

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>03/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD</b> <b>WILKESBORO, NC 28697</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments  The Adult Care Licensure Section and the Wilkes County Department of Social Services conducted an annual, follow-up and complaint survey on March 25, 2015 through March 30, 2015.  The complaint investigation was initiated by the County Department of Social Services on January 16, 2015.	D 000		
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: TYPE B VIOLATION  Based on record review and interviews the facility failed to assure referral to meet routine health care needs of residents by failing to notify the physician for 2 of 2 residents who refused sliding scale insulin when required (Residents #15 and #5).  The findings are:  A. Review of Resident #15's most current FL2 dated 01/29/15 revealed: - Diagnoses included diabetes mellitus type II (DMII). - Finger stick blood sugar (FSBS) order every morning. - Physician orders for Lantus 25 units every morning and 15 units at bedtime (Lantus is a long	D 273		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 273	<p>Continued From page 1</p> <p>acting insulin used to treat DM).</p> <p>Review of the most current Physician order sheet dated 01/31/15 revealed orders for FSBS before meals and every night and dose with Humulin R sliding scale insulin (SSI) as:</p> <ul style="list-style-type: none"> <li>- 71-200 = 0 units</li> <li>- 201-250 = 2 units</li> <li>- 251-300 = 4 units</li> <li>- 301-350 = 6 units</li> <li>- 351-400 = 8 units</li> <li>- 401-450 = 10 units and notify MD</li> </ul> <p>Review of Resident #15's Medication Administration Record (MAR) for February 2015 revealed:</p> <ul style="list-style-type: none"> <li>- SSI was required 28 times at 6:30am.</li> <li>- The resident refused 10 times of the 28 times that SSI was required at 6:30am.</li> <li>- Routine Lantus 15 units scheduled for 8:00pm was refused 6 times between 02/20/15 through 02/25/15.</li> <li>- Review of FSBS results on 02/21, 02/22, 02/23, 02/24, 02/25 (5 consecutive days) at 6:30am ranged 91-297.</li> <li>- No documentation on the back of MAR or in the resident's record that the Physician was notified for refusal of SSI.</li> </ul> <p>Review of Resident #15 MAR's for March 1 through March 26, 2015 revealed:</p> <ul style="list-style-type: none"> <li>- SSI was required 30 times at 6:30am.</li> <li>- The resident refused 14 times that the SSI was required at 6:30 am.</li> <li>- No documentation on the MAR that the Physician was notified of the resident's refusals of SSI.</li> <li>- Routine Lantus 15 units scheduled for 8:00pm was refused 5 times between 03/01/15 through 03/5/15.</li> </ul>	D 273		

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D 273	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- Review of the FSBS results on 03/15, 03/16, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24 (10 consecutive days) ranged 185-229.</li> <li>- No documentation on back of MAR that the Physician was notified about the resident's refusals of insulin.</li> </ul> <p>Interview with Resident #15 on 03/26/15 at 2:00pm revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented.</li> <li>- The resident could not remember all times she had refused but had felt weak several times and did not want insulin.</li> </ul> <p>Refer to interview with the facility's Registered Nurse (RN) on 03/27/15 at 11:3am.</p> <p>Interview with the Physician on 03/27/15 at 4:05pm revealed:</p> <ul style="list-style-type: none"> <li>- He expected to be notified after a resident refused 3 times, "especially for insulin".</li> <li>- He was not aware Resident #15 had refused insulin.</li> <li>- Had he been made aware, he would have evaluated the resident to determine if adjustments or changes in medications were needed.</li> </ul> <p>B. Review of Resident #5's most current FL2 dated 12/12/14 included:</p> <ul style="list-style-type: none"> <li>- Diagnoses of diabetes mellitus type II (DMII).</li> <li>- Physician orders for Humalog insulin 2 units twice a day after lunch and supper. (Humalog is a fast acting insulin to treat DM).</li> <li>- Physician orders for Lantus 60 units at bedtime. (Lantus is a long acting insulin used to treat DM).</li> </ul> <p>Review of the most current signed Physician Order sheet dated 01/05/15 revealed orders for finger stick blood sugar (FSBS) before meals and</p>	D 273		

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D 273	<p>Continued From page 3</p> <p>every night and dose with Humalog sliding scale insulin (SSI) as:</p> <ul style="list-style-type: none"> <li>- 70-150 = 0 units.</li> <li>- 151-250 = 2 units.</li> <li>- 251-300 = 4 units.</li> <li>- 301-350 = 6 units</li> <li>- 351-400 = 8 units.</li> <li>- 401-450 = 10 units.</li> <li>- Greater than 450 or less than 50 = call MD (Medical Doctor).</li> </ul> <p>Review of Resident #5's Medication Administration Record (MAR) for February 2015 revealed:</p> <ul style="list-style-type: none"> <li>- SSI was required 26 times at 6:30am.</li> <li>- The resident refused 18 times of the 26 times that SSI was required at 6:30am.</li> <li>- Consecutive refusals were documented 02/19/15 through 02/28/15 at 6:30am.</li> <li>- FSBS that required SSI ranged 179-329 at 6:30am.</li> <li>- No documentation on the MAR or in the resident's record that the MD was notified regarding the refusals of insulin.</li> </ul> <p>Review of Resident #5's MAR for March 1 through March 26, 2015 revealed:</p> <ul style="list-style-type: none"> <li>- SSI was required 18 times at 6:30am.</li> <li>- The resident refused 16 times that SSI was required at 6:30am.</li> <li>- The resident refused 3 of 4 consecutive times that SSI was required on 03/16/15 (6:30am, 11:30am and 4:30pm.)</li> <li>- FSBS that required SSI ranged 166-448 at 6:30am.</li> <li>- No documentation on the MAR or in the resident's record that the MD was notified regarding the refusals of insulin.</li> </ul> <p>Interview with Resident #5 on 03/27/15 at 2:40pm</p>	D 273		

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D 273	<p>Continued From page 4</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented.</li> <li>- The resident did sometimes refuse to take insulin injections but did not say why.</li> <li>- The resident could not remember exact days or times the refusals occurred.</li> <li>- The resident stated staff did not offer the insulin at a later time and did not know if staff informed the MD.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 03/25/15 at 10:30am and 03/30/15 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>- She had worked at the facility 2 years.</li> <li>- It was her responsibility to monitor MARs but she had not been doing this.</li> <li>- She was not aware Resident #5 had refused so many SSI doses.</li> <li>- She had not notified Resident #5's physician about the refusals to take SSI.</li> <li>- They did not have a written policy on medication refusals, but staff should notify MD after a resident refused a medication 3 times.</li> </ul> <p>Refer to interview with the facility's Registered Nurse (RN) on 03/27/15 at 11:3am.</p> <p>Interview with Resident #5's Physician on 03/30/15 at 9:45am revealed:</p> <ul style="list-style-type: none"> <li>- Facility staff were supposed to notify him if residents refuse a medication 3 times "especially insulin".</li> <li>- He was not aware that Resident #5 had refused so many morning doses of SSI.</li> <li>- Had he been notified, he would have made adjustments to change or discontinued FSBS/SSI.</li> </ul> <p>_____</p> <p>Interview with facility Registered Nurse (RN) on</p>	D 273		

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D 273	<p>Continued From page 5</p> <p>03/27/15 at 11:31am revealed:</p> <ul style="list-style-type: none"> <li>- There was no written policy about medication refusals.</li> <li>- The facility protocol was to notify the Physician after 3 refusals. Staff should attempt three times for the first dose required, prior to the second dose the Physician should be called.</li> <li>- She stated she trained staff to call the Physician after 2 missed doses.</li> <li>- If a resident was exhibiting a behavior the Physician needed to know in order to better evaluate the resident and get them back on track.</li> <li>- She would expect staff to ask another medication aide or herself (to attempt to get the resident to take the medication) if residents refused.</li> <li>- The RN was responsible for reviewing the MARs.</li> <li>- She had not reviewed the MARs during the last month.</li> </ul> <p>_____</p> <p>A Plan of Protection was submitted by the facility on 03/27/15 with an addendum on 04/08/15 that included:</p> <ul style="list-style-type: none"> <li>- The facility MD will be contacted for direction regarding resident's refusals of medications.</li> <li>- The facility nurse and RCC will immediately inservice all medication aides regarding what to do in the event of medication refusals.</li> </ul> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 14, 2015.</p>	D 273		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:</p>	D 276		

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D 276	<p>Continued From page 6</p> <p>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</p> <p>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record review and interviews the facility failed to assure referral to meet routine health care needs of residents by failing to take blood pressures as ordered for 5 of 7 residents, (Resident #15, #11, #12, #13, #14).</p> <p>The findings are:</p> <p>1. Review of Resident #15's current FL2 dated 01/29/15 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included hypertension (high blood pressure).</li> <li>- Physician orders for Metoprolol 12.5mg twice a day (used to treat high blood pressure) (BP).</li> <li>- Orders to hold Metoprolol for BP less than 125 (did not specify diastolic or systolic).</li> </ul> <p>Review of Resident #15's Medication Administration Record (MAR) February and March, 2015 revealed no documentation of blood pressures.</p> <p>Review of Resident #15's Vitals Log Sheet for February and March 2015 revealed blood pressures documented:</p> <ul style="list-style-type: none"> <li>- February 07, 2015: BP documented as 163/89.</li> <li>- March 05, 2015: BP documented as refused.</li> </ul>	D 276		

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D 276	<p>Continued From page 7</p> <p>Refer to interview with Resident Care Coordinator (RCC) on 03/27/15 at 10:35am.</p> <p>Refer to interview with the Physician on 03/27/15 at 4:05pm.</p> <p>Refer to interview with Administrator in Charge 03/30/15 at 2:34pm.</p> <p>2. Review of Resident #11's current FL2 dated 01/29/15 revealed: - Diagnoses included hypertension (high blood pressure). - Physician orders for Lisinopril 20mg twice a day (used to treat high blood pressure).</p> <p>Review of Resident #11's Medication Administration Record (MAR) February and March, 2015 revealed no documentation of blood pressures.</p> <p>Review of Resident #11's Vitals Log Sheet revealed BPs were done only one time a month: - February 07, 2015: BP documented as 154/89. - March 06, 2015: BP documented as 140/102.</p> <p>Refer to interview with RCC on 03/27/15 at 10:35am.</p> <p>Refer to interview with the Physician on 03/27/15 at 4:05pm.</p> <p>Refer to interview with Administrator in Charge 03/30/15 at 2:34pm.</p> <p>3. Review of Resident #12's current FL2 dated 06/20/19 revealed: - Diagnoses included hypertension (high blood pressure). - Physician orders for Norvasc 5mg once a day</p>	D 276		

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D 276	<p>Continued From page 8</p> <p>(used to treat high blood pressure).</p> <ul style="list-style-type: none"> <li>- Physician orders for blood pressures (BP) once weekly.</li> </ul> <p>Review of Resident #12's Medication Administration Record (MAR) February and March, 2015 revealed no documentation of blood pressures.</p> <p>Review of Resident #12's Vitals Log Sheet for February and March 2015 revealed BPs were only done one time a month:</p> <ul style="list-style-type: none"> <li>- February 08, 2015: BP documented as 116/60.</li> <li>- March 06, 2015: BP documented as 120/64.</li> </ul> <p>Refer to interview with RCC on 03/27/15 at 10:35am.</p> <p>Refer to interview with the Physician on 03/27/15 at 4:05pm.</p> <p>Refer to interview with Administrator in Charge 03/30/15 at 2:34pm.</p> <p>4. Review of Resident #13's current FL2 dated 10/16/14 revealed.:</p> <ul style="list-style-type: none"> <li>- Diagnoses that included hypertension (high blood pressure).</li> <li>- Physician orders for Lisinopril 30mg once a day (used to treat high blood pressure).</li> <li>- Physician orders for blood pressures (BP) once weekly.</li> </ul> <p>Review of Resident #13's Medication Administration Records (MARs) for February and March, 2015 revealed no documentation of BPs.</p> <p>Review of Resident #13's Vitals Log Sheet for February and March 2015 revealed BPs were only done one time a month:</p>	D 276		

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D 276	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>- February 08, 2015: BP documented as 136/88.</li> <li>- March 07, 2015: BP documented as 126/70.</li> </ul> <p>Refer to interview with RCC on 03/27/15 at 10:35am.</p> <p>Refer to interview with the Physician on 03/27/15 at 4:05pm.</p> <p>Refer to interview with Administrator in Charge 03/30/15 at 2:34pm.</p> <p>5. Review of Resident #14's current FL2 dated 01/29/15 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included hypertension (high blood pressure).</li> <li>- Physician orders for Lisinopril 10mg once daily (used to treat high blood pressure).</li> <li>- Physician orders for blood pressures (BP) once weekly.</li> </ul> <p>Review of Resident #14's Medication Administration Record (MAR) for February and March, 2015 revealed no documentation of blood pressures.</p> <p>Review of Resident #14's Vitals Log Sheet for February and March 2015 revealed no BPs had done.</p> <p>Refer to interview with Resident Care Coordinator on 03/27/15 at 10:35am.</p> <p>Refer to interview with the Physician on 03/27/15 at 4:05pm.</p> <p>Refer to interview with Administrator in Charge 03/30/15 at 2:34pm.</p>	D 276		

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D 276	<p>Continued From page 10</p> <p>Interview with Resident Care Coordinator on 03/27/15 at 10:35am revealed:</p> <ul style="list-style-type: none"> <li>- She was responsible for adding BP orders to MARs.</li> <li>- She was responsible for assuring BPs are done as ordered and "I just haven't done it."</li> </ul> <p>Telephone interview with Physician on 03/27/15 at 4:05pm revealed:</p> <ul style="list-style-type: none"> <li>- The order should be done the way it was written, if its daily it should be done daily.</li> <li>- Orders for weekly and daily BPs mean resident's BPs must be monitored closely.</li> <li>- BP's could get so high a resident would need to be hospitalized.</li> <li>- Residents should be monitored closely until medications were right and the BP stable.</li> </ul> <p>Interview with Administrator in Charge on 03/30/15 at 2:34pm revealed:</p> <ul style="list-style-type: none"> <li>- There were no written policies.</li> <li>- The parameters were usually on the MAR.</li> <li>- The Resident Care Coordinator (RCC) was responsible for making sure BP orders were put on the MAR.</li> <li>- The RCC was responsible for following up to make sure orders were being followed.</li> <li>- He was not sure why follow up was not being done.</li> </ul> <p>_____</p> <p>A Plan of Protection was submitted by the facility on 03/27/15 with an addendum on 04/08/15 that included:</p> <ul style="list-style-type: none"> <li>- The RCC will conduct a review of all residents' FL2s to verify the frequency of BP orders, transfer them to the MAR to be done per physician order.</li> <li>- Medication Aides will be inserviced to ensure vital signs are done per physician orders and</li> </ul>	D 276		

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D 276	Continued From page 11  MARs will be double checked.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 14, 2015.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service  10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.  This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 7 of 7 sampled residents with No Concentrated Sweets (NCS) diet orders (Residents #5, #10, #11, #12, #13, #14 and #15).  The findings are:  Observations in the kitchen on 03/25/15 at 12:05pm revealed: - A therapeutic diet roster was posted. - A notebook on the counter next to the food service plating area was open to "Weekly Overview Simplified Menus for Spring/Summer Week 1".  Interview with the Kitchen Manager on 03/25/15 at 12:10pm revealed: - He used the menu in the notebook on the counter for all residents.	D 310		

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D 310	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>- He did not use a therapeutic diet menu.</li> <li>- "All residents are served the same food that is on the menu."</li> <li>- Diabetics were served the same food as everyone with the exception of sugar free drinks.</li> </ul> <p>Observation of the "Weekly Overview Simplified Menus for Spring/Summer Week 1" on 03/25/15 at 12:15pm revealed the lunch menu was listed as roast pork, gravy, mashed potatoes, glazed carrots, bread with margarine, chocolate pudding cake coffee, tea, Sanka.</p> <p>Observation of the lunch meal on 03/25/15 at 12:20pm revealed all residents were served shredded roast pork, cooked carrots, rice pilaf, slice of wheat bread, vanilla pudding, water, coffee, sweetened and unsweetened iced tea.</p> <p>Interview with Kitchen Manager on 03/25/15 at 2:50pm revealed:</p> <ul style="list-style-type: none"> <li>- He had been working at the facility for "about 6 years".</li> <li>- He used the regular menu to order food.</li> <li>- He used the regular menu for meal preparation and serving.</li> <li>- He did not reference the diabetic diet menu.</li> <li>- He kept a copy of all residents' diet orders in a notebook.</li> <li>- He knew there were residents with a NCS diet order yet "doesn't serve them anything different".</li> </ul> <p>Interviews with five diabetic residents on 03/25/15 from 1:30pm to 2:30pm revealed:</p> <ul style="list-style-type: none"> <li>- My diabetes is "pretty stable".</li> <li>- One resident indicated they felt weak about 3 times over the last 5 months.</li> <li>- One resident stated they "felt fine".</li> <li>- One resident indicated not having any problems nor "feeling bad".</li> </ul>	D 310		

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D 310	<p>Continued From page 13</p> <p>Interview with the Operations Manager on 03/25/15 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>- He supervised the Kitchen Manager.</li> <li>- He was not aware that the Kitchen Manager was using only the regular diet menu for meal preparation and ordering food products.</li> <li>- He was responsible to monitor food service operations.</li> </ul> <p>Interview and observation with the Operations Manager on 03/25/15 at 3:15pm revealed:</p> <ul style="list-style-type: none"> <li>- He provided a copy of a therapeutic diet menu.</li> <li>- He had instructed to Kitchen Manager to use the therapeutic diet menu when ordering food products and preparing meals.</li> </ul> <p>A. Review of Resident #5's current FL2 dated 12/12/14 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included diabetes type II.</li> <li>- NCS diet order.</li> </ul> <p>B. Review of Resident #10's current FL2 dated 10/13/14 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included diabetes type II.</li> <li>- NCS diet order.</li> </ul> <p>C. Review of Resident #11's current FL2 dated 01/29/15 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included diabetes type II.</li> <li>- NCS diet order.</li> </ul> <p>D. Review of Resident #12's record revealed:</p> <ul style="list-style-type: none"> <li>- Current FL2 dated 06/20/14</li> <li>- Diagnoses included diabetes type II.</li> <li>- NCS diet order dated 09/30/14.</li> </ul> <p>E. Review of Resident #13's current FL2 dated 10/16/14 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included diabetes type II.</li> </ul>	D 310		

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D 310	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>- NCS diet order.</li> </ul> <p>F. Review of Resident #14's current FL2 dated 01/29/15 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included diabetes type II.</li> <li>- NCS diet order.</li> </ul> <p>G. Review of Resident #15's current FL2 dated 01/29/15 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included diabetes type II.</li> <li>- NCS diet order.</li> </ul> <p>Observation in the kitchen on 03/26/15 at 12:05pm revealed the Kitchen Manger referenced the notebook on the counter next to the food service plating area which was open to the therapeutic diet menu.</p> <p>Interview with the Kitchen Manager on 03/26/15 at 12:06pm revealed moving forward he will use the therapeutic diet menu when ordering food products and preparing meals.</p> <p>Interview with the Operations Manager on 03/26/15 at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>- He supervised the Kitchen Manager.</li> <li>- He had originally trained the current Kitchen Manager to use the "daily breakdown menu" when ordering food products and preparing meals.</li> <li>- He was not aware that the Kitchen Manager was using only the regular diet menu for meal preparation and ordering food products.</li> </ul> <p>Review of Kitchen Manager's personnel record revealed completion of food service orientation with a posttest dated 11/28/2010.</p> <p>Phone interview with facility's physician on 03/27/15 at 4:05pm revealed:</p>	D 310		

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D 310	Continued From page 15  - He expected the facility to provide diabetics with a NCS diet. - Serving diabetic residents a regular diet would affect their blood sugar levels.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights  10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.  This Rule is not met as evidenced by: TYPE A2 VIOLATION  Based on observations, interviews, and record reviews, the facility failed to assure residents were free from mental abuse as evidenced by residents' fears and concerns of one resident's behaviors (Resident #3).  The findings are:  Review of Resident #3's Resident Register revealed an admission date of 01/22/15.  Review of Resident #3's current FL2 dated 01/29/15 revealed: - Diagnoses included schizoaffective and bipolar disorder. - Medications included Clonazepam, Depakote, Trazadone, and clozapine (all used for the treatment of mental disorders).  Review of a subsequent physician's order sheet dated 02/23/15 revealed an order for the addition of Haldol 2.5mg twice per day due to increased	D 338		

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D 338	<p>Continued From page 16</p> <p>agitation. (Haldol is an antipsychotic medication used in the treatment of schizophrenia).</p> <p>Review of Resident #3's current care plan dated 01/25/15 revealed:</p> <ul style="list-style-type: none"> <li>- Limited assistance needed with eating, toileting, bathing, dressing and grooming.</li> <li>- No assistance required for ambulation and transfer.</li> <li>- The care plan did not address any specific tasks related to Resident #3's mental illness.</li> <li>- The care plan did not address or give any direction/guidance for staff in redirecting Resident #3's behaviors.</li> </ul> <p>Random observations of Resident #3 on 03/25/15 and 03/26/15 revealed:</p> <ul style="list-style-type: none"> <li>- In the hallway, Resident #3 was frequently loud and used profanity towards residents and surveyors.</li> <li>- The resident got in the faces and grabbed the arms of the Surveyors to get their attention.</li> <li>- The resident would be agitated one minute and within a few seconds, smiled and laughed.</li> <li>- The resident paced back and forth in the hallway and outside in the court yard.</li> <li>- Staff interacted with Resident #3 often by redirecting, encouraging to use a quieter tone and walking out side with the resident on several occasions.</li> </ul> <p>Observation of Resident #3 on 03/25/15 between 5:21pm and 5:30pm revealed:</p> <ul style="list-style-type: none"> <li>- Resident #3 outside in the courtyard.</li> <li>- Resident #3 yelled, cursed, looked into window where surveyors were working.</li> <li>- Resident #3 talked to someone (not visualized by surveyors) and pointed to the sky.</li> <li>- Director of Operations entered courtyard, redirected the resident and the resident moved to</li> </ul>	D 338		

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D 338	<p>Continued From page 17</p> <p>another part of the courtyard and calmed/quieted down.</p> <ul style="list-style-type: none"> <li>- Resident #3 yelled at a female resident who was entering the building.</li> <li>- Both Resident #3 and the female resident yelled and cursed each other.</li> <li>- The Maintenance Director (who was on the front porch) went over and spoke to the female resident and directed her into the building.</li> <li>- Resident #3 continued to talk to self out in the courtyard.</li> </ul> <p>Review of a Nurse's Note dated 03/05/15 at 10:30pm revealed Resident #3:</p> <ul style="list-style-type: none"> <li>- Flipped the switch (an emergency door release switch located below the keypad) and walked down to [local highway].</li> <li>- Was then placed on 15 minute checks.</li> <li>- There was no documentation the Physician was notified.</li> </ul> <p>Review of a Nurse's Note dated 03/20/15 (no time) revealed:</p> <ul style="list-style-type: none"> <li>- Resident #3 flipped the switch (an emergency door release switch located below the keypad) and went out side.</li> <li>- Local mental health team was called and informed about the resident being upset due to a previous facility not sending the resident funds.</li> <li>- Telephone calls were made to previous facility regarding funds, which "would be mailed today."</li> <li>- The resident was still agitated and local law enforcement was called.</li> <li>- Local authorities came out to talk with the resident.</li> <li>- Resident #3 continued to be agitated and wouldn't come in the building.</li> <li>- The facility psychiatrist was called.</li> <li>- An order for Haldol 5mg now x 1 dose was ordered.</li> </ul>	D 338		

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D 338	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- The local mental health team was called, came and stayed with the resident until his medications were taken.</li> </ul> <p>Review of a Nurse's Note dated 03/21/15 at 8:30pm revealed:</p> <ul style="list-style-type: none"> <li>- A verbal altercation occurred between Resident #3 and another resident on 200 hall.</li> <li>- Resident #3 broke a plunger handle and threatened to beat the other resident.</li> <li>- Staff intervened and took the plunger handle from Resident #3.</li> <li>- The crisis line was called and Resident #3 finally calmed down.</li> </ul> <p>Review of a Nurse's Note dated 03/22/15 (no time documented) revealed:</p> <ul style="list-style-type: none"> <li>- Resident #3 was roaming the hall; had a confrontation with other residents and staff; was yelling and "had most of the residents up".</li> <li>- Many residents complained about the noise.</li> <li>- Staff asked the resident to "please not be so loud".</li> <li>- The resident became agitated and angry.</li> </ul> <p>Review of a Nurse's Note dated 03/23/15 (no time documented) revealed:</p> <ul style="list-style-type: none"> <li>- Resident #3 was still mad and yelling because his money wasn't there.</li> <li>- Staff informed the resident that efforts were in process to get the funds from the other facility.</li> <li>- Resident #3 continued to be angry and the Operations Manager gave the resident \$20.00.</li> <li>- The resident was taken out for lunch at a local fastfood restaurant.</li> <li>- Once back at the facility, Resident #3 refused to get out of the car.</li> <li>- Staff talked with and encouraged the resident to go back inside the facility.</li> </ul>	D 338		

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D 338	<p>Continued From page 19</p> <p>Interview with Resident #3 03/26/15 at 2:15pm revealed:</p> <ul style="list-style-type: none"> <li>- The resident was unable to focus on the subject being discussed.</li> <li>- The resident interjected nonsensical words during the conversation.</li> <li>- The resident used words that were not relevant to the conversation.</li> <li>- The resident would rapidly and intermittently change his facial expressions; smiled, frowned, grimaced during the interview.</li> <li>- Resident had to be redirected back to the conversation many times during the interview.</li> </ul> <p>Confidential interviews with 5 staff members revealed:</p> <ul style="list-style-type: none"> <li>- Resident #3 did get loud occasionally, but generally calmed down just as quickly.</li> <li>- They had never seen Resident #3 become physically aggressive with anyone.</li> <li>- Resident #3 was always easily redirected.</li> <li>- He would get loud with other residents and staff.</li> <li>- No residents had ever voiced a concern about him being loud.</li> <li>- Resident #3 did get loud and use profanity.</li> <li>- Some staff confirmed 4 residents had shared their concerns with staff.</li> <li>- Some staff reported they were not aware of any residents who were intimidated by Resident #3.</li> </ul> <p>Interviews with 4 residents revealed they had fears and concerns regarding Resident #3's behaviors.</p> <p>Interview with one resident on 03/25/15 at 10:25am revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented.</li> <li>- The resident was afraid of Resident #3.</li> <li>- The resident kept her door closed and would</li> </ul>	D 338		

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D 338	<p>Continued From page 20</p> <p>not go into a room or area were Resident #3 was.</p> <ul style="list-style-type: none"> <li>- She had told Staff D (Personal Care Aide) she was afraid of Resident #3.</li> <li>- She had gone to the main dining room on 03/21/15 to get a snack and Resident #3 was in dining room singing a song loudly with "very foul words". She asked Resident #3 to stop being so loud and Resident #3 became angry and yelled and cursed. She left the main dining room, "scared", went to her room and closed the door. She informed Staff D (Persona Care Aide) of the incident and was told to "look over" Resident #3 and Staff D would go get her a snack.</li> <li>- She had observed Resident #3 in a verbal altercation with another resident when Resident #3 got angry, loud and "blew up".</li> <li>- She witnessed when Resident #3 banged a plunger stick on a wall (did not give exact date) and another resident attempted to take the stick away when staff intervned and Resident #3 cursed the staff.</li> <li>- She stated Resident #3 yelled, cursed, hits things and scared her often.</li> <li>- "Staff try their best to redirect him but he does what he wants to."</li> </ul> <p>Interview with a second resident on 03/30/15 at 10:09am revealed:</p> <ul style="list-style-type: none"> <li>- The resident was alert and oriented.</li> <li>- She did not feel safe with Resident #3 in facility.</li> <li>- Resident #3 had offered to pay her for sex and called her names when she refused.</li> <li>- Resident #3 had entered her room without permission and Resident #3 had been difficult to get out of her room but staff intervned and re-directed Resident t#3 from the room.</li> <li>- She had recently signed a petition for Resident #3 to be discharged from the facility.</li> <li>- She had shared her concerns with the</li> </ul>	D 338		

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D 338	<p>Continued From page 21</p> <p>Resident Care Coordinator, Business Office Manager, Staff F (PCA), Staff C (PCA), and Staff A (Medication Aide) in the past and staff had attempt to redirect Resident #3.</p> <p>Interview with a third resident 03/30/15 at 10:21am revealed:</p> <ul style="list-style-type: none"> <li>- She was alert and oriented.</li> <li>- She did not feel safe with Resident #3 in facility.</li> <li>- Resident #3 had offered to pay her for sex, called her names, cursed and screamed at her when she refused.</li> <li>- Resident #3 had entered her room without knocking and her roommate was changing her clothes. Resident #3 was redirected by staff.</li> <li>- Resident #3 had exposed himself in the courtyard and in the A-wing dining room on several occasions but staff intervened and re-directed him.</li> <li>- Resident #3 and another male resident would "get into it all the time" (verbal altercations using profanity). She was not aware if there had been any physical altercations with Resident #3 and any other residents.</li> <li>- Many staff tried to talk to Resident #3 about his behaviors.</li> <li>- She stated she had signed a petition to have Resident #3 discharged from the facility because residents were afraid of Resident #3's behaviors. <ul style="list-style-type: none"> <li>- 19 residents had signed the petition to give to the Ombudsman later in the week (just in case Resident #3 returned to the facility).</li> </ul> </li> <li>- She had informed the Resident Care Coordinator (RCC), Business Office Manager, Staff F (PCA), Staff C (PCA), and Staff A (Medication Aide), about her concerns related to Resident #3.</li> <li>- Staff had tried to re-direct Resident #3 many times.</li> </ul>	D 338		

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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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D 338	<p>Continued From page 22</p> <p>Interview with a fourth resident on 03/30/15 at 10:2am revealed:</p> <ul style="list-style-type: none"> <li>- She was alert and oriented.</li> <li>- Resident #3 often spoke mean and nasty to her.</li> <li>- Resident #3 would come in her room without knocking, but staff would always redirect him.</li> <li>- Resident #3 argued with the other residents in the facility.</li> <li>- Resident #3 had asked her to have sex with him.</li> <li>- She had told the Resident Care Coordinator (RCC), Business Office Manager, Staff F (PCA), Staff C (PCA), and Staff A (Medication Aide) about her concerns regarding Resident #3's behaviors (unsure of exact dates and times).</li> </ul> <p>Refer to interview with Operations Manager on 03/25/15 at 5:05pm and 03/27/15 at 9:40am.</p> <p>Refer to interview with RCC on 03/26/15 at 10:30am.</p> <hr/> <p>Interview with the Operations Manager on 03/25/15 at 5:05pm and 03/27/15 at 9:40 am revealed:</p> <ul style="list-style-type: none"> <li>- He was not aware of any resident altercations with Resident #3.</li> <li>- He was not aware of any residents being fearful of Resident #3.</li> <li>- He had called Resident #3's physician on 03/26/15 and updated him on Resident #3's behavior.</li> <li>- The local mental health team was notified and came to the facility on 03/26/15 to evaluate Resident #3.</li> <li>- Police were notified and arrived at 6:00am on 03/27/15 to transport Resident #3 to local hospital</li> </ul>	D 338		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>03/30/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>		
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D 338	Continued From page 23  for involuntary commitment. - Notice of immediate discharge was sent to the hospital with Resident #3.  Interview with the Resident Care Coordinator (RCC) on 03/26/15 at 10:30am revealed: - She was to provide supervision of residents, identification of the problem, call crisis line, the local mental health team and the physician if any resident's behavior continued. - When a resident had a problem, she talked to them, identified the problem and called the crisis line if needed. - If behaviors did not decrease, staff monitored the resident closely, walked around with them, took them outside. - Resident #3 had been placed on 15 minute checks for three days beginning 03/03/15. - Resident #3 cursed at residents and staff had attempted to redirect Resident #3. - The RCC reported she was aware that one resident was fearful of Resident #3 but not aware of any other residents who were afraid.  A Plan of Protection was submitted by the facility on 03/26/15 that included: - Resident #3 will be placed on 1 on 1 care. - Facility psychiatrist will be contacted regarding Resident #3's behaviors and alternate placement. - Random interviews will be done with residents to discuss their feelings about safety in the facility.  CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 29, 2015.	D 338		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	<p>Continued From page 24</p> <p>10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</p> <p>This Rule is not met as evidenced by: Based on record review and interviews the facility failed to accurately document medication administration of controlled medications on the Medication Administration Records (MARs) for 3 of 4 sampled residents. (Residents #2, #16, and #17.)</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL2 dated 03/12/15 revealed: - Diagnoses that included dementia and hearing impairment. - Physician orders for Oxycodone 7.5mg every 4 hours as needed for pain.</p>	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 03/30/2015</b>
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D 367	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>- Resident #2 was disoriented to place and time.</li> </ul> <p>Review of Resident #2's MAR for January 2015 revealed the Oxycodone 7.5mg documented as given 9 times on these dates:</p> <ul style="list-style-type: none"> <li>- Twice on the 13th.</li> <li>- Once on the 15th, 18th, 21st, 24th, 25th, 27th and 29th.</li> </ul> <p>Review of the back of the January 2015 MAR revealed Oxycodone documented 9 times on:</p> <ul style="list-style-type: none"> <li>- Once on the 13th at 1:00am and at 5:00am.</li> <li>- Once on the 18th at 8am.</li> <li>- Once on the 22nd at 2:00am and 6:00am.</li> <li>- Once on the 23rd at 2:00am and 6:00am.</li> <li>- Once on the 24th at 4:00am.</li> <li>- Once on 29th at 8:00pm.</li> </ul> <p>Review of the January 2015 Controlled Drug Receipt/Record/Disposition Form for Resident #2's revealed the Oxycodone 7.5mg had been signed out as administered 83 times.</p> <p>Review of Resident #2's MAR for February 2015 revealed the Oxycodone 7.5mg documented as administered 2 times on these dates:</p> <ul style="list-style-type: none"> <li>- Once on the 22nd.</li> <li>- Once on the 23rd.</li> </ul> <p>Review of the back of the February 2015 MAR revealed documentation that Oxycodone 7.5mg was administered 2 times on:</p> <ul style="list-style-type: none"> <li>- Once on the 22nd at 2:00am</li> <li>- Once on the 23rd at 2:00am.</li> </ul> <p>Review of the February 2015 Controlled Drug Receipt/Record/Disposition Form for Resident #2's revealed the Oxycodone had been signed out as given 67 times.</p>	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>03/30/2015</b>
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D 367	<p>Continued From page 26</p> <p>Review of Resident #2's Medication Administration Record (MAR) for March 2015 revealed the Oxycodone 7.5mg documented as administered 5 times on these dates:</p> <ul style="list-style-type: none"> <li>- Once on the 5th, 6th, and 8th.</li> <li>- Twice on the 12th.</li> </ul> <p>Review of the back of the March 2015 MAR revealed Oxycodone 7.5mg documented as administered 6 times:</p> <ul style="list-style-type: none"> <li>- Once on 5th at 8:00am.</li> <li>- Once on the 6th at 3:00am.</li> <li>- Once on the 8th at 5:00am.</li> <li>- Twice on the at 4:00pm and 8:00pm.</li> <li>- Once on 3/? [illegible date and time].</li> </ul> <p>Review of the March 2015 Controlled Drug Receipt/Record/Disposition Form for Resident #2's revealed the Oxycodone had been signed out as administered 43 times.</p> <p>Interview with Staff B, Medication Aide (MA), on 03/26/15 at 12:45pm revealed:</p> <ul style="list-style-type: none"> <li>- Resident #2 did not ask for pain medication.</li> <li>- She gave Resident #2 pain medication when she was "passing meds" because she did not want the resident to be in pain.</li> <li>- She did not say how she knew Resident #2 might need pain medication.</li> <li>- She "did not think" about documenting the Oxycodone administration on the MAR because she just got "busy and forgot".</li> </ul> <p>Observation on 03/26/15 at 12:45pm revealed Oxycodone on hand for Resident #2 matched the Controlled Drug Receipt/Record/Disposition form.</p> <p>Refer to interview with the RCC on 03/26/15 at 1:00pm.</p>	D 367		

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D 367	<p>Continued From page 27</p> <p>A telephone interview conducted with a local Home Health (HH) Agency nurse on 03/27/15 at 11:30am and revealed:</p> <ul style="list-style-type: none"> <li>- Resident #2 had been receiving HH services 2 times a week for several weeks regarding wound care.</li> <li>- The resident "moaned" a lot, but it was difficult to determine if or at what level of pain the resident may have due to cognition.</li> <li>- She was not aware if or how much pain medication Resident #2 received.</li> </ul> <p>Resident #2 was observed all 4 days of the survey ambulating independently throughout the facility using a walker. Observations and record review on 03/25/15 and 03/27/15 revealed the resident was determined to not be interviewable.</p> <p>B. Review of Resident #16's current FL2 dated 05/12/14 revealed a diagnosis of dementia without behavior disturbance.</p> <p>Review of a physician order dated 10/14/14 revealed Oxycontin 10mg one tablet every twelve hours as needed for pain.</p> <p>Review of Resident #16's Medication Administration Record (MAR) for January 2015 revealed Oxycontin 10mg documented as administered 18 times.</p> <p>The facility could not provide a January 2015 controlled Drug Receipt/Record/Disposition form.</p> <p>Review of Resident #16's MAR for February 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Oxycontin documented as administered 11 times.</li> <li>- The back of the MAR documented Oxycontin administered 1 time with no date.</li> </ul>	D 367		

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D 367	<p>Continued From page 28</p> <p>Review of the February 2015 Controlled Drug Receipt/Record/Disposition form for Resident #16 revealed the Oxycontin had been signed out as given 15 times.</p> <p>Review of Resident #16's MAR for March 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Oxycontin documented as administered 18 times.</li> <li>- The back of the MAR documented no administration of the Oxycontin.</li> </ul> <p>Review of the March 2015 Controlled Drug Receipt/Record/Disposition form for Resident #16 revealed the Oxycontin had been signed out as given 43 times.</p> <p>Interview with Resident #16 on 03/30/15 at 10:10am revealed:</p> <ul style="list-style-type: none"> <li>- The resident could not recall how many times she had requested pain medication.</li> <li>- The resident did not remember getting any "extra" medication.</li> <li>- The resident did not verbalize having uncontrolled pain.</li> </ul> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/26/15 at 1:00pm.</p> <p>C. Review of Resident #17's current FL2 dated 10/30/14 revealed:</p> <ul style="list-style-type: none"> <li>- A diagnosis of dementia.</li> <li>- Physician orders for Norco 7.5/325mg every 6 hours as needed for pain.</li> <li>- Resident #17 was intermittently disoriented.</li> </ul> <p>Review of Resident #17's Medication Administration Record (MAR) for January 2015 revealed:</p>	D 367		

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D 367	<p>Continued From page 29</p> <ul style="list-style-type: none"> <li>- Hydrocodone (generic for Norco) documented as administered 3 times.</li> <li>- The back of the MAR for the hydrocodone documented administered 1 time.</li> </ul> <p>Further review of the January 2015 controlled Drug Receipt/Record/Disposition form revealed hydrocodone had been signed out as administered 53 times.</p> <p>Review of Resident #17's MAR for February 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Hydrocodone documented as administered 3 times.</li> <li>- The back of the MAR for the hydrocodone documented administered 1 time.</li> </ul> <p>Review of the February 2015 Controlled Drug Receipt/Record/Disposition form for Resident #17 revealed the hydrocodone was signed out as administered 7 times.</p> <p>Review of Resident #17's MAR for March 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Hydrocodone documented as administered 12 times.</li> <li>- The back of the MAR documented hydrocodone as administered 4 times.</li> </ul> <p>Review of the March 2015 Controlled Drug Receipt/Record/Disposition form for Resident #17 revealed the hydrocodone had been signed out as administered 2 times.</p> <p>Observations and interview with Resident #17 on 03/30/15 at 11:00am revealed the resident was not interviewable.</p> <p>Refer to interview with the Resident Care Coordinator on 03/26/15 at 1:00pm.</p>	D 367		

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D 367	Continued From page 30  Interview with the Resident Care Coordinator on 03/26/15 at 1:00pm revealed: - She had worked at the facility 2 years. - It was her responsibility to monitor the MARs but she had not been doing this. - Staff were supposed to sign out the PRN narcotics on the controlled count sheet then document them on the MAR when given. - She was supposed to check the MARs weekly for accuracy. - She did not check the MARs because she was "too busy."	D 367		
D 401	10A NCAC 13F .1009(a)(2) Pharmaceutical Care  10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (2) review of all aspects of medication administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas;  This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to assure the quarterly on-site	D 401		

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D 401	<p>Continued From page 31</p> <p>medication review included a review of all aspects of the facility's systems for medication administration, including documentation of medication administration for controlled substances for 3 of 4 sampled residents (#2, #16, and #17).</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL2 dated 03/12/15 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included dementia and hearing impairment.</li> <li>- Physician orders for Oxycodone 7.5mg every 4 hours as needed for pain.</li> <li>- Resident #2 was disoriented to place and time.</li> </ul> <p>Review of Resident #2's MAR (Medication Administration Record) for January 2015 revealed the Oxycodone documented as given 9 times on these dates:</p> <ul style="list-style-type: none"> <li>- Twice on the 13th.</li> <li>- Once on the 15th, 18th, 21st, 24th, 25th, 27th and 29th.</li> </ul> <p>Review of the back of the January 2015 MAR revealed Oxycodone documented 9 times on:</p> <ul style="list-style-type: none"> <li>- Twice on the 13th at 1:00am and at 5:00am.</li> <li>- Once on the 18th at 8am.</li> <li>- Twice on the 22nd at 2:00am and 6:00am.</li> <li>- Twice on the 23rd at 2:00am and 6:00am.</li> <li>- Once on the 24th at 4:00am.</li> <li>- Once on the 29th at 8:00pm.</li> </ul> <p>Review of the January 2015 Controlled Drug Receipt/Record/Disposition Form for Resident #2 revealed the Oxycodone had been signed out as administered 83 times.</p> <p>Review of Resident #2's Medication</p>	D 401		

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D 401	<p>Continued From page 32</p> <p>Administration Record (MAR) for February 2015 revealed the Oxycodone 7.5 mg documented as given 2 times; once on the 22nd and once on the 23rd.</p> <p>Review of the back of the February 2015 MAR revealed documentation that Oxycodone 7.5mg was administered 2 times on:</p> <ul style="list-style-type: none"> <li>- Once on the 22nd at 2:00am.</li> <li>- Once on the 23rd at 2:00am.</li> </ul> <p>Review of the February 2015 Controlled Drug Receipt/Record/Disposition Form for Resident #2 revealed the Oxycodone had been signed out as given 67 times.</p> <p>Review of Resident #2's MAR for March 2015 revealed the Oxycodone documented as given 5 times on these dates:</p> <ul style="list-style-type: none"> <li>- Once on the 5th, 6th, and 8th.</li> <li>- Twice on the 12th.</li> </ul> <p>Review of the back of the March 2015 MAR revealed Oxycodone documented as given 6 times on:</p> <ul style="list-style-type: none"> <li>- Once on the 5th at 8:00am.</li> <li>- Once on the 6th at 3:00am.</li> <li>- Once on the 8th at 5:00am.</li> <li>- Once on the 12th at 4:00pm and once at 8:00pm.</li> <li>- Once on [3/? illegible date and time].</li> </ul> <p>Review of the March 2015 Controlled Drug Receipt/Record/Disposition Form for Resident #2's revealed the Oxycodone had been signed out as given 43 times.</p> <p>Interview with Staff B (Medication Aide) on 03/26/15 at 12:45pm revealed:</p> <ul style="list-style-type: none"> <li>- Resident #2 did not ask for pain medication.</li> </ul>	D 401		

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D 401	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>- She gave Resident #2 pain medication when she was "passing meds" because she did not want the resident to be in pain.</li> <li>- She did not say how she knew Resident #2 might need pain medication.</li> <li>- She she "did not think" about documenting the Oxycodone administration on the MAR because she just got "busy and forgot".</li> </ul> <p>Observation on 03/26/15 at 12:45pm revealed Oxycodone on hand for Resident #2 matched the Controlled Drug Receipt/Record/Disposition form.</p> <p>Review of Resident #2's quarterly pharmacy review dated 02/06/15 revealed no recommendations.</p> <p>Refer to interview with the facility's consulting pharmacy staff on 03/27/15 at 11:00am.</p> <p>Refer to the interview with the Operations Manager on 03/26/15 and 03/30/15 at 3:00pm.</p> <p>B. Review of Resident #16's current FL2 dated 05/12/14 revealed a diagnosis of dementia without behavior disturbance.</p> <p>Review of a physician order dated 10/14/14 revealed Oxycontin 10mg one tablet every twelve hours as needed for pain.</p> <p>Review of Resident #16's Medication Administration Record (MAR) for January 2015 revealed Oxycontin 10mg documented as administered 18 times.</p> <p>The facility could not produce a January 2015 controlled Drug Receipt/Record/Disposition form by the time of exit.</p>	D 401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>03/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
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D 401	<p>Continued From page 34</p> <p>Review of Resident #16's MAR for February 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Oxycontin documented as administered 11 times.</li> <li>- The back of the MAR documented Oxycontin administered 1 time with no date.</li> </ul> <p>Review of the February 2015 Controlled Drug Receipt/Record/Disposition form for Resident #16 revealed the Oxycontin had been signed out as given 15 times.</p> <p>Review of Resident #16's MAR for March 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Oxycontin documented as administered 18 times.</li> <li>- The back of the MAR documented no administration of the Oxycontin.</li> </ul> <p>Review of the March 2015 Controlled Drug Receipt/Record/Disposition form for Resident #16 revealed the Oxycontin had been signed out as given 43 times.</p> <p>Review of Resident #16's quarterly pharmacy review dated 02/06/15 revealed no recommendations.</p> <p>Refer to interview with the facility's consulting pharmacy staff on 03/27/15 at 11:00am.</p> <p>Refer to the interview with the Operations Manager on 03/26/15 and 03/30/15 at 3:00pm.</p> <p>C. Review of Resident #17's current FL2 dated 10/30/14 revealed:</p> <ul style="list-style-type: none"> <li>- A diagnosis of dementia.</li> <li>- Orders for Norco 75/325mg every 6 hours as needed for pain.</li> </ul>	D 401		

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D 401	<p>Continued From page 35</p> <ul style="list-style-type: none"> <li>- Resident #17 was intermittently disoriented.</li> </ul> <p>Review of Resident #17's Medication Administration Record (MAR) for January 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Hydrocodone (generic for Norco) documented as administered 3 times.</li> <li>- The back of the MAR for the hydrocodone documented administered 1 time.</li> </ul> <p>Further review of the January 2015 controlled Drug Receipt/Record/Disposition form revealed hydrocodone had been signed out as administered 53 times.</p> <p>Review of Resident #17's MAR for February 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Hydrocodone documented as administered 3 times.</li> <li>- The back of the MAR for the hydrocodone documented as administered 1 time.</li> </ul> <p>Review of the February 2015 Controlled Drug Receipt/Record/Disposition form for Resident #17 revealed the hydrocodone was signed out as administered 7 times.</p> <p>Review of Resident #17's MAR for March 2015 revealed:</p> <ul style="list-style-type: none"> <li>- Hydrocodone documented as administered 12 times.</li> <li>- The back of the MAR documented hydrocodone as administered 4 times.</li> </ul> <p>Review of the March 2015 Controlled Drug Receipt/Record/Disposition form for Resident #17 revealed the hydrocodone had been signed out as given 2 times.</p> <p>Refer to interview with the facility's consulting</p>	D 401		

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D 401	<p>Continued From page 36</p> <p>pharmacy staff on 03/27/15 at 11:00am.</p> <p>Refer to the interview with the Operations Manager on 03/26/15 and 03/30/15 at 3:00pm.</p> <hr/> <p>Telephone interview with the facility's consulting pharmacy staff on 03/27/15 at 11:00am revealed a quarterly pharmacy review had been conducted at the facility on 02/06/15 which included:</p> <ul style="list-style-type: none"> <li>- MAR review.</li> <li>- Matching drug orders.</li> <li>- Review of drug storage.</li> <li>- Review of medication card sign out sheets.</li> <li>- Review of a "sample" of controlled substances.</li> <li>- Resident #2's medication review done 02/06/15) did not include a review of controlled drugs.</li> <li>- The consulting pharmacy staff stated controlled medication sign out sheets had not been compared to documentation of administration on the MARs and the consulting pharmacy staff was not aware of the discrepancy between the controlled drug sheet and the documentation on the MARs.</li> </ul> <p>Interview with the Operations Manager on 03/26/15 and 03/30/15 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>- He was not aware staff were not documenting controlled substance administration on the MARs as compared to the controlled drug sign out sheet.</li> <li>- He was not aware the pharmacy consultant was supposed to review all aspects of medication administration to include documentation of medications.</li> </ul>	D 401		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	<p>Continued From page 37</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care referral and follow-up.</p> <p>The findings are:</p> <p>A. Based on record review and interviews the facility failed to assure referral and follow-up to meet routine health care needs of residents by failing to obtain blood pressures as ordered for 5 of 7 sampled residents, (Resident #15, #11, #12, #13, #14)[Refer to Tag D 276 10A NCAC 13F .0902(c)(3)(4). (Type B Violation)].</p> <p>B. Based on record review and interviews the facility failed to assure referral to meet routine health care needs of residents by failing to notify the physician for 2 of 2 residents who refused sliding scale insulin when required (Residents #15 and #5). [Refer to Tag D 273 10A NCAC 13F .0902(b) (Type B Violation)].</p>	D912		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse,</p>	D914		

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D914	<p>Continued From page 38</p> <p>neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from abuse by not addressing their fears and concerns related to one resident's behaviors.</p> <p>The findings are: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from mental abuse as evidenced by residents' fears and concerns of one resident's behaviors (Resident #3). [Refer to Tag D 338, 10A NCAC 13F .0909 Resident Rights. (Type A2 Violation).]</p>	D914		