

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 03/13/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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{D 000}	Initial Comments The Adult Care Licensure Section and the Swain County Department of Social Services conducted a follow-up survey on March 11-12, 2015 with an exit conference via telephone on March 13, 2015.	{D 000}		
D 131	<p>10A NCAC 13F .0406(a) Test For Tuberculosis</p> <p>10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 4 sampled staff (Staff C) was tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.</p> <p>The findings are:</p> <p>Review of Staff C's personnel record revealed: -Hire date of 9/21/12 as a Personal Care Aide (PCA). -Documentation of a TB skin test placed on 10/11/12 and read as negative on 10/13/12. -No documentation of a second TB skin test. -A re-hire date of 02/10/15 as a PCA. -No documentation TB skin testing had been done upon re-hire.</p>	D 131		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Division of Health Service Regulation

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D 131	<p>Continued From page 1</p> <p>Interview with Staff C on 3/12/15 at 2:05pm revealed: -She had not been tested for TB since she had been re-hired on 2/10/15. -She had not been tested for TB in the 12 months prior to being re-hired.</p> <p>Interview with the Co-Administrator on 3/12/15 at 1:45pm revealed: -He and the Administrator were responsible for ensuring all new employees had the required documentation in their personnel records. -Employees received the TB skin testing at the local Urgent Care. -When the TB skin testing result was received by the facility, it was checked as having been completed on the check-off sheet in the front of each employee's personnel file. -The facility did not re-hire former employees, but Staff C had been an exception. -He was not aware Staff C should have been treated as a new hire and previous documentation was not applicable. -He was unaware the TB test in Staff C's personnel record dated 10/11/12 could not be "brought forward" and used in her current personnel record.</p> <p>Interview with the Administrator on 3/12/15 at 3:20pm revealed: -The facility did not re-hire former employees. -An exception had been made with Staff C. -Upon re-hire, the TB testing from 10/11/12 was "brought forward" and used in Staff C's new personnel record. -She was not aware Staff C had to have current TB test results in her personnel record. -She would send Staff C for TB testing immediately and follow-up with the provider to</p>	D 131		

Division of Health Service Regulation

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D 131	Continued From page 2 ensure a second TB skin test was completed.	D 131		
{D 137}	<p>10A NCAC 13F .0407(a)(5) Other Staff Qualifications</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: Based on interview and record review, the facility failed to assure 1 of 4 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR).</p> <p>The findings are:</p> <p>Review of Staff C's personnel record revealed: -Hire date of 9/21/12 as a Personal Care Aide (PCA). -Documentation a Health Care Personnel Registry (HCPR) check had been done on 12/17/12. -A re-hire date of 02/10/15 as a PCA. -No documentation a HCPR check had been done upon re-hire.</p> <p>Interview with Staff C on 3/12/15 at 2:05pm revealed she did not know if the facility had done a HCPR check when she was re-hired.</p> <p>Interview with the Co-Administrator on 3/12/15 at 1:45pm revealed: -He and the Administrator were responsible for ensuring all new employees had the required</p>	{D 137}		

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 03/13/2015
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{D 137}	Continued From page 3 documentation in their personnel records. -The facility did not re-hire former employees, but Staff C had been an exception. -He was not aware Staff C should have been treated as a new hire and previous documentation was not applicable. -He was unaware the HCPR check in Staff C's personnel record dated 12/17/12 could not be "brought forward" and used in her current personnel record. Interview with the Administrator on 3/12/15 at 3:20pm revealed: -The facility did not re-hire former employees. -An exception had been made with Staff C. -Upon re-hire, the HCPR check from 12/17/12 was "brought forward" and used in Staff C's current personnel record. -She was not aware Staff C had to have a HCPR check done upon re-hire. Review of the HCPR check obtained by the facility on 3/12/15, during survey, revealed no substantiated findings for Staff C.	{D 137}		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing	D 161		

Division of Health Service Regulation

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D 161	<p>Continued From page 4</p> <p>competency is assured through facility staff oversight and supervision.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 4 sampled non-licensed personnel, Staff C, a Personal Care Aide (PCA) was competency validated by return demonstration prior to performing Licensed Health Professional Support (LHPS) tasks.</p> <p>The findings are:</p> <p>Review of the personnel record for Staff C, Personal Care Aide (PCA) on 3/12/15 revealed: -A hire date of 9/21/12. -A Licensed Health Professional Support (LHPS) task validation sheet dated 9/25/12. -A re-hire date of 2/10/15. -No documentation of competency validation since re-hire or prior to performing LHPS tasks.</p> <p>Interview with the contracted Nurse Consultant on 3/12/15 at 11:30am revealed: -LHPS competency validation of the unlicensed staff prior to their performing the LHPS tasks was her responsibility. -The Administrator would verbally tell her when a new employee needed training. -She was not aware Staff C, PCA, had not been competency validated. -Tasks performed in the facility included: applying TED (support) hose, care of a well established colostomy, care of a stage II pressure ulcer, oxygen administration and monitoring, monitoring of continuous positive air pressure devices (CPAP and BiPAP), clean dressing changes, ambulation using assistive devices that require physical assistance and transferring semi-ambulatory residents.</p>	D 161		

Division of Health Service Regulation

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D 161	<p>Continued From page 5</p> <ul style="list-style-type: none"> - Once competency validated, all PCAs in the facility could perform the task as listed above. <p>Interview with the Co-Administrator on 3/12/15 at 1:45pm revealed:</p> <ul style="list-style-type: none"> -He and the Administrator were responsible for ensuring all new employees had the required documentation in their personnel records. -The facility did not re-hire former employees, but Staff C had been an exception. -He was not aware Staff C should have been treated as a new hire and previous documentation was not applicable. -He was unaware the LHPS check-off sheet in Staff C's personnel record dated 9/25/12 could not be "brought forward" and used in her current personnel record. <p>Interview with Staff C on 3/12/15 at 3:09pm revealed:</p> <ul style="list-style-type: none"> -She had previously been hired on 9/21/12 and moved out of the area. -When she returned, she re-applied at the facility and had been re-hired on 2/10/15. -She was a Personal Care Aide and was currently training to be a Medication Aide. -She usually worked the second (3:00pm to 11:00pm) and third (11:00pm to 7:00am) shifts. -Since re-hire, she had assisted residents with "showers, incontinence care, brought them to meals and socialized with them. -She changed linens, took out the trash and cleaned up if a resident had an accident. <p>Interview with the Administrator on 3/12/15 at 3:20pm revealed:</p> <ul style="list-style-type: none"> -The facility did not re-hire former employees. -An exception had been made with Staff C. -Upon re-hire, the LHPS task validation sheet dated 9/25/12 had been "brought forward" and 	D 161		

Division of Health Service Regulation

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D 161	Continued From page 6 used in Staff C's current personnel record. -She was not aware Staff C needed to have an LHPS task validation sheet completed upon re-hire. -She would have the contracted Nurse Consultant complete an LHPS competency validation for Staff C the following day.	D 161		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION 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 5 sampled residents (Residents #1, #3 and #5) related to medications not being available. The findings are: A. Review of Resident #3's current FL2 dated 12/22/14 revealed: -Diagnoses of Dementia, Parkinson's disease, Chronic Migraine and Chronic Pain. -Medication order for Quetiapine, 100mg, two	{D 273}		

Division of Health Service Regulation

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{D 273}	<p>Continued From page 7</p> <p>tablets orally twice a day (Quetiapine is the generic for Seroquel and is an antipsychotic medicine used to treat schizophrenia). -Medication order for Quetiapine, 100mg, three tablets orally every night at bedtime.</p> <p>Interviews with Resident #3 on 3/11/15 at 9:50am and 3/12/15 at 5:35pm revealed: -This past week his Seroquel, which keeps him "stable", ran out. -He had just gotten it back that morning. -He had "gone without the Seroquel for 2 days." -He was starting to get "angry and didn't feel right" because he hadn't had the medication. -He also stated the Seroquel "kept him out of trouble". -He had talked to a medication aide on 3/9/15 at 1:00pm, who told him when a medication ran out before it had been reordered, there was a 2 day wait before the medication arrived at the facility. -He had not spoken with the Administrator or the Co-Administrator stating, "What can they do? I just have to wait". -Without the Quetiapine, he became angry and confused. -He stated, "I wander and it gets me into trouble." -He felt his medications were not at a therapeutic level since he had missed them. -He stated he slept too much now (since not receiving them) and if it was better, he would be able to do more.</p> <p>Review of Resident #3's Medication Administration Record (MAR) for March 2015 revealed: -Computer generated Quetiapine medication listed on the MAR coincided with the physician's orders. -Quetiapine was documented as administered as ordered March 1 through 9, 2015 at 8:00am.</p>	{D 273}		

Division of Health Service Regulation

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{D 273}	Continued From page 8 -The Quetiapine was circled as not given on: 3/9/15 at 2:00pm. 3/9/15 at 8:00pm. 3/10/15 at 8:00am. 3/10/15 at 2:00pm. 3/10/15 at 8:00pm. Documentation on the back of the 2015 MAR revealed: -On "3/10 2:P Quetiapine on order" with Staff F, Medication Aide (MA) initials. -On "3/10 8:P Quetiapine on order" with Staff E, MA initials. -There was no documentation why the Quetiapine had not been given on 3/9/15 at 2:00pm and 8:00pm. -There was no documentation on the MAR that the physician or the pharmacy had been notified the resident was out of the medication. Observation on 3/11/15 at 11:20am of medication on hand revealed: -The pharmacy had delivered the Quetiapine to the facility about 2:00am that morning. -One dose of Quetiapine had been removed from the medication card. -The resident had received the prescribed dose of Quetiapine that morning at 8:00am. Interview with Staff F, MA, on 3/11/15 at 3:20pm revealed circled initials on the MAR meant a medication was not given and staff were expected to make a comment as to why on the back of the MAR. Interview with Staff D, MA, on 3/12/15 at 10:45am revealed: -It was the responsibility of the MA's to reorder medications. -Staff D did not know the reason why Resident #3	{D 273}			

Division of Health Service Regulation

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{D 273}	<p>Continued From page 9</p> <p>had run out of the Quetiapine. -Staff D had not contacted the Resident's physician or the pharmacy. -She was not aware she needed to notify the physician if residents were out of medication.</p> <p>Interview with Resident Care Coordinator (RCC) on 3/12/15 at 10:50am revealed: -She was not aware that Resident #3 had missed 5 doses of Quetiapine. -She reviewed the staff shift change notebook and indicated there was no entry concerning Resident #3 running out of the Quetiapine medication. -She had not notified the resident's physician or the pharmacy because she did not know Resident #3 was out of medication. -She did not know if there was a written policy for re-ordering medications. -She was not aware if there was a system for following-up on ordering medications. -She was not aware if MAR audits were being done and if so, who was responsible.</p> <p>Interview with the Co-Administrator on 3/12/15 at 4:25pm revealed: -It was the RCC's responsibility to assure the physician was notified of medication issues. -It was the Administrator who supervised the RCC.</p> <p>Interview with Staff E, MA, on 3/12/15 at 6:52pm revealed: -He did not know why Resident #3's medications had not been reordered and why the resident was going without medication. -It was the responsibility of the first MA who reached the reorder sticker, to remove it and send it to the pharmacy. -When a medication ran out before it was</p>	{D 273}		

Division of Health Service Regulation

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{D 273}	<p>Continued From page 10</p> <p>reordered, it took several days for the medication to come from the pharmacy.</p> <p>Telephone interview with Resident #3's Primary Care Provider's Physician's Assistant (PA) on 3/13/15 at 10:15am revealed: -He would expect the facility to notify him of any medication issues. -He had not been notified Resident #3 had missed 5 doses of Quetiapine . -He would have wanted to be notified. -The effect on Resident #3 for missing 5 doses of Quetiapine could be for him to become angry and to possibly hurt himself or others.</p> <p>Record review revealed no documentation of any history of violent or injurious behavior to Resident #3 or others.</p> <p>Telephone interview with the Administrator on 3/13/15 at 10:20am revealed: -She was not aware Resident #3 had been out of Quetiapine medication and had missed five doses. -She was not aware if Resident #3's physician or the pharmacy had been notified.</p> <p>Refer to interview with the Administrator on 3/13/15 at 10:20am.</p> <p>Refer to facility's policy for re-ordering of medications.</p> <p>B. Review of Resident #1's current FL2 dated 12/22/14 revealed: -Diagnoses including anxiety and mental status change. -An order for zolpidem (a medication to aid in sleep), 10 milligram (mg) dose at hour of sleep.</p>	{D 273}		

Division of Health Service Regulation

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{D 273}	<p>Continued From page 11</p> <p>Review of a Licensed Health Professional Support (LHPS) note dated 1/23/15 revealed: -The "resident requires monitoring of mood/mental status due to history of anxiety" and "requires consistent medication regimen" for pain management and moods.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for February 2015 revealed: -Staff initials for zolpidem in the date blocks for 2/26/15, 2/27/15 and 2/28/15 with all staff initials circled. -On the reverse side of the MAR was documented "2-26-15 @10pm zolpidem on order" with staff initials. -On the reverse side of the MAR was documented "2-27-15 @10pm need new RX [prescription] for zolpidem " with staff initials and in the result/response column was documented "Dr. [doctor] notified" with staff initials. -There was no documentation on the reverse side of the MAR for zolpidem for 2/28/15.</p> <p>Interview with Resident #1 on 3/11/15 at 9:30am revealed: -She was alert and oriented. -Her medications ran out "quite often" and a few weeks prior the facility ran out of her zolpidem, resulting in her going without it for three nights. -The staff informed the resident a doctor had to call the medication in and the resident told the staff to call the doctor. -The resident could not sleep at all during the three nights the zolpidem was not given.</p> <p>An interview with Staff F, Medication Aide (MA), on 3/11/15 at 3:20pm revealed: -She did not know why the zolpidem was not given or not available.</p>	{D 273}		

Division of Health Service Regulation

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{D 273}	<p>Continued From page 12</p> <ul style="list-style-type: none"> -Possible reasons for a medication to be unavailable included an expired prescription with a time lag waiting for a doctor to return it. -A message may not have been passed for someone to pick up the medication at the pharmacy and the pharmacy might not have it ready at time of pick-up. -When initials on the MAR were circled it meant the medication was not given. -Staff were expected to make a comment on the back of the MAR as to why the medication was not given. <p>Interview with Staff D, MA, on 3/12/15/at 11:10am revealed Resident #1 was not given zolpidem because it was not available and it "just didn't get reordered".</p> <p>Interview with the RCC (Resident Care Coordinator) on 3/12/15 at 11:21am revealed the RCC was not aware Resident #1 had missed 3 doses of zolpidem on 2/26/15, 2/27/15 and 2/28/15.</p> <p>Interview with the Physician's Assistant (PA) on 3/13/15 at 10:15pm revealed:</p> <ul style="list-style-type: none"> -The PA had not been notified Resident #1 had missed 3 doses of zolpidem on 2/26/15, 2/27/15 and 2/28/15. -The PA would have wanted to be notified. -The effect on Resident #1 for missing 3 doses of zolpidem would have resulted in not being able to sleep on those nights. <p>Interview with the Pharmacy Manager at the local pharmacy that filled Resident #1's prescriptions on 3/13/15 at 1:25pm revealed:</p> <ul style="list-style-type: none"> -A 28 day supply for zolpidem was filled on 1/29/15. -The resident would have been out of zolpidem 	{D 273}		

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 03/13/2015
NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON		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 273}	<p>Continued From page 13</p> <p>on 2/26/15.</p> <p>-The next order for zolpidem was on 3/1/15 for a 30 day supply.</p> <p>-An order for zolpidem was received by the Pharmacist on 3/1/15 at 2:34 pm and was picked up on 3/1/15 at 3:50pm.</p> <p>Refer to interview with the Administrator on 3/13/15 at 10:20am.</p> <p>Refer to facility's policy for re-ordering of medications.</p> <p>C. Review of Resident #5's record revealed:</p> <p>-The current FL2 dated 12/22/14 with diagnoses that included GERD (gastrointestinal reflux disease).</p> <p>-A physician's order for Nexium 40mg once a day. (Nexium is used to treat acid reflux/GERD).</p> <p>Observations on 03/11/15 at 10:05am revealed Staff F, Medication Aide (MA), punched 8 medications for Resident #5 out of a multi-dose package. (A pre-filled package from the pharmacy with one large bubble that contained all morning medications.)</p> <p>-Nexium was not one of the 8 medications dispensed.</p> <p>-Resident #5 took the medications with water.</p> <p>At this time, Staff F, MA, proceeded to document all morning medications on the Medication Administration Record (MAR) as given and stated the resident had requested to wait until after breakfast to take the morning medications.</p> <p>Review of Resident #5's February 2015 MAR on 03/11/15 revealed:</p> <p>-A computer generated slot for Nexium 40mg to be given at 8:00am on each MAR.</p>	{D 273}		

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 03/13/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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{D 273}	<p>Continued From page 14</p> <p>-Staff initials indicating Nexium had been given as ordered February 1 through 23, 2015.</p> <p>-On February 24, 2015, the Nexium slot was circled indicating the medication was not given.</p> <p>-Staff initials in the Nexium slots indicating the medication was given as ordered on February 25, 26, 27, and 28 but no medication had been in the facility for the resident.</p> <p>Review of Resident #5's March 2015 MAR on 03/11/15 revealed:</p> <p>-The Nexium slots for 3/4, 3/10, 3/11 and 3/12 were circled indicating the medication had not been given.</p> <p>-A notation on the back of the MAR dated 3/12/15 that the medication was not in stock.</p> <p>Interview with Staff F, MA, on 03/11/15 at 10:10am Staff F revealed:</p> <p>-She did not see the Nexium (which was a "purple pill") in with the other medications, now that she thought about it.</p> <p>-The Nexium should have been in the multi-dose package with all the other medications, but the pharmacy must have left it out.</p> <p>-She would follow up with the pharmacy to see why the Nexium was not in the package.</p> <p>-She did had not compared the medications on the MAR with the label on the package before signing the MAR.</p> <p>-She did not know how long Resident #4 had been out of Nexium.</p> <p>Observations on 3/11/15 at 2:15pm of the medications on hand for Resident #5 revealed:</p> <p>-Five days remained in the bubble-pack for Resident #5.</p> <p>-Descriptions on the label of the medications in the bubble package revealed no Nexium was in the package.</p>	{D 273}		

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 03/13/2015
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{D 273}	Continued From page 15 Telephone interview with the pharmacy staff on 03/12/15 at 3:00pm revealed: -Routine medications were automatically sent out in multi-dose packs every 7 days. -A 7 day supply of Nexium 40mg had last been filled for Resident #5 on February 16, 2015 which should have lasted through February 23, 2015. -No more Nexium had been sent to the facility since that time, because they were waiting on a Prior Authorization from the physician. -When a Prior Authorization was needed, the pharmacy would fax the facility and the physician to make them aware. -The pharmacy did not know when or if the request for Prior Authorization had been sent to the facility or the physician. Telephone interview with staff at Resident #5's Physician's office on 03/13/15 at 1:30pm revealed: -They had never received a request for Prior Authorization for the Nexium. -No one had made them aware that Resident #5 had been out of Nexium. Interview with Resident #5 on 03/12/15 at 10:45am revealed: -He did not know all the names of his medications. -He had not had any problems with increased indigestion or heart burn. Interview with the RCC (Resident Care Coordinator) on 03/12/15 at 10:45am revealed: -She was not aware Resident #5 was out of Nexium until "yesterday". -She had called the pharmacy and was told they were waiting on a Prior Authorization for refill. -The physician had not been notified that	{D 273}			

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 03/13/2015
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{D 273}	<p>Continued From page 16</p> <p>Resident #5 was out of Nexium.</p> <p>Interview with the Administrator on 3/13/15 at 10:20am revealed her expectation related to unavailable medications would be:</p> <ul style="list-style-type: none"> -For staff to contact Pharmacy. -For staff to check for reorder. -For staff to contact the MD or the Physician's Assistant. -For staff to complete the shift change communication form. <p>Review of the facility's policy for re-ordering medications revealed:</p> <ul style="list-style-type: none"> -While completing a medication pass, the MA was to be aware of any bubble packs that were in the blue row on the medications cards. -When a medication had been administered from the blue portion of the card, the MA was to make sure to remove the re-order sticker and place it on the pharmacy re-order sheet and fax it immediately. -When the pharmacy sent a report of "Medication No Longer Covered", the MA will contact the Physician's Assistant as soon as possible to write an order for a medication equivalent making sure that medication is ordered in a timely manner so that no lapse of time occurred. -For medications on cyclic order, make sure all medications are ordered for new cycles. -Check medications in the medication cart and in overstock supply to be sure that unnecessary ordering does not take place. -Check need to re-order narcotics by referring to the narcotic count sheets. <hr/> <p>A Plan of Protection provided by the facility on 3/12/15 revealed:</p> <ul style="list-style-type: none"> -The Primary Care Physicians would be notified 	{D 273}		

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 03/13/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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{D 273}	Continued From page 17 of medications not in the building at this time. -All orders for low numbers of medications will be directed to the RCC for ordering. -All documentation will be completed by the MA on duty when stock is low and documentation will be placed in a designated folder for the RCC to complete the process. -A Medication Aide meeting had been scheduled for 3/13/15 with the facility Nurse Consultant, the Resident Care Coordinator, the Co-Administrator and the Administrator to discuss areas cited during the survey and will be held weekly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2015.	{D 273}		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on these findings, the previous Type A2	{D 358}		

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 03/13/2015
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{D 358}	<p>Continued From page 18 violation was not abated.</p> <p>Based on observation, interview and record review, the facility failed to assure medications, which included Quetiapine, Ambien and Nexium, were administered as ordered for 3 of 13 sampled residents (Residents #1, #3 and #5).</p> <p>The findings are:</p> <p>A. Review of Resident #3's current FL2 dated 12/22/14 revealed: -Diagnoses of Dementia, Parkinson's disease, Chronic Migraine and Chronic Pain. -Medication order for Quetiapine, 100mg, two tablets orally twice a day (Quetiapine is the generic for Seroquel and is an antipsychotic medicine used to treat schizophrenia). -Medication order for Quetiapine, 100mg, three tablets orally every night at bedtime.</p> <p>Interview with Resident #3 on 3/11/15 at 9:50am revealed: -This past week his Seroquel, which keeps him "stable", ran out. -He had just gotten it back that morning. -He had "gone without the Seroquel for 2 days." -Without the Quetiapine he became angry and confused. -He was starting to get "angry and didn't feel right" because he hadn't had the medication. -The Seroquel "kept him out of trouble". -He had talked to a "nurse" at the facility who told him when a medication ran out before it had been reordered, there was a 2 day wait before the medication arrived at the facility. -He had not spoken with the Administrator or the Co-Administrator stating, "What can they do? I just have to wait".</p>	{D 358}		

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 03/13/2015
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{D 358}	<p>Continued From page 19</p> <p>Review of Resident #3's Medication Administration Record (MAR) for March 2015 revealed:</p> <ul style="list-style-type: none"> -Computer generated Quetiapine medication listed on the MAR coincided with the physician's orders. -Quetiapine was documented as administered as ordered March 1 through 9, 2015 at 8:00am. -The Quetiapine was circled as not given on: <ul style="list-style-type: none"> 3/9/15 at 2:00pm. 3/9/15 at 8:00pm. 3/10/15 at 8:00am. 3/10/15 at 2:00pm. 3/10/15 at 8:00pm. <p>Further review of Resident #3's MAR for March 2015 revealed:</p> <ul style="list-style-type: none"> -Documentation of back of MAR indicated "3/10 2:P Quetiapine on order" with Staff F, Medication Aide (MA) initials. -Documentation of back of MAR indicated "3/10 8:P Quetiapine on order" with Staff E, MA initials. <p>Interview with Staff F, MA, on 3/11/15 at 3:20pm revealed circled initials on the MAR meant a medication was not given and staff were expected to make a comment as to why on the back of the MAR.</p> <p>Interview with Staff D, MA, on 3/12/15 at 10:45am revealed:</p> <ul style="list-style-type: none"> -It was the responsibility of the MA's to reorder medications. -When a MA administers medications from the "blue section" on the medication blister pack, they are to remove a "sticker" and place it on the pharmacy reorder form. -"That is how it has been since I started as a (MA) about one year ago." -Staff D primarily worked the 11:00pm to 7:00am 	{D 358}			

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 03/13/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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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 20</p> <p>shift and "had very few meds" to administer. - "If I came across a blue line I will reorder, otherwise I assume it is being done." - Staff D did not know the reason why Resident #3 ran out of the Quetiapine.</p> <p>Interview with Resident Care Coordinator (RCC) on 3/12/15 at 10:50am revealed: - The process was, when a MA comes to the blue line on a medication blister pack, they are to "pull the strip" and place it on the pharmacy reorder form. - The MA is to make her aware that a medication needed to be reordered. - She would fax the form to the pharmacy by 2:00pm and the medication would be delivered early in the morning on the following day. - She did not know if there was a written policy for reordering medications. - She was not aware that Resident #3 had missed 5 doses of Quetiapine. - She reviewed the staff shift change notebook and indicated there was no entry concerning Resident #3 running out of the Quetiapine medication. - She was not aware of a system to follow-up on ordering medications. - She was not aware if MAR audits were being done and if so, who was responsible.</p> <p>Interview with Co-Administrator on 3/12/15 at 4:25pm revealed: - It was the RCC's responsibility to assure the medications were reordered. - It was the Administrator who supervised the RCC.</p> <p>Interview with Resident #3 on 3/12/15 at 5:35pm revealed: - Without the Quetiapine, he became angry and</p>	{D 358}		

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 03/13/2015	
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{D 358}	<p>Continued From page 21</p> <p>confused.</p> <p>-He stated, "I wander and it gets me into trouble."</p> <p>-He felt his medications were not at a therapeutic level since he had missed them.</p> <p>-He stated he slept too much now (since not receiving them) and if it was better, he would be able to do more".</p> <p>Interview with Staff E, MA, on 3/12/15 at 6:52pm revealed:</p> <p>-He did not know why resident medications had not been reordered and why resident's were going without medication.</p> <p>-It was the responsibility of the first MA who reached the reorder sticker, to remove it and send it to the pharmacy.</p> <p>-When a medication ran out before it was reordered, it took several days for the medication to come from the pharmacy.</p> <p>Review of Resident #3's record revealed no documented incidents of the resident being angry, hurting himself or others.</p> <p>Interview with the Physician's Assistant (PA) by telephone on 3/13/15 at 10:15am revealed:</p> <p>-The PA had not been notified Resident #3 had missed 5 doses of Quetiapine .</p> <p>-The PA would have wanted to be notified.</p> <p>-The effect on Resident #3 for missing 5 doses of Quetiapine could be for him to become angry and possibly hurting himself or others.</p> <p>Refer to interview with the Administrator on 3/13/15 at 10:20am.</p> <p>Refer to the facility's policy for re-ordering of medication.</p> <p>B. Review of Resident #1's current FL2 dated</p>	{D 358}		

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 03/13/2015
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{D 358}	<p>Continued From page 22</p> <p>12/22/14 revealed: -Diagnoses including anxiety and mental status change. -An order for zolpidem (a medication to aid in sleep), 10 milligram (mg) dose at hour of sleep.</p> <p>Review of a Licensed Health Professional Support (LHPS) note dated 1/23/15 revealed the "resident requires consistent medication regimen" for pain management and moods.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for February 2015 revealed: -Staff initials for zolpidem in the date blocks for 2/26/15, 2/27/15 and 2/28/15 with all initials circled. -On the reverse side of the MAR was documented "2-26-15 @10p zolpidem on order " with staff initials. -On the reverse side of the MAR was documented "2-27-15 @10p need new RX [prescription] for zolpidem" with staff initials and in the result/response column was documented "Dr. [doctor] notified" with staff initials.</p> <p>Interview with Resident #1 on 3/11/15 at 9:30am revealed: -She was alert and oriented. -Her medications ran out "quite often" and a few weeks prior, the facility ran out of her zolpidem, resulting in her going without it for three nights. -The staff informed her a doctor had to call the medication in to the pharmacy. -She had told the staff to call the doctor. -She could not sleep during the three nights the zolpidem was not given.</p> <p>An interview with Staff F, Medication Aide (MA), on 3/11/15 at 3:20pm revealed:</p>	{D 358}		

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 03/13/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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{D 358}	<p>Continued From page 23</p> <ul style="list-style-type: none"> -She did not know why the zolpidem was not given or not available. -Possible reasons for a medication to be unavailable included an expired prescription with a time lag waiting for a doctor to return it. -A message may not have been passed for someone to pick up the medication at the pharmacy and the pharmacy might not have had it ready at time of pick-up. -When initials on the MAR were circled it meant the medication was not given. -Staff were expected to make a comment on the back of the MAR. <p>Interview with Staff D, MA, on 3/12/15/at 11:10am revealed Resident #1 was not given zolpidem because it was not available and it "just didn't get reordered ".</p> <p>Interview with the Resident Care Coordinator (RCC) on 3/12/15 at 11:21am revealed she was not aware Resident #1 had missed 3 doses of zolpidem on 2/26/15, 2/27/15 and 2/28/15.</p> <p>Interview with the Physician's Assistant (PA) on 3/13/15 at 10:15am revealed:</p> <ul style="list-style-type: none"> -The PA had not been notified Resident #1 had missed 3 doses of zolpidem on 2/26/15, 2/27/15 and 2/28/15. -The PA would have wanted to be notified. -The effect on Resident #1 for missing 3 doses of zolpidem would have resulted in not being able to sleep on those nights. <p>Interview with the Pharmacy Manager on 3/13/15 at 1:25pm revealed:</p> <ul style="list-style-type: none"> -A 28 day supply for zolpidem was filled on 1/29/15. -The resident would have been out of zolpidem on 2/26/15. 	{D 358}		
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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 03/13/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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{D 358}	<p>Continued From page 24</p> <p>-The next order for zolpidem was on 3/1/15 for a 30 day supply. -An order for zolpidem was received by the Pharmacist on 3/1/15 at 2:34 pm and was picked up by the facility on 3/1/15 at 3:50pm.</p> <p>Refer to interview with the Administrator on 3/13/15 at 10:20am.</p> <p>Refer to the facility's policy for re-ordering of medication.</p> <p>C. Review of Resident #5's record revealed: -A current FL2 dated 12/22/14 with diagnoses that included GERD (gastrointestinal reflux disease). -A physician's order for Nexium 40mg once a day. (Nexium is used to treat acid reflux/GERD).</p> <p>Observations on 03/11/15 at 10:05am revealed Staff F, Medication Aide (MA), punched 8 medications for Resident #5 out of a multi-dose package. (A pre-filled package from the pharmacy with one large bubble that contained all morning medications.) -Nexium was not one of the 8 medications dispensed. -Resident #5 took the medications with water.</p> <p>At this time, Staff F, MA, proceeded to document all morning medications on the MAR as given and stated the resident had requested to wait until after breakfast to take the morning medications.</p> <p>Review of Resident #5's February 2015 MAR on 03/11/15 revealed: -A computer generated slot for Nexium 40mg to be given at 8:00am on each MAR. -Staff initials indicating Nexium had been given as ordered February 1 through 23, 2015. -On February 24, 2015, the Nexium slot was</p>	{D 358}		

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 03/13/2015
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{D 358}	<p>Continued From page 25</p> <p>circled indicatng the medication was not given. -Staff initials in the Nexium slots indicating the medication was given as ordered on February 25, 26, 27, and 28 but no medication had been in the facility for the resident.</p> <p>Review of Resident #5's March 2015 MAR on 03/11/15 revealed: -The Nexium slots for 3/4, 3/10, 3/11 and 3/12 were circled indicating the medication had not been given. -A notation on the back of the MAR dated 3/12/15 that the medication was not in stock.</p> <p>Interview with Staff F, MA, on 03/11/15 at 10:10am revealed: -She did not see the Nexium (which was a "purple pill") in with the other medications, now that she thought about it. -The Nexium should have been in the multi-dose package with all the other medications, but the pharmacy must have left it out. -She would follow up with the pharmacy to see why the Nexium was not in the package. -She did had not compared the medications on the MAR with the label on the package before signing the MAR. -She did not know how long Resident #5 had been out of Nexium.</p> <p>Observations of the medications on hand for Resident #5 revealed: -Five days remained in the bubble-pack package for Resident #5. -Descriptions on the label of the medications in the bubble pack revealed no Nexium was in the package.</p> <p>Telephone interview with the pharmacy staff on 03/12/15 at 3:00pm revealed:</p>	{D 358}		

Division of Health Service Regulation

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{D 358}	<p>Continued From page 26</p> <ul style="list-style-type: none"> -Routine medications were automatically sent out in multi-dose packs every 7 days. -A 7 day supply of Nexium 40mg had last been filled for Resident #5 on February 16, 2015 which could have lasted through February 23, 2015. -No more Nexium had been sent to the facility since that time, because they were waiting on a Prior Authorization from the physician. -When a Prior Authorization was needed, the pharmacy would fax the facility and the physician to make them aware. -The pharmacy did not know when or if the request for Prior Authorization had been sent to the facility or the physician. <p>Telephone interview with staff at Resident #5's Physician's office on 03/13/15 at 1:30pm revealed:</p> <ul style="list-style-type: none"> -They had never received a request for Prior Authorization for the Nexium. -No one had made them aware that Resident #5 had been out of Nexium. <p>Interview with Resident #5 on 03/12/15 at 10:45am revealed:</p> <ul style="list-style-type: none"> -He did not know all the names of his medications. -He had not had any problems with increased indigestion or heart burn. <p>Interview with the RCC (Resident Care Coordinator) on 03/12/15 at 10:45am revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #5 was out of Nexium until "yesterday". -She had called the pharmacy and was told they were waiting on a Prior Authorization for refill. -The physician had not been notified that Resident #5 was out of Nexium. 	{D 358}			

Division of Health Service Regulation

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{D 358}	<p>Continued From page 27</p> <p>Interview with the Administrator on 3/13/15 at 10:20am revealed her expectations related to unavailable medications would be for staff to:</p> <ul style="list-style-type: none"> -Contact Pharmacy. -Check for reorder. -Contact the MD or the Physician's Assistant. -Complete the shift change communication form. <p>Review of the facility's policy for re-ordering medications revealed:</p> <ul style="list-style-type: none"> -While completing a medication pass, the MA was to be aware of any bubble packs that were in the blue row on the medications cards. -When a medication had been administered from the blue portion of the card, the MA was to make sure to remove the re-order sticker and place it on the pharmacy re-order sheet and fax it immediately. -When the pharmacy sent a report of "Medication No Longer Covered", the MA will contact the Physician's Assistant as soon as possible to write an order for a medication equivalent making sure that medication is ordered in a timely manner so that no lapse of time occurred. -For medications on cyclic order, make sure all medications are ordered for new cycles. -Check medications in the medication cart and in overstock supply to be sure that unnecessary ordering does not take place. -Check need to re-order narcotics by referring to the narcotic count sheets. <hr/> <p>A Plan of Protection provided by the facility on 3/12/15 revealed:</p> <ul style="list-style-type: none"> -The Primary Care Physicians would be notified of medications not in the building at this time. -All orders for low numbers of medications will be directed to the RCC for ordering. -All documentation will be completed by the MA 	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 28 on duty when stock is low and documentation will be placed in a designated folder for the RCC to complete the process. -A Medication Aide meeting had been scheduled for 3/13/15 with the facility Nurse Consultant, the Resident Care Coordinator, the Co-Administrator and the Administrator to discuss areas cited during the survey and will be held weekly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2015.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, 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 resident rights, health care referral, and medication administration. The findings are: A. 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 5 sampled residents (Residents #1, #3 and #5) related to medications not being available.	{D912}		

Division of Health Service Regulation

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{D912}	Continued From page 29 [Refer to Tag 273 10A NCAC 13F .0902(b) (Type B Violation).] B. Based on observation, interview and record review, the facility failed to assure medications, which included Quetiapine, Ambien and Nexium, were administered as ordered for 3 of 13 sampled residents (Residents #1, #3 and #5). [Refer to Tag 358 10A NCAC 13F .1004(a) (Type B Violation).]	{D912}		
D992	G.S. § 131D-45 Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled	D992		

Division of Health Service Regulation

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D992	<p>Continued From page 30</p> <p>substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 4 sampled staff (Staff C) hired after 10/1/13 before the employee began working at the facility.</p> <p>The findings are:</p> <p>Review of Staff C's personnel file revealed: -Staff C was hired on 2/10/15. -Staff C was hired as a personal care aide (PCA). -No documentation a controlled substance exam/screening had been completed.</p> <p>Interview on 3/12/15 at 1:30pm with Staff C, PCA revealed: -The Administrator had not asked her to submit to a drug test when she was hired 2/10/15. -She did not know she was supposed to have submitted the controlled substance exam/screening prior to being hired.</p> <p>Interview on 3/12/15 at 3:20pm with the Administrator revealed: -She was responsible for controlled substance exam/screening on new hires. -She did not know why Staff C, PCA had not had</p>	D992		

Division of Health Service Regulation

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D992	Continued From page 31 a drug test completed when hired. -She would send Staff C for drug testing the next day.	D992			