</p> <p>to the brim of the plastic medication cup. -It could not be determined how much Tylenol elixir was measured by the MA to be administered to the resident. -The MA poured Miralax powder 17 gm in the containers' cap and the powder measured less than the 17 gm measurement line in the container cap.</p> <p>Review of Medication Administration Records (MARs) on 1/23/14 revealed Staff B administered medications to 4 residents residing at the facility.</p> <p>Interview on 1/22/15 at 2:30 pm with Staff B revealed: -Her main job duty was medication aide and had been passing medications to the residents since she began employment at the facility. -The last training she attended was at the facility in December 2014. -She could not recall who conducted the training and what the training consisted of. -She had attended facility orientation training in November 2014. -The medication training in orientation was all the training she had done. -She could not recall if she completed the medication clinical skills validation checklist. -She could not recall completing the 5, 10 or 15 hour medication aide training.</p> <p>Interview on 1/23/15 at 3:00 pm with the Administrator revealed: -She was not aware Staff B was not measuring liquid and powder medications correctly. -She was not aware Staff B had not completed the medication aide training. -She had contacted the Facility Nurse and she had not completed the medication clinical skills validation checklist for Staff B.</p>	C935		
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C935	<p>Continued From page 15</p> <p>-The Medical Records staff person and the Supervisor In Charge/MA were both responsible to assure staff training and competencies were completed and filed in personal records.</p> <p>-She would assure that Staff B completed additional medication aide training as soon as possible.</p> <p>-She would assure the Facility Nurse completed the medication clinical skills validation checklist for Staff B with return demonstration.</p> <p>Interview with 2 residents on 1/23/15 revealed:</p> <p>-They relied on staff to administer their medications.</p> <p>-They could not recall or identify any specific medication aides who administered medications to them.</p> <p>The facility provided a Plan of Protection on 2/2/15 as follows: Immediately, all medication aides will have medication administration competency evaluation re-checked by the Facility Nurse to be completed by February 23, 2015. No medication aide who has not been re-checked will dispense medications.</p> <p>The Facility Nurse will validate medication aides quarterly and will perform random medication pass evaluation forms for each medication aide over the next 90 days and every 90 days ongoing.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 9, 2015.</p>	C935		

Shook, Linda

From: Harrison, Carolyn
Sent: Wednesday, February 25, 2015 7:17 PM
To: Kathy@AlmostHomeGroup.com; Shook, Linda
Cc: Stout, Nina; Griffis, Angela; Kinsey, Libby
Subject: The Perryman House 1-23-15 POCA
Attachments: The Perryman House 1-23-15 4EFK11 POCA.pdf

Hi Linda,

Attached is the POCA for The Perryman House HAL-029-009 in Davidson County. The POC was approved on 2/25/15.

Carolyn Harrison, RN, BSN
NC Department of Health and Human Services
Adult Care Licensure Section- Division of Health Service Regulation
Home-Based Lexington Region
12 Barbetta Drive, Asheville, NC 28806
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<http://www.ncdhhs.gov/dhsr>

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