

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL060119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/26/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KESTRAL RIDGE FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9305 KESTRAL RIDGE DRIVE CHARLOTTE, NC 28269</b>
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C 000	Initial Comments  The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey on March 25, 2015 with an exit conference via telephone on March 26, 2015.	C 000		
C 176	<p>10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation</p> <p>10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family 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, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on Record reviews and interviews, the facility failed to assure at least one staff person on the premises at all times had completed a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, within the last 24 months for 2 of 3 sampled staff (Staff A and C).</p>	C 176		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 176	<p>Continued From page 1</p> <p>The findings are:</p> <p>Upon entrance to the facility on 03/25/15 at 9:00 am, Staff C revealed the following:</p> <ul style="list-style-type: none"> <li>-She was the Supervisor-in-Charge (SIC) and the Medication Aide (MA) on duty.</li> <li>-She had been employed by the facility for four years.</li> <li>-She also performed personal care services to the residents as well as food preparation.</li> <li>-She was the only staff person on duty in the facility.</li> <li>-The facility staff were scheduled to work several days at a time for 24 hour shifts and she had been at the facility since 03/22/15.</li> <li>-She would be getting off work at 5:00 pm on 03/25/15.</li> <li>-Staff A would be coming into work at 5:00 pm on 03/25/15 and would work until 03/28/15 at 5:00 pm.</li> <li>-There were presently two residents living at the facility.</li> </ul> <p>A. Review of the personnel file for Staff C revealed:</p> <ul style="list-style-type: none"> <li>-She was hired by the facility on 09/29/11.</li> <li>-Her position was a SIC and MA.</li> <li>-She took the approved CPR certification course on 02/09/13 and it had expired on 02/28/15.</li> </ul> <p>Interview with Staff C on 03/25/15 at 3:10 pm revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator was responsible for ensuring that a staff person was on duty that had a current CPR and choking management training.</li> <li>-Staff C was not aware until 03/25/15 that her CPR had expired on 02/28/15.</li> <li>-She would go on-line today to find available an CPR training classes that was approved by American Heart Association American Red Cross,</li> </ul>	C 176		

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C 176	<p>Continued From page 2</p> <p>which was the agency that provided her last training.</p> <p>-The facility did not have a staff schedule that showed when staff worked in March 2015.</p> <p>-Staff discussed and planned the work schedule, but did not have a written work schedule for the facility.</p> <p>-Staff who worked during March 2015 would have signed off on the Resident's Medication Administration Record's (MARs) on the days they worked.</p> <p>Review of the March 2015 MAR's for the two residents of the facility revealed documentation Staff C was on duty and documented administration of medications to residents on 03/02/15, 03/03/15 03/05/15, 03/06/15, 03/09/15, 03/10/15, 03/11/15, 03/15/15, 03/16/15, 03/17/15, 03/18/15, 03/22/15, 03/23/15, 03/24/15, and 03/25/15.</p> <p>Interview with the Administrator on 03/25/15 at 5:15 pm revealed:</p> <p>-She was not aware that Staff C's CPR had expired on 02/28/15.</p> <p>-She would have Staff C to complete a CPR class as soon as it was available.</p> <p>Refer to additional interview with the Administrator on 03/26/15 at 1:30 pm.</p> <p>B. Review of the personnel file for Staff A revealed:</p> <p>-He was hired by the facility on 02/23/13.</p> <p>-His position was a Supervisor-In-Charge (SIC) and Medication Aide (MA).</p> <p>-He took the approved CPR certification course on 02/09/13 and it had expired on 02/28/15.</p> <p>Interview with Staff A on 03/25/15 at 5:13 pm</p>	C 176		

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C 176	<p>Continued From page 3</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-He worked as an SIC and was currently taking training to become the manager of the facility.</li> <li>-He realized recently his CPR had expired on 02/28/15 and made the Administrator aware, but could not recall when he notified her.</li> <li>-He would take the CPR training as soon as possible.</li> <li>-He was scheduled to work at the facility from 03/25/15 at 5:00 pm until 03/28/15 at 5:00 pm for 24-hour shifts.</li> </ul> <p>Review of the March MAR's for the two residents of the facility revealed documentation Staff A was on duty and documented administration of medications to residents on 03/01/15, 03/04/15, 03/05/15, 03/07/15, 03/08/15, 03/09/15, 03/11/15, 03/12/15, 03/13/15, 03/14/15, 03/15/15, 03/18/15, 03/19/15, 03/20/15, 03/21/15, and 03/22/15.</p> <p>Interview with the Administrator on 03/25/15 at 5:15 pm revealed:</p> <ul style="list-style-type: none"> <li>-She was aware that Staff A's CPR had expired on 02/28/15.</li> <li>-She had instructed Staff A to obtain his CPR as soon as possible.</li> <li>-She did not know if he had scheduled the training.</li> </ul> <p>Refer to additional interview with the Administrator on 03/26/15 at 1:30 pm.</p> <hr/> <p>Interview with the Administrator on 03/26/15 at 1:30 pm revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for ensuring that staff had a current CPR and that there was someone one the premises at all times with CPR certification and choking management training.</li> <li>-She did not have a system in place to alert her when staff's CPR's would expire.</li> </ul>	C 176		

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C 176	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-There was only one staff person scheduled to work at a times.</li> <li>-Staff were scheduled to work 24 hour shifts for three to four days each week.</li> <li>-Staff A and Staff C were the two staff persons who worked in March 2015 with the exception of 03/04/15.</li> <li>-The staff person who worked on 03/04/15 had a current CPR.</li> </ul> <hr/> <p>On 03/25/15, the SIC submitted a Plan of Protection as follows:</p> <ul style="list-style-type: none"> <li>-Both SIC's will complete a CPR course by Saturday March 28, 2015.</li> <li>-SIC's will bring in documentation of completed CPR course to the facility.</li> <li>-Facility will assure that a staff member who has current CPR certification is scheduled to work in the facility and on the premises at all times until SIC's have completed CPR training and ongoing.</li> <li>-Facility will review all employee files to assure SIC's scheduled to work have a current CPR certification.</li> </ul> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 9, 2015.</p>	C 176		
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:</p> <ul style="list-style-type: none"> <li>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</li> <li>(2) rules in this Section and the facility's policies and procedures.</li> </ul>	C 330		

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C 330	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure a medication (hydrogen peroxide ear drops) was administered to 1 of 2 sampled residents (#2) as ordered by a licensed prescribing practitioner.</p> <p>The findings are:</p> <p>Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 12/28/13.</p> <p>Review of Resident #2's current FL-2 dated 01/12/2015 revealed: - Diagnoses listed on the FL-2 included dementia, depression, hypercalcemia, Alzheimer's disease, hypothyroidism, hyperlipidemia, hypertension, and osteoporosis. - A physician's order for hydrogen peroxide 2 drops both ears 2 times a week.</p> <p>Review of Resident #2's record revealed there was no subsequent order after 01/12/15 in the resident record that the hydrogen peroxide ear drops had been discontinued or changed.</p> <p>Review of Resident #2's Medication Administration Records (MAR) revealed: - Resident #2's February, and March 2015 MARs reflected instructions on both MARs for the administration of hydrogen peroxide to instill one to two drops in each ear twice a week. - Documentation of administration by the facility staff of hydrogen peroxide ear drops to Resident #2 on 3 of 8 occasions from 02/01/15 - 02/28/15 with no time documented. - The March 2015 MAR revealed no documentation of administration of hydrogen</p>	C 330		

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C 330	<p>Continued From page 6</p> <p>peroxide ear drops to Resident #2's from 03/1/15-03/25/15.</p> <p>Observation on 03/25/15 at 11:00 am of Resident #2's medications in the facility's medication drawer labeled with Resident # 2's name revealed:</p> <ul style="list-style-type: none"> <li>- A 60 milliliter (ml) bottle of hydrogen peroxide with a dropper.</li> <li>- The instructions on the medication label had faded and were not legible.</li> <li>- The bottle was less than half full.</li> </ul> <p>Telephone interview with the pharmacy on 03/25/15 revealed:</p> <ul style="list-style-type: none"> <li>- Resident #2's hydrogen peroxide ear drops were last filled on 03/03/14 for 60 ml with instructions on the label as 1 to 2 drops twice a week in each ear.</li> <li>- Sixty ml of hydrogen peroxide was equal to 1200 drops and at 8 drops per week, 60 ml would last for over a year.</li> <li>- The pharmacy had not received any subsequent orders that the hydrogen peroxide ear drops were discontinued or changed.</li> </ul> <p>Interview with two Supervisors-in-Charge (SIC)/Medication Aides(MAs) on 03/25/15 at 11:00 am and 5:00 pm revealed:</p> <ul style="list-style-type: none"> <li>- Both SIC/MAs revealed they had not administered hydrogen peroxide ear drops to Resident #2 on any day in March.</li> <li>-One of the SIC/MAs had administered the hydrogen peroxide ear drops to Resident #2 on 02/03/15.</li> <li>-Neither staff was sure why the ear drops had not been administered to Resident #2 twice a week in February 2015 and why they had not been administered to Resident #2 on any day in March 2015.</li> </ul>	C 330		

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C 330	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>- Neither staff was able to produce documentation reflecting Resident #2's order for hydrogen peroxide ear drops had been changed or discontinued after 01/12/15.</li> </ul> <p>A third SIC/MA who had administered the ear drops on 02/09/15 and 02/23/15 was not available for interview.</p> <p>Interview with Resident #2 on 03/25/15 at 11:40 am revealed:</p> <ul style="list-style-type: none"> <li>- She was supposed to get hydrogen peroxide in her ears two times per week to help with itching in her ears.</li> <li>- She did not think the ear drops of hydrogen peroxide had been making a difference</li> <li>- Her ears had not been itching much because she had been keeping them cleaned with a q tip.</li> <li>- She wrote down the dates the facility staff had administered ear drops to her in her own calendar.</li> <li>- The last date she had written down on her calendar the facility administered ear drops to her was on 02/23/15.</li> </ul> <p>Resident #2's physician was not available for interview.</p> <p>Interview with the Administrator on 03/25/15 at 12:00 pm revealed:</p> <ul style="list-style-type: none"> <li>- She was not sure why hydrogen peroxide ear drops were ordered for Resident #2 by the physician.</li> <li>- The only thing she remembered was the original order dated 02/10/14 was for one to two drops in each ear twice a week.</li> <li>-She had clarified with the resident's physician on 09/19/14 that the order was for 2 drops in each ear twice a week.</li> <li>- She did not know why the ear drops had not</li> </ul>	C 330		

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C 330	Continued From page 8  been administered to Resident #2 twice a week in February 2015 or on any day in March 2015. - She did not recall the order for the ear drops had been discontinued or changed. - She could not locate any order in the resident record that the order for the ear drops had been discontinued or changed.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights  G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.  This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to staff having current training on Cardio-Pulmonary Resuscitation (CPR).  The findings are:  Based on Record reviews and interviews, the facility failed to assure at least one staff person on the premises at all times had completed a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, within the last 24 months for 2 of 3 staff (Staff A and C). [Refer to Tag C176, 10A NCAC 13G.0507. (Type B Violation)]	C 912		