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	HAL035027		R 06/04/2015

NAME OF PROVIDER OR SUPPLIER
ESSEX MANOR ASSISTED LIVING FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE
844 HIGHWAY 39 S.
LOUISBURG, NC 27549

(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 conducted an annual and follow-up survey and complaint investigation on 5/27/15 to 5/29/15 and 6/1/15 to 6/4/15.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the floors were clean and in good repair in the facility common area sitting/television room and the kitchen. The findings are: Observations throughout the survey from 5/27/15 to 5/29/15 and from 6/1/15 to 6/4/15 of the facility's common area sitting/television room floor revealed: - Carpet covered the floor and was heavily stained with dark circles most noticable in 9 areas around the outside of the room. - The areas with the most noticable heavy stains were: an area approximately 3 feet in diameter next to the entrance door, 5 separate areas approximately 1 foot in diameter stained circle areas in the corner toward the dining area and on the entrance side of the room, an area approximately 3 feet in diameter next to the dining area, and in front of the television.	D 074		

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D 074	Continued From page 1 Interview on 6/4/15 at 10.55 am with a housekeeper revealed: - He had worked at the facility for about 8 months. - He routinely vacumed the carpet in the common area sitting room but the carpet had a lot of stains. - Residents were constantly spilling drink cups on the carpet. - He had cleaned the carpet with a steam cleaner but that was maybe a month or 2 months ago. Interview with the manager on 6/4/15 at 5:00 pm revealed: - The carpet on the facility's common area sitting/television room floor was steam cleaned 6 months ago. - Residents spilled drinks on the carpet all the time. - The carpet needed replacing, however, the facility had many repairs that were being done and replacing the carpet was delayed to take care of other repairs.	D 074		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation and interview, and record	D 080		

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D 080	Continued From page 2 review, the facility failed to assure all 30 of 30 residents were treated with respect, consideration, and dignity related to the facility's negation to provide clean towels and wash cloths to residents for bathing and showering. The facility shall assure the rights of all residents are guaranteed under G.S 131D-21. The findings are: Observation of the linen closet on 5/29/15 at 9:30am revealed: - No towels or washcloths were available. - [Staff overheard telling residents there were no washcloths available for bathing.] Interview with the Administrator in Training on 5/28/15 at 9:40am revealed: - There is enough towels and washcloths for everyone, staff is washing linen every day. - If staff were out of linen they would tell her. - No one had told her there was no wash cloths or towels, for residents to bathe. Confidential interviews with 6 residents revealed: - The facility had been out of clean towels and wash cloths all week. - The linen company did not get paid so they came and took all their towels and wash cloths back. - The linen company came and took back all the towels, but one resident had stashed a supply in her closet and was able to cut the towels to make washcloths for a couple of the residents. - One resident was in his room at 3:15pm waiting for towels so that he could shower. - It was hot and he sweat a lot and did not want to come out of his room until he had showered. - One resident was in tears and reported having to wear the same clothing for 3 days, because she did not want to put clean clothes on	D 080		

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D 080	Continued From page 3 without having a shower. - She hand asked staff for clean towels for 3 days and they had not been provided, she had been unable to shower or change clothes for 3 days. - She had been " begging staff for towels every day for 3 days " and no one had given her any, so she " had not been able to shower and put on clean clothes " . - Staff told them, they would have to wash towels before they could shower or wash their face for the day. - The facility had about 4 washcloths and about 10 towels that was having to be washed in between resident use. - The company that delivers towels came and took their towels back. - They have to cut up the leftover towels to make washcloths. - He received towels at 11:30am to wash his face. He could not wash his face before breakfast, because there were no clean washcloths available. - He had been asking for clean towels all morning. Interview with the Facility Manager on 5/29/15 at 2:15pm revealed: - The facility has had a linen contract since he came to the facility 2 years ago. - They have been with the same linen supply company with no breaks in service. - He called the facility last night to ensure there were clean towels. - He did not know the linen count was low. - There was no detergent to wash towels. - The new linen supply would be in the building Monday morning [6/1/15]. - He called over an employee to show the linen supply.	D 080		

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D 080	Continued From page 4 Observation of linen supply 5/29/15 at 2:30pm revealed: - No bath towels, hand towels or washcloths on the shelves. - 7 bath towels and 3 washcloths were in the dryer and had not yet dried. Interview with an Aide on 5/29/15 at 2:30pm revealed, those were all of the towels at the facility right now. Confidential interview with 3 facility staff revealed: - The facility did not have any clean towels and bath cloths. - The linen company took them back because they did not get paid for their service. - Towels were then ordered from another company and the check bounced and they came and took back the towels. - This had been going on for 2 weeks. - They have to wash towels every day, so that the residents can shower. - It takes time to get the towels and wash cloths washed and dried, so the residents can take their shower. - There is a list of resident showers for each day, there had not been enough towels and washcloths for the residents to get their showers when they were supposed to. Confidential interviews with 16 residents on 5/29/15 between 2:35pm and 3:00pm revealed: - Ten of the residents interviewed had not been able to shower or bathe, due to towels not being available. - Three of the 10 residents that were unable to shower or wash up said it was their shower day. - One resident was given a washcloth to shower with and was told there was not a bath	D 080		

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D 080	Continued From page 5 towel available. Observation of the linen room on 6/1/15 at 9:15am [Monday morning] revealed: - 2 hand towels and 3 bath towels, no wash towels available. Interview with a resident on 6/1/15 at 10:20am revealed: - She was waiting on towels to take a shower, had not received towels. - The towels were being washed. Interview with the linen supplier on 6/1/15 at 12:25pm revealed: - The facility has had a contract with his company for a long time now, he did not remember how long. - Monday May 18, 2015 was the last time clean linen was delivered to the facility. - Last Monday May 25, 2015, he picked up all the dirty linen. - The facility was low on funds, so there was no clean linen delivered to the facility. - This was his first delivery of clean linen since May 18, 2015. Observation of the linen supply on 6/1/15 at 2:00pm revealed: - Multiple bundles of clean bath towels, hand towels and wash cloths were stocked on the shelves of the linen closet. - Clean linen was placed on a cart and distributed to the residents. _____ The Plan of Protection received from the Facility Manager on 6/4/15 revealed: - The building has towels and wash cloths for	D 080		

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D 080	Continued From page 6 every resident. - The resident ' s rooms will be checked for soiled linen. - All residents will be checked and offered showers at their choosing. - Clean towels will be available as well as washcloths at all times. - The staff will be instructed by the Administrator in Training to ensure there is always a two day supply of towels and washcloths folded and in the linen room. - The linen supply will be monitored daily by the Administrator in Training. - The Restorative Aide will be responsible for checking with all residents for showers and bathing. - They shower and bathing schedules will be checked by the Restorative Aide for compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2015.	D 080		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the building and all fire safety equipment was maintained in a safe and operating condition regarding 2 of 5 fire extinguishers.	D 105		

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D 105	Continued From page 7 The findings are: The facility was licensed for 56 residents and the census was 30 residents. (The census was confirmed during the initial tour on 5/27/15.) Observations from 5/27/15 to 5/29/15 and 6/01/15 to 6/04/15 revealed: - The facility had 5 fire extinguishers located throughout the building, including the kitchen and exterior laundry room. - The facility had one fire extinguisher station with the hook for the extinguisher on the wall but the extinguisher was not on the hook. - The fire extinguishers had service tags indicating the time the extinguishers were placed in service, with serviced November 2013 indicated on the tag. - The service tags also indicated the expiration for the fire extinguisher was one year from the date placed in service. (The expiration date therefore was November 2014.) - The fire extinguishers had indicator dials displaying the status of the unit as recharge(red), "OK"(green), and overcharged. Continued observation of the fire extinguishers revealed: - The indicator dials for 4 of the fire extinguishers displayed "green"(OK). - One extinguisher (located outside the main office door) had "recharge" displayed on the indicator dial. - All the fire extinguishers were 7 months expired according to the service tags. Later observation of the fire extinguisher, identified by the manager as the fire extinguisher belonging on the empty hook, revealed the indicator dial displayed "recharge".	D 105		

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D 105	Continued From page 8 A copy of the latest County Inspections Department's "Fire Prevention Inspection Report" was requested on 5/27/15, 5/30/15, 6/02/15, and 6/04/15 from the manager, and as of exit on 6/04/15 was not provided. Interview on 6/02/15 at 12:00 pm with a representative of the County Inspections Department revealed: - The County Inspections Department did not do routine yearly inspections that were licensed by agencies. - The facility was responsible to contact the County Inspections Department for fire inspections to remain compliant with the individual licensing agencies. - The facility had not contacted the County Inspections Department for an inspection and were responsible to notify the Department when an inspection was due. - An inspection and "Fire Prevention Inspection Report" was done today (6/02/15). - The facility was responsible to keep fire extinguishers in operating condition and have regular maintenance preformed. - The facility needed to replace the missing fire extinguisher with another one in case it was needed. Interview on 6/02/15 at 2:30 pm with the manager revealed: - He had the fire extinguisher that was missing on one hall in storage. - He stated the fire extinguisher had been removed because a resident had used it inappropriately toward another resident a while back (no exact date given). - He stated he forgot to put the fire extinguisher back on the wall.	D 105		

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D 105	Continued From page 9 - He stated some of the records, including the fire report, had not been located after a former employee left. - He had not called the County Inspections Department to come to the facility because he thought they routinely came to the building and were running behind. - He stated he had not had the fire extinguishers serviced but would by new ones to replace the out of date extinguishers.	D 105		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director (2) The activity director hired on or after July 1, 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity Professionals meets this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005. This Rule is not met as evidenced by: Based on interviews and observations the facility failed to ensure employment of activity director hired on or after July 1, 2005 completed or complete, within nine months of employment or	D 129		

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D 129	Continued From page 10 assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. The findings are: Interview with the Supervisor/Medication Aide on 5/27/15 at 9:20 am revealed, the Restorative aide was identified as the Activity Aide. Interview with the Restorative Aide on 5/28/15 at 10:10am revealed: - She worked 9:00am -5:00pm (4 days/week), she was off on Wednesdays and weekends. - Her duties at the facility are to work 1:1 with residents that need more assistance than others. Such as: assisting residents with grooming and other personal care. - She did " help out " with activities, there was not an activity person at the facility at that time. - She had not received any training in activities. Confidential interview with 2 staff revealed: - There was no Activities Director on staff at the facility. - They had not seen the residents do any activities. - Sometimes some of the residents will play cards, but that had not happened in a while. Interview with the Facility Manager on 6/4/15 at 5:30pm revealed: - The person that had been trained and worked in the role of Activity Director was no longer working at the facility. - The night shift medication aide has been the acting Activities Director. - She had received training in activities. - He is not aware of the training she has	D 129		

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D 129	Continued From page 11 received. Observation of the Activity Calendar on the wall revealed: - The month of May 2015 was filled in. - There was no activities listed for any day in June 2015.There were no outings scheduled on the calendar for the Month of May 2015.	D 129		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by:	D 164		

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D 164	Continued From page 12 Based on interview and record review, the facility failed to assure 4 of 4 medication aides sampled (Staff A, B C and D) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: 1. Review of Staff A's medication aide (MA) personnel record revealed: - She was hired as a MA on 10/31/14. - There was no documentation of training on the care of residents with diabetes. Interview with Staff A on 5/29/15 at 9:40am revealed: - She was hired as MA in 2014. - She did not recall being trained on the care of residents with diabetes while working at the facility. - She performed finger stick blood sugars and has given insulin to residents at the facility. - She is now working at the facility as the Administrator in Training. - She usually works as a Medication Aide as emergency back- up. Refer to interview with the Administrator in Training on 5/29/15 at 9:40am. 2. Review of Staff B's MA personnel record revealed: - She was hired as a medication aide on 3/23/15. - There was no documentation of training on the care of residents with diabetes. Interview with Staff B on 5/28/15 at 10:05am revealed: - She was hired on 3/23/15 as a Medication Aide.	D 164		

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D 164	Continued From page 13 - She had not received training on the care of diabetic residents. - She performed finger stick blood sugars and has given insulin to residents at the facility. Refer to interview with the Administrator in Training on 5/29/15 at 9:40am. 3. Review of Staff C ' s MA personnel record revealed: - No hire date was found in her record. - She completed the medication clinical skills validation on 3/26/15. - She passed the medication exam on 3/22/06. - There was no documentation of training on the care of residents with diabetes. Staff C was not available for interview. Refer to interview with the Administrator in Training on 5/29/15 at 9:40am. 4. Review of Staff D's MA personnel record revealed. - She was hired as a Medication Aide on 5/27/15. - There was no documentation of training on the care of residents with diabetes. Interview with Staff D on 5/29/15 at 11:10am revealed: - She had not taken training on the care of residents with diabetes. - She performed finger stick blood sugars and had given insulin to residents at the facility. Refer to interview with the Administrator in Training on 5/29/15 at 9:40am. _____ Interview with the Administrator in Training on	D 164		

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STREET ADDRESS, CITY, STATE, ZIP CODE
844 HIGHWAY 39 S.
LOUISBURG, NC 27549

(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 164	Continued From page 14 5/29/15 at 9:40am revealed: - Staff qualifications are checked by the Business Office Manager (BOM). - She had been out for the last couple of weeks. - It had been her responsibility to check staff qualifications in the absence of the BOM. The BOM was not available for interview.	D 164		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to have at least one staff person on the premises for 13 of 34 night shifts between 5/1/15 and 6/3/15 who had completed within the last 24 months a course on cardio-pulmonary	D 167		

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	HAL035027		R 06/04/2015

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D 167	Continued From page 15 resuscitation (CPR) and choking management. The findings are: Review of the May 2015 staffing schedule revealed there were 4 staff routinely scheduled for night shift. Review of personnel files revealed: - Staff A and D were certified in CPR. - Staff C, E and F were not certified in CPR. Review of the May 2015 staffing schedule for night shift revealed: - Staffing for the 11 of 31 night shifts were comprised of various combinations of Staff C, E, and F; therefore, there were no CPR-certified staff person on the premises. Review of the June 2015 staffing schedule for night shift revealed: - There were 2 shifts where Staff C and Staff F, worked and no CPR- certified staff was on the premises. - There were 9 of 27 scheduled night shifts when staff C was scheduled to be on duty, therefore, there was no CPR-certified staff person on the premises. Interview on 6/4/15 at 5:30pm with the Facility Manager revealed: - The facility hours are comprised of 2 shift 7:00am-7:00pm, and 7:00pm -7:00am. - There was a medication aide assigned during all shifts. - He thought all of the medication aides scheduled had been CPR certified. - There had been a lot of recent staff turnover. - He did not realize there were shifts without a CPR-certified staff member on site. - He would adjust the schedule to assure at	D 167		

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D 167	Continued From page 16 least one CPR-certified staff member was scheduled for each shift. _____ On 6/4/15 the Facility Manager submitted the following Plan of Protection: - The schedule will be adjusted to reflect all accepted CPR certified employees. - No shift will be without a CPR certified staff with proper accepted documentation. - As part of our continuing education program, all staff will be reviewed for CPR certification. - Any future employees will be CPR certified before hiring. - All staff where certification is not valid will receive CPR classes paid for by the Licensee. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2015	D 167		
D 169	10A NCAC 13F .0509 Food Service Orientation 10A NCAC 13F .0509 Food Service Orientation The adult care home staff person in charge of the preparation and serving of food shall complete a food service orientation program established by the Department or an equivalent within 30 days of hire for those staff hired on or after July 1, 2004. Registered dietitians are exempt from this orientation. The orientation program is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. This Rule is not met as evidenced by: Based on record review and interview the facility	D 169		

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D 169	Continued From page 17 failed to assure staff person in charge (dining service manager) of food preparation and serving meals, had completed a food service orientation program, established by the department or an equivalent within 30 days of hire. The findings are: Interview with the Supervisor on duty 5/27/15 at 9:25am revealed: - The cook was the Dietary Manager. - He was working in the kitchen on 5/27/15. Interview with the cook on 5/27/15 at 10:10am revealed: - He had been working at the facility for a little over 4 months. - He had not taken the food service orientation. - He did not order the food at the facility. - He was not the Dietary Manager, the Restorative Aide was the Dietary Manager. - The Facility Manager did all of the shopping for the groceries at the facility. Interview with the Restorative Aide on 5/29/15 at 3:45pm revealed: - She used to be the Dietary Manager, but now the cook was the Dietary Manager. - She did not order the food. - The Facility manager purchased the food from various markets. - She did not ever have the food service orientation. Interview with another cook on 5/28/15 at 1:30pm revealed: - She was hired at the facility on 11/13/14, as a personal care aide. - She had been cooking at the facility for 2-3 months as a back- up. - She was filling in for another cook that	D 169		

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D 169	Continued From page 18 cooked in the evening from time to time. - She serves all of the residents the same thing, she just cut back on the servings sizes for the diabetics. - She had not taken the food service orientation. Interview with the Facility Manager on 6/4/15 at 5:30pm revealed: - He had not had the food service orientation. - None of the kitchen staff have had the food service orientation. Observation of the facility kitchen on 6/1/15 at 10:15am revealed there was not a 3 day supply of perishable foods on hand. Interview with the Facility Manager on 6/4/15 revealed: - When the facility is short staffed a cook, he fills in by cooking. - The facility does not have a contract with a food delivery service. - He buys all of the food for the facility from area food stores. - He shops for grocery by the week and sometimes by the day. - He understands he was supposed to have foods like milk on hand at all times. - He has a communication issue with the staff. - They are supposed to communicate the needs with him, before food gets that low. - They don ' t always let him what they need before it is too low.	D 169		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites	D 176		

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D 176	Continued From page 19 (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. 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 and interview, the facility failed to assure an administrator or administrator in charge was responsible for the total operation of the facility, to meet and maintain the rules in rule areas of Housekeeping and Furnishings, Resident Rights, Health Care, Medication Administration, and Training on Cardio Pulmonary Resuscitation. 1. Based on observation and interview, and record review, the facility failed to assure all 30 of 30 residents were treated with respect, consideration, and dignity related to the facility's negation to provide clean towels and wash cloths to residents for bathing and showering. [Refer to	D 176		

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D 176	Continued From page 20 Tag 080 10A NCAC 13F .0306 (a)(6) Housekeeping and Furnishings (Type B Violation)]. 2. Based on interviews and record review, the facility failed to assure referral and follow up to meet the health care needs of 2 of 5 sampled residents (Resident #9, #11), failed to notify one resident's primary physician of the resident not having a walker after the resident fractured his foot and failed to have the resident seen for a follow-up by an orthopedic as ordered (#11) and failed to obtain an appointment with a nephrologist for bladder mass (Resident #9). [Refer to Tag 0273 10A NCAC 13F .0902 (b) Health Care (Type B Violation)]. 3. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 4 residents (# 4 and #5) observed during medication administration, and 2 of 4 sampled residents (#3 and #11) related to errors with administration. [Refer to tag 358 10A NCAC 13F .1004 (a) Medication Administration (Type B violation)]. 4. Based on interviews and record reviews, the facility failed to have at least one staff person on the premises for 13 of 34 night shifts between 5/1/15 and 6/3/15 who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management. [Refer to tag 167 10A NCAC 13F .0507 Training on Cardio Pulmonary Resuscitation (Type B Violation)].	D 176		

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D 176	Continued From page 21 The Plan of Protection received from the Facility Manager on 6/4/15 revealed: - The Administrator in Training and Licensee will communicate daily to ensure that all rules are followed and the residents are protected. - As part of our continuing program to improve the quality of life for the residents, continuing education will continue to be instituted to ensure all rules and regulations are followed. - This includes hiring new staff, ensuring proper follow up inspections by pharmacist, doctors, -Licensed Health Professional Nurses, and Psych Doctors. - Management of the facility will follow the 2015 rules and regulations manual. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2015	D 176		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide personal care and grooming (finger nails and toenails were clean and cut) for 3 of 3 sampled residents who were dependent on staff for grooming. (Resident #9, #12 and #13).	D 269		

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D 269	Continued From page 22 The findings are: A. Review of Resident #13's current FL-2 dated 10/27/14 revealed: - Diagnoses included Schizophrenia-paranoid type, Mild MR (mental retardation), and hypertension. - The resident was ambulatory. Review of Resident #13's Care Plan dated 5/5/14 revealed the resident was assessed for limited assistance with grooming and personal hygiene. Observation of Resident #13 on 6/4/15 at 4:00 pm revealed: - The fingernails on both of the resident's hands were 1/4 inch to 3/8 inch long. - The toenails on both of the resident's feet were 1/4 inch to 3/8 inch long and curled over the ends of the toes on all the toes except the big toes. - The toenails on both big toes were 1/4 inch to 3/8 inch long and jagged. Interview on 6/4/15 at 4:10 pm with Resident #13 revealed: - He needed assistance with trimming his nails. - Previous staff members at the facility had trimmed his fingernails and toenails. - The toenail on one of his big toes (did not specify which toe) had been ingrown a while back but it had cleared up. - The toenails that were curled over the toes were not bothering him with walking. - No staff had offered to trim his toenails or fingernails in months. Confidential interview with a resident revealed staff did not assist residents with trimming nails.	D 269		

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D 269	Continued From page 23 Confidential interview with a staff member revealed: - The staff member helped residents with personal care. - The staff member stated Resident #13 needed a "special approach" to cut his nails; most of the time he refuses to let staff cut his nails. - The staff member did not know the last time Resident #13's nails were cut. Refer to interview on 6/04/15 at 4:20 pm with a day shift personal care aide. Refer to interview on 6/04/15 at 4:30 pm with the Restorative Aide. Refer to interview on 6/04/25 at 5:30 pm with the manager. B. Review of Resident #12's current FL-2 dated 5/01/15 revealed: - Diagnoses included dementia, hypertension, and end stage renal disease. - The resident was semi-ambulatory. - The resident had impaired sight. - The resident was assessed for total care. Observation of Resident #12 on 6/02/15 at 4:35 pm revealed: - Staff were guiding Resident #12 toward the dining area. - The fingernails on both of the resident's hands were 1/4 inch to 3/8 inch long. - The fingernails were jagged and unshaped. Interview on 6/02/15 at 4:35 pm and 6/4/15 at 4:10 pm with Resident #12 revealed: - He had limited vision. - He needed assistance with trimming his nails because he could not see well.	D 269		

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D 269	Continued From page 24 - Previous staff members at the facility had trimmed his fingernails and toenails. - No staff had offered to trim his toe nails or finger nails in months. Confidential interview with a resident revealed staff did not assist residents with trimming nails. Confidential interview with a staff member revealed: - The staff member helped residents with personal care. - The staff member had trimmed Resident #12's nails in the past. - The staff member did not know the last time Resident #12's nails were cut. Refer to interview on 6/04/15 at 4:20 pm with a day shift personal care aide. Refer to interview on 6/04/15 at 4:30 pm with the Restorative Aide. Refer to interview on 6/04/25 at 5:30 pm with the manager. C. Review of Resident #9's current FL-2 dated 05/22/15 revealed diagnoses included acute renal failure, altered mental status, lower left lobe pneumonia and severe sepsis. Review of the Resident Register for Resident #9 revealed the resident was admitted to the facility 03/20/14. Observation on 6/04/15 at 5:45 pm of Resident #9 revealed: - The resident was standing at the entrance to the dining hall. - The resident's fingernails on both hands were	D 269		

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D 269	Continued From page 25 between 1/4 inch and 3/8 inch long. Interview on 6/02/15 at 4:35 pm and 6/4/15 at 4:10 pm with Resident #9 revealed: - He stated he "was going[planning] to tell someone to cut his nails". - He needed staff to cut his nails. - He was not aware of the last time he had his fingernails trimmed. Confidential interview with a resident revealed staff did not assist residents with trimming nails. Confidential interview with a staff member revealed: - The staff member helped residents with personal care. - The staff member did not know the last time Resident #9's nails were cut. Refer to interview on 6/04/15 at 4:20 pm with a day shift personal care aide. Refer to interview on 6/04/15 at 4:30 pm with the Restorative Aide. Refer to interview on 6/04/25 at 5:30 pm with the manager. _____ Interview on 6/04/15 at 4:20 pm with a day shift personal care aide revealed: - He had worked at the facility for about 4 weeks. - He assisted residents with bathing, transfers, and dressing. - He had not assisted any resident with trimming nails. Interview on 6/04/15 at 4:30 pm with the Restorative Aide revealed: - She had worked at the facility for several years.	D 269		

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D 269	Continued From page 26 - She assisted with personal care for residents. - She did not assist residents with trimming nails. - She thought the medication aides occasionally assisted residents with nails trimming. Interview on 6/04/25 at 5:30 pm with the manager revealed: - The Administrator in Training (AIC) was responsible for monitoring nail care. - He was not aware if the AIC had been monitoring resident's nail care by the staff. - He stated the facility had a Podiatrist on sight about a week ago, and many residents were seen by the Podiatrist. - He stated he was aware some of the residents were not treated by the Podiatrist do to insurance billing and reimbursement but he did not know which residents. _____ Review of the Plan of Protection received from the Facility Manager on 6/4/15 revealed: All Residents will have their nails cut and will be checked for any grooming needed, on 6/4/15 after dinner. Nails will be cut on 6/5/15 for all nondiabetic residents. The Administrator in Training will have and in-service meeting with all staff regarding documentation of all residents that refuse grooming and the importance of the personal care log. The in-service will be signed and placed in their staff folder.	D 269		
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	D 273		

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D 273	Continued From page 27 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 interviews and record review, the facility failed to assure referral and follow up to meet the health care needs of 2 of 5 sampled residents (Resident #9, #11), failed to notify one resident's primary physician of the resident not having a walker after the resident fractured his foot and failed to have the resident seen for a follow-up by an orthopedic as ordered (#11) and failed to obtain an appointment with a nephrologist for bladder mass (Resident #9). The findings are: A. Review of Resident #11's current FL-2 dated 5/19/2015 revealed: - Diagnoses included depression, hypertension, and hyperlipidemia. - The resident was ambulatory. Observation on 5/27/15 at 10:30 am during the initial tour of the facility revealed Resident #11 was wearing a lace-up canvas boot with a hard bottom. The resident was ambulating around the facility without an assistive device. Interview on 5/27/15 at 11:30 am with Resident #11 revealed:	D 273		

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D 273	Continued From page 28 - He had fractured his foot off premises. - He was able to move around the facility if he took his time. Review of Resident #11's Care Plan dated 6/18/14 revealed the resident was independent for all activities of daily living except assessed for supervision for eating. Review of a discharge summary for Resident #11 from a local hospital emergency department dated 5/25/15 revealed diagnosis of fracture mid metatarsal right foot. 1. Review of a discharge summary for Resident #11 from a local hospital emergency department dated 5/25/15 revealed an order for a walker. Interview on 6/3/15 at 2:35 pm and 6/04/15 at 11:15 am with the Administrator in Training (AIT) revealed: - She was currently working as AIT and managed most of the health care and medication administration for the facility. - She was responsible to process new orders (including hospital discharges), schedule appointments, arrange transportation to appointments, and monitor medication administration. - She was aware of the order for a walker for Resident #11 from the emergency department discharge on 5/25/15. - Resident #11 worked part time at a local grocery store and the accident had occurred at the grocery store on 5/25/15. - The resident was taken to the emergency department by a representative of the grocery store and transported back to the facility with the discharge summary. - Resident #11 had seen the house Nurse	D 273		

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	HAL035027		R 06/04/2015

NAME OF PROVIDER OR SUPPLIER
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D 273	Continued From page 29 Practitioner (NP) the day after his accident (5/26/15). - She had not seen the walker come from the pharmacy. - She stated she had spoken to the resident after the NP visit (not sure if the same day or the next day and the resident had refused the facility getting the walker) and notified the physician the resident had refused the walker. - She stated she had not documented any information about the walker in the resident's record but she would attempt to contact the NP for verification of the refusal. Telephone interview on 6/04/15 at 11:30 am with a representative at the contract pharmacy provider revealed: - Documentation the pharmacy received a fax for the walker at the pharmacy on 5/26/15 (The pharmacy was closed for a holiday on 5/25/15). - The order for the walker was sent to the department of the pharmacy that processed orders for durable medical equipment (DME). - The representative could not find documentation for the walker being shipped, or notes for contact with the facility regarding the walker subsequent to receiving the order. - The representative stated she would follow up with the DME department and return a call. - No further telephone calls were received. Interview with Resident #11 on 6/4/15 at 11:45 am revealed: - He was aware of the order for the walker from the hospital emergency department on 5/25/15. - He stated he "was supposed to have gotten the walker but he never got it." - He stated the facility told him it was coming (on 5/26/15) but it never came in. - He stated he "did not refuse" the walker.	D 273		

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D 273	Continued From page 30 - When he saw the NP on 5/26/15, the NP said the walker was coming, but it never got here. - He used a pair of crutches the facility gave him for a day or two and then walked on the foot. - If he had the walker the first couple of days, he would have used it. Telephone interview on 6/4/15 at 3:20 pm with the facility NP revealed: - She saw Resident #11 the day after he injured his right foot. - She received a text message from the facility earlier on 6/04/15 asking if she remembered receiving information regarding Resident #11 refusing the walker. - She responded that she thought that she received a text from the facility stating Resident #11 was refusing the walker but she was not sure what day the facility might have notified her. - She stated she had seen Resident #11 on 6/02/15 and did not ask the resident about the walker, rather she had taken staff's word that the resident had refused the walker. Interview on 6/04/15 at 5:30 pm with the Facility Manager revealed: - The AIT was responsible for monitoring residents' health care referrals. - The AIT was assisted by the owner with managing the resident's care. 2. Review of a discharge summary for Resident #11 from a local hospital emergency department dated 5/25/15 revealed orders for the resident follow-up with [Physician Name] Orthopedic clinic in 1 to 2 days. Review of Resident #11's record revealed no documentation for Resident #11 seeing an orthopedic physician prior to 6/04/15 and no	D 273		

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D 273	Continued From page 31 notification to the primary care provider for the orthopedic follow-up being scheduled prior to 6/02/15. Interview on 6/03/15 at 12:20 pm with the Administrator in Training (AIT) revealed: - Appointments were routinely scheduled by the Business Office Manager (BOM). - The BOM was currently on leave and had been out for about 2 weeks. - The AIT was responsible to schedule appointments while the BOM was out. - All paperwork from physician visits, hospital visits, and phone calls was reviewed by the AIC for follow-up appointments and forwarded to the BOM. - The facility used a binder calendar book to log scheduled appointments made by the BOM or AIT. - The calendar was reviewed daily for appointments scheduled for the next day and the current day. - The BOM or AIT arranged transportation to the scheduled appointments using staff at the facility as drivers. Interview on 6/03/15 at 5:00 pm with Resident #11 revealed: - He had not seen an orthopedic doctor since the hospital visit on 5/25/15 for the fractured right foot. - He had seen the facility Nurse Practitioner when she came to the facility on the day after the hospital visit. - He was not aware he was supposed to have an orthopedic follow-up within 1 to 2 days from 5/25/15. - The facility staff informed him on 6/02/15 that he had scheduled an appointment with the orthopedic clinic on 6/04/15.	D 273		

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D 273	Continued From page 32 Interview on 6/04/15 at 12:00 pm with the Nurse Practitioner revealed: - She was in the facility on 5/26/15 and again on 6/02/15. - She was not aware the facility had not scheduled an orthopedic follow-up until 6/02/15. - She became aware Resident #11 missed an appointment scheduled for the orthopedic clinic when the clinic called the facility on 6/02/15, and she was working in the office where the phone call was received. - The facility was responsible to assure follow-up appointments were made as requested or ordered. - She stated she expected the facility to assure residents kept appointments that were scheduled. Telephone interview on 6/04/15 at 11:08 am with a representative of the orthopedic clinic revealed: - Review of the clinic's appointment log documented Resident #11 had an appointment scheduled for 6/02/15 at 9:30 am but it could not be determined when the appointment was made or by whom it was made. - The clinic documentation revealed the appointment was cancelled on 6/02/15 and rescheduled for 6/04/15 but no information for the reason. - The clinic showed no documentation for an appointment for Resident #11 prior to 6/02/15. Interview on 6/04/15 at 12:15 pm with the AIT on revealed: - The appointment was made by the BOM before she went out on leave. - She thought the BOM had made Resident #11's appointment with the orthopedic clinic at the earliest time the clinic had available, but she did not recall if the BOM had told the AIT the date of	D 273		

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D 273	Continued From page 33 the appointment. - Resident #11 missed the scheduled orthopedic clinic appointment on 6/02/15. - The AIT's review of the appointment book revealed an appointment scheduled for another resident on the same day (6/02/15) had been crossed out (for cancelled) and the cross mark went down into the time slot for Resident #11. - She overlooked the appointment for Resident #11 when she prepared the list of residents needing transportation for 6/02/15. - The AIT was not aware Resident #11 had missed the appointment until the clinic called the facility to ask where the resident was and why he had missed the appointment. - The AIT stated she rescheduled the appointment for 6/04/15 with the clinic. Interview on 6/04/15 at 5:00 pm with Resident #11 revealed: - He had been to an orthopedic clinic appointment earlier in the day. - The clinic gave him a new walking boot. - The boot was much more comfortable than the previous boot given to him at the hospital (on 5/25/15). - He was able to get around much better with the new boot. Interview on 6/04/15 at 5:30 pm with the Manager revealed: - The AIT was responsible for monitoring residents' health care. - The AIT was assisted by the owner with managing the resident's care. B. Review of Resident #9's current FL2 dated 5/22/15 revealed: - Diagnoses included severe sepsis, left lower lobe pneumonia with hypoxia, acute renal failure	D 273		

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D 273	Continued From page 34 and altered mental status. Review of Resident #9 ' s Resident Register revealed he was admitted to the facility 3/20/14. Review of physician ' s provider visit/encounter forms, physician notes and discharge instructions between 10/2/14 and 5/22/15 revealed: - Resident #9 received a referral to follow up with urologist in 3 weeks, from a discharge instruction dated 11/18/14, follow up information was highlighted. - Physician orders to schedule urology consult to follow up bladder mass, per provider visit/encounter form dated 12/10/14. - Physician note dated 3/27/15, noted the need for Resident #9 to have a urology consult for a bladder mass noted in a CAT scan in November 2014. - A physician order for a urology consult for bladder mass, per provider visit/encounter form dated 5/5/15. Interview with Resident #9 ' s current healthcare provider on 6/2/15 at 1:50pm revealed: - Resident #9 was hospitalized in November of 2014 and a bladder mass was discovered. - He was referred for follow-up with urologist in November and multiple times by his previous physician and no one took him or made an appointment. - An appointment was requested by the healthcare provider in May 2015 when she became his physician. - The only appointment they could get was 6/1/15 and he did not go. - He was scheduled for the urology consult again on 6/10/15. Interview with the Nurse at Resident #9 ' s	D 273		

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D 273	Continued From page 35 previous physician ' s office on 6/3/15 at 11:05am revealed: - On 3/27/15, during an appointment, Resident #9 could not recall having seen the urologist. The physician reordered the urology consult and asked the facility to call with appointment date. - There was no record of colonoscopy or urology appointment in the Resident ' s record. - She could not find any documentation from the urologist in Resident ' s chart. - The physician was no longer the physician for the facility, but when he was seeing residents at facility there were issues with residents not getting appointments. Interview with the Administrator in Training on 6/3/15 at 2:35pm revealed: - She started working at the facility as a medication aide in October 2014. - She left the facility in December 2014. - She returned to the facility as Resident Care Coordinator in February 2015. - She began working as Administrator in Training about 3 -4 weeks ago. - She is responsible for following up on physician orders. - The " Business Office Manager (BOM) schedules appointments " . - The BOM had been on leave for 10 days. - When residents have an appointment, she monitors, reviews phone calls, discharges and reads through paperwork looking for follow ups, and gave the paperwork to the BOM to make the appointments. - The BOM would then make the appointment, make a copy and put it in a folder on the wall and the request is placed in an appointment book, or write the appointment date and time on the board in the medication room. - The night shift Medication Aide would make a	D 273		

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D 273	Continued From page 36 copy of the information to be sent with the resident. - She was not aware Resident #9 had a urology consult ordered or an appointment. - She was not aware of a consult for a colonoscopy. - She does remember he had " some appointment, she is not sure what it was or when it was " . Additional interview with Administrator in Training on 6/3/15 at 4:20pm revealed: - She spoke with the BOM over the telephone and asked about the appointments for Resident #9. - The BOM told her she tried to set an appointment with the urologist on 4/1/15 and she was unable to set appointment due to a past balance owed by resident. - The BOM called the Resident ' s responsible party and informed her of the issue. - The responsible party said she was going to call back and she never called back. Review of resident log for Resident #9 revealed: - An entry noted on 3/30/15 at 10:30am documented a call to urologist and spoke with office staff. - She was told of a balance owed and needed to be paid before appointment could be made. - The note was signed by previous Administrator in training. - No documentation of notification to physician or responsible party noted. - An entry dated 12/10/14 at 10:30pm documented resident was seen by physician and urology consult was ordered to follow up bladder mass. - The physician requested to be notified when the appointment was made.	D 273		

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D 273	Continued From page 37 Interview with the Facility Manager on 6/4/15 at 5:30pm revealed: - The facility had been working on the issue with Resident ' s insurance. - Resident #9 ' s responsible party had been getting calls regarding his appointments. - He did not know if Resident #9 had gone to the urology appointment or not. Based on observation, interview, and record review the resident determined not to be interviewable. Resident #9 ' s responsible party was not available for interview. _____ ----------Review of the Plan of Protection received on 6/5/15 revealed: - All the resident ' s charts will be reviewed tonight, by Management and the Administrator in Training for all missed and follow up appointments. - All physicians will be contacted in the morning for follow up rescheduling. - All visits will be kept in a separate log with all follow up visits posted in a clear jacket in the chart noting all follow up visits. - The Administrator in Training and the Resident Care Coordinator will be responsible for checking daily. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2015.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support	D 280		

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D 280	Continued From page 38 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure the registered nurse who was responsible for the Licensed Health Professional Support (LHPS) evaluations and reports participated in the onsite review and evaluation of 1 of 3 sampled resident's (#1,) health status, care plan and care quarterly, in regards to fasting blood sugars and subcutaneous injections. The findings are: Review of Resident #1's current FL-2 dated 1/24/15 revealed: - Diagnoses of diabetes, gastrointestinal bleed	D 280		

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D 280	Continued From page 39 secondary to diverticulosis, sigmoid and left sided colitis, and hypertension. - Physician's orders for fasting blood sugars two times per day and subcutaneous injections three times a day. Review of the Resident Register revealed, Resident #2 was admitted to the facility 1/19/15. Review of LHPS revealed LHPS documentation completed 1/31/15. Refer to interview with the Facility Manager on 6/4/15 at 5:30pm. _____ Interview with the Facility Manager on 6/4/15 at 5:300pm revealed: - He was not aware the LHPS evaluations had not been completed. - He would contact the Nurse that does the evaluations and have her get those done immediately.	D 280		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and documentation review, the facility failed to assure foods stored in the kitchen refrigerator were	D 283		

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D 283	Continued From page 40 protected from contamination. The findings are: Observation of the kitchen refrigerator between 5/27/215 at 10:10am and 6/1/15 at 3:00pm revealed: - The facility had been using the refrigerator to store perishable foods such as milk, bread, juice, eggs, condiments, deli meats, and fresh fruit and vegetables. Observations of the lunch meal on 5/27/15 and the lunch meal on 5/28/15 revealed: - The residents had eaten foods that had been stored in the refrigerator. Observation of the refrigerator on 6/1/15 at 9:30am revealed: - About a ½ inch of Water collected on the refrigerator floor. - There was no food was placed on the refrigerator floor. - Food was stored on the shelves of the refrigerator, including the top shelf. Interview with the cook on 6/1/15 at 9:30am revealed: - The bottom of the refrigerator fills up with water about every 2 days. - Water also backs up onto the floor around the refrigerator. Observation of the facility kitchen refrigerator on 6/1/15 at 3:00pm revealed: - 8 gallons of milk, 4 loaves of bread, 6 (½) gallons of juice, 9 dozens of eggs, 2 gallons of salad dressing, 2 bunches of lettuce, 2 watermelons, and 1 package of deli meat. - The watermelons were sitting on the bottom of the refrigerator floor in a 1-2 inch puddle of water.	D 283		

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D 283	Continued From page 41 - Water from the bottom of the refrigerator was leaking onto the kitchen floor. - The drain on the top shelf of the refrigerator was draining water into the refrigerator. - A 10lb package of ground beef was sitting on the counter near the sink thawing out (per interview discarded by staff). Interview with the county health inspector on 6/1/15 at 3:00pm revealed: - The water leaking into the refrigerator and the water collected on the floor of the refrigerator was grey water. - The water is contaminated which had caused all of the food in the refrigerator to be contaminated with bacteria that could cause serious illness to the residents if ingested. Interview with the Facility Manager on 6/1/15 at 3:05 revealed: - The drain to the refrigerator was backing up into the refrigerator. - He would have to crack the floor to get it out. - He was made aware of the water draining into the refrigerator in February of 2013. - He had continued to use the refrigerator. - He said he would stop using the refrigerator until he could get it fixed. - He was not aware that the water draining in the refrigerator could cause illness to the residents. - All of the food that was in the refrigerator was thrown out. - Food is not usually thawed by sitting on the counter, he is aware it must be under running water to thaw properly. - The ground beef that was sitting on the counter thawing was thrown in the garbage. - He said he had another refrigerator that was not in use and was in good repair.	D 283		

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	HAL035027		R 06/04/2015

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D 283	Continued From page 42 Observation of the kitchen on 6/1/15 at 3:15pm revealed: - The cook removed all of the food and condiments from the refrigerator and placed them in the garbage can. Observation of the kitchen on 6/2/15 at 9:30am revealed: - Perishable food items such as milk, eggs, fresh fruit and vegetables, bread, juice and salad dressings were stored in 2 different refrigerators. - The refrigerator with the drainage issue was not in use. - There was no water on the kitchen floor.	D 283		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations, review of menu, and interviews, the facility failed to maintain a 3 day supply of perishable foods the 30 residents that resided at the facility. The findings are: Interview with the cook on 5/27/15 at 10:10am revealed: - He had been working as the cook at the	D 285		

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D 285	Continued From page 43 facility for a little over 4 months. - The food is usually delivered to the facility every Wednesday, usually before he got in at 6:00am. - There is was no delivery when he got to work this morning. - He had all the supplies he needed to complete the menu for lunch and dinner. - If there was something he needed to complete the meal, the Facility Manager would make sure he had it in time to prepare the meal. - If he needed to make any substitutions, he would write them in the substitution book. - For lunch today it will be resident's choice. - They will be served hot dogs, zucchini, slaw, juice and water. Observation of perishable foods on hand on 6/1/15 at 9:30 a.m. revealed: - One 1/2 gallon of milk was in the refrigerator. - No eggs were in the refrigerator. - No juice was in the refrigerator. - There was 1 loaf of bread in the refrigerator. - 2 bunches of wilted celery was in the refrigerator. - A package of deli meat with about 10 slices of deli meat was in the refrigerator. - 2 gallon jugs of salad dressing. Review of the lunch menu for 6/1/15 revealed: - The lunch menu consisted of the following: - Turkey breast/lemon - Thyme sauce - Parmesan pasta - Buttered zucchini - Baked roll - Homemade ranger cookie Interview with the cook on 6/1/15 at 10:15am revealed:	D 285		

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D 285	Continued From page 44 - He was worried because the refrigerator had never been that empty. - It was frustrating and it made it hard to do his job. - For breakfast the residents had grits, sausage, toast, milk and juice. - This morning he was down to the last 3 gallons of milk and the last 3 containers of juice. - " Now there is only a ½ gallon of milk and there is no more juice " . - There is meat in the freezer, but my refrigerated foods are low. - They will have more food, I ' m sure he [Facility Manager] will bring food on his way in. - He would have the food at the facility in time for snack. Observation of refrigerator on 6/1/15 at 11:00am revealed; - The following items were in the refrigerator: - 8 gallons of milk. - 6 gallons of tropical juice. - 6 dozen of eggs. - Fresh apples. - 4 heads of lettuce. - 4 gallon bags of shredded cheese. - One bag garlic cloves. - A 10lb bag of white potatoes. - 2 watermelons. - A 100 pack of hot dogs. - 6 loaves of bread. - 6 packages of hot dog buns - Frozen zucchini. - Chicken leg quarters. - Ground beef. - 2 bunches of Bananas. - 2 large packages of deli meats. Observation of the lunch meal on 6/1/15 at 12:00 revealed, residents were served the following:	D 285		

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D 285	Continued From page 45 - Hot dogs, zucchini, slaw, juice and water. Confidential interviews with 3 residents revealed: - They always have food at the facility. - She had toast for the second time since last August and it was great. - They only get 1 piece of chicken and are not allowed to have seconds. Facility grocery receipts were requested of Facility Manager on 6/1/15 and were never produced. Interview with the Facility Manager on 6/4/15 revealed: - The facility does not have a contract with a food delivery service. - He buys all of the food for the facility from area food stores. - He shops for grocery by the week and sometimes by the day. - He understands he was supposed to have foods like milk on hand at all times. - He has a communication issue with the staff. - They are supposed to communicate the needs with him, before food gets that low. - They don't always let him know what they need before it is too low.	D 285		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care	D 317		

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D 317	Continued From page 46 exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations and interviews and record review the facility failed to provide a minimum of 14 hours of a variety of planned group activities per week for residents. The findings are: Observation on 5/27/15 at 9:20am through 6/4/15 at 8:30pm revealed: - There was no announcement of an activity taking place. - There was no arts and crafts supplies observed in the facility day room area or dining area. - There were no residents observed doing arts and crafts or other activity. - There was an activities calendar on the wall written on a dry erase board that listed activities for the month of May 2015. Interview with the Supervisor/Medication Aide on 5/27/15 at 9:20 am revealed the Restorative aide was identified as the Activity Aide. Interview with the Restorative Aide on 5/28/15 at 10:10am revealed: - She worked 9:00am -5:00pm (4 days/week), she was off on Wednesdays and weekends. - Her duties at the facility are to work 1:1 with residents that need more assistance than others.	D 317		

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D 317	Continued From page 47 Such as: assisting residents with grooming and other personal care. - She did "help out" with activities, there was not an activity person at the facility at that time. - She had not received any training in activities. Observation of activities between 5/27/15 at 9:20am and 6/4/15 at 8:30pm revealed: - On 5/27/15 at 10:30 am and 6/3/15 at 10:30am a church group visited the facility and had service with the residents for 45 minutes. - There were several residents participating in the service. - The above listed activity was the only activity witnessed between 5/27/15 and 6/4/15. Observations of residents between 5/27/15 at 9:20am and 6/4/15 at 8:30pm revealed: - Throughout the day there would be between 8-15 residents sitting in the day room watching TV. - Five to six residents spent multiple hours through the day sitting in the dining room. - Two residents could be seen pacing the parking lot throughout the day. - Residents would go to their rooms and lay down napping throughout the day. Review of the Activity Calendar on the wall at the facility revealed: - Two dry erase boards hung in the hallway outside of the dining room, near the day room. - The dry erase board titled May 2015 calendar, was filled in with one activity listed per day. - The May 2015 calendar revealed the following activities: - The activities listed did not have a start or stop time listed. - 5/27/15- bingo.	D 317		

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D 317	Continued From page 48 - 5/28/15 - Zumba. - 5/29/15 - kick ball. - 5/30/15 - visitors. - 5/31/15 - visitors. - The activity board was not updated after May 31, 2015. - There was a dry erase board on the wall titled June 2015. - There were no entries listed on any of the days in June. Confidential interviews with 7 residents revealed: - There are no activities offered to the residents on a regular basis. - There was a church group that " visited the facility 2 times since February". - The activities listed on the activity calendar are not activities that are done at the facility. - "It would be nice to have something to do." - "If the facility offered activities it wouldn't be so boring around here." - They "have not played bingo at all this month". - "The church people come about every other month". - They have not ever done Zumba. - They have not ever played kick ball. Confidential interview with 2 staff revealed: - There was no Activities Director on staff at the facility. - They had not seen the residents do any activities. - Sometimes some of the residents will play cards, but that had not happened in a while. Interview with the Facility Manager on 5/28/15 at 2:30pm revealed: - The facility had a Restorative Aide that worked 4 days per week Monday, Tuesday,	D 317		

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D 317	Continued From page 49 Wednesday, and Friday. - She assisted the residents that are blind and the residents that need special attention for reasons like memory loss. - She "monitors residents every 2 hours and provides extra eyes on the floor". Interview with the Facility Manager on 6/4/15 at 5:30pm revealed: - The person that had been trained and worked in the role of Activity Director was no longer working at the facility. - The night shift medication aide has been the acting Activities Director. - She had received training in activities. - He is not aware of the training she has received. Based on observations, interviews, and record review, the facility failed to arrange for the 30 residents residing at the facility to have the opportunity to participate in at least one outing every other month. The findings are: Confidential interviews with 7 residents revealed: - They don't go on any outings out in the community. - The only time they go out is for doctor appointments. - They used to go out sometimes, but now the van is broken. - There had not been transportation to go on outings for the last 2 -3 months. - "The 2 vans are not in use, the transmission on one of them is out and the other one does not have insurance on it". Observation of the Activity Calendar on the wall revealed: - The month of May 2015 was filled in.	D 317		

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D 317	Continued From page 50 - There were no outings scheduled on the calendar for the Month of May 2015. - There was no activities listed for any day in June 2015. Interview with the facility Foundation Administrator on 5/28/15 at 12:45pm revealed: - She had been employed by the Licensee for 2 years as a Foundation Administrator. - She is responsible for making sure the building is safe and secure for the residents. - "The resident come to me with any problems". Interview with the Facility Manager on 6/4/15 at 5:30pm revealed: - The "facility has 2 vans for outings". - There was a 7 passenger van and a 15 passenger van. - The "7 passenger van is down right now, but the 15 passenger van is working properly". - The facility Foundation Administrator had taken some residents on an outing. - She was not trained in activities. - The residents had been going shopping every month when they got their money. " That is they if chose to go". - There were a few residents that got caught shoplifting when they went on an outing. - He ' s not sure what to do when them, since he can ' t trust them to go into a store without shoplifting. - There was an "employee that had been trained in activities and had been acting activity person, she no longer worked at the facility." - He was looking into making the night shift medication aide into the activity director, she has had some activity training. - He was not aware of how many hours of training she has had.	D 317		

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D 317	Continued From page 51 - He did not have a copy of her activity training paperwork.	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to arrange for the 30 residents residing at the facility to have the opportunity to participate in at least one outing every other month. The findings are: Confidential interviews with 7 residents revealed: - They don't go on any outings out in the community. - The only time they go out is for doctor appointments. - They used to go out sometimes, but now the van is broken. - There had not been transportation to go on outings for the last 2 -3 months. - "The 2 vans are not in use, the transmission on one of them is out and the other one does not have insurance on it". Observation of the Activity Calendar on the wall revealed: - The month of May 2015 was filled in.	D 319		

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D 319	Continued From page 52 - There were no outings scheduled on the calendar for the Month of May 2015. - There was no activities listed for any day in June 2015. Interview with the facility Foundation Administrator on 5/28/15 at 12:45pm revealed: - She had been employed by the Licensee for 2 years as a Foundation Administrator. - She is responsible for making sure the building is safe and secure for the residents. - "The resident come to me with any problems". Interview with the Facility Manager on 6/4/15 at 5:30pm revealed: - The "facility has 2 vans for outings". - There was a 7 passenger van and a 15 passenger van. - The "7 passenger van is down right now, but the 15 passenger van is working properly". - The facility Foundation Administrator had taken some residents on an outing. - She was not trained in activities. - The residents had been going shopping every month when they got their money. "That is they if chose to go". - There were a few residents that got caught shoplifting when they went on an outing. - He's not sure what to do when them, since he can't trust them to go into a store without shoplifting. - There was an "employee that had been trained in activities and had been acting activity person, she no longer worked at the facility." - He was looking into making the night shift medication aide into the activity director, she has had some activity training. - He was not aware of how many hours of training she has had.	D 319		

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D 319	Continued From page 53 - He did not have a copy of her activity training paperwork.	D 319		
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: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 4 residents (# 4 and #5) observed during medication administration, and 2 of 4 sampled residents (#3 and #11) related to errors with administration. The findings are: A. The medication error rate was 9% as evidenced by the observation of 3 errors out of 32 opportunities during the 8:00 a.m. and 11:00 a.m./12:00 noon medication passes on 05/28/15. 1. Review of Resident #5's current FL-2 dated 01/19/15 included diagnoses of asthma, hypertension, and congestive heart failure.	D 358		

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D 358	Continued From page 54 Review of the Resident Register revealed the date for admission to the facility was blank. Interview on 5/28/15 at 11:00 am with Resident #5 revealed he was admitted to the facility on 2/13/15. a. Review of the current FL-2 dated 01/19/15 and physician order dated 02/13/15 revealed an order for Breo-Ellipta 100/25mcg inhale one puff daily. (Breo-Ellipta is used to treat chronic obstructive pulmonary disease by relaxing the muscles in the airways and increasing airflow to the lungs.) Observation during the 8:00 am medication pass on 05/28/15 at 7:45 am revealed: - The contract pharmacy prepackaged the residents' medications in plastic strips, with several medications in each package, labeled with the time of administration. - The Medication Aide (MA) used the medication administration record (MAR) to compare the medications in the prepackaged strips and the MAR prior to administering the medications. - The MA administered 10 oral medication, and one nebulizer solution to Resident #5. - The MA did not administer any Breo-Ellipta to Resident #5 during the 8:00 am medication pass. - The MA documented administration of the 8:00 am medications on the May 2015 medication administration record (MAR) immediately after administration of medications. Review of Residen # 5's May 2015 MAR revealed: - Breo-Ellipta 100/25mcg inhale one puff daily was listed and scheduled for administration at 8:00 am daily. - Administration of Breo-Ellipta daily was	D 358		

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D 358	Continued From page 55 documented from 5/01/15 to 5/28/15, including 5/28/15. Telephone interview on 5/28/15 at 11:15 am with the contract pharmacy representative revealed: - Breo-Ellipta 100/25mcg was dispensed for a 30 day supply for Resident #5 on 2/13/15, 2/25/15, and 04/07/15. (The pharmacy was unable to explain why there were 2 dispensing dates in February but thought it may have something to do with insurance and prior authorization for billing.) - Resident #5 should be running out of medication or already out. - The facility had not reordered Breo-Ellipta since 04/07/15. Interview on 5/28/15 at 11:40 am with Resident #5 revealed: - He took a lot of medications each day. - He was not aware of all the medications by name but he knew he did not get his inhaler this morning. - He used the nebulizer solution and was getting along just fine with his breathing so far today. Interview on 05/28/15 at 2:40 pm with the medication aide revealed: - She was nervous during the medication pass. - She recalled she did not administer Breo-Ellipta to Resident #5. - She overlooked documenting Breo-Ellipta as not administered when she went down the medications on the MAR for documentation. - She thought the resident had the medication on cart during the medication pass on 5/27/15 but he must have run out. Interview on 05/28/15 at 5:00 pm with the Administrator in Training (AIT) revealed: - The medication aide had been very nervous	D 358		

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D 358	Continued From page 56 during the medication pass. - She had told the AIT that Resident #5 did not have Breo-Ellipta for administration and the pharmacy had been contacted today (05/28/15). b. Observation during the 8:00 am medication pass on 05/28/15 at 7:45 am revealed: - The contract pharmacy prepackaged the residents' medications in plastic strips, with several medications in each package, labeled with the time of administration. - The medication aide used the medication administration record (MAR) to compare the medications in the prepackaged strips and the MAR prior to administering the medications. - Medication aide administered 10 oral medication, including 2 furosemide 40 mg tablets (80mg) to Resident #5. (Furosemide is used to treat swelling and high blood pressure.) - Medication aide documented administration of the 8:00 am medications on the May 2015 medication administration record (MAR) immediately after administration of medications. Review of Resident #5's record revealed: - Furosemide 40 mg was not listed on the current FL-2 dated 01/19/15. - A subsequent telephone physician's order dated 01/28/15 ordering furosemide 40 mg (2) tablets in the morning and (1) tablet at bedtime. (The order was from the previous facility and was not signed.) - A physician encounter form dated 03/30/15 listing Resident #5's medications, not including furosemide 40 mg (2) tablets in the morning and (1) tablet at bedtime. - No order to discontinue furosemide. - No documentation for the facility contacting Resident #5's physician regarding furosemide 40 mg.	D 358		

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D 358	Continued From page 57 Telephone interview on 05/28/15 at 11:15 am with the pharmacy provider representative revealed: - Resident #5 had transferred to the facility from another facility that the pharmacy provided medications and medication administration records (MAR). - Pharmacy received the FL-2 dated 01/19/15 from the current facility on 02/17/15. - Pharmacy had not received an order to discontinue furosemide. - The pharmacy had not received the physician encounter form dated 03/30/15 from the facility. - The FL-2 dated 01/19/15, from the previous facility, and the subsequent physician's order dated 01/28/15, from the previous facility, for furosemide 40 mg were used to prepare the resident's MAR and package the medications. Interview on 5/28/15 at 11:40 am with Resident #5 revealed: - He took a lot of medications each day. - He thought he took a medication for fluid because he had experienced swelling in his ankles and a fluid pill helped the swelling. - He depended on the staff to administer medications as ordered. Interview on 5/28/15 at 2:40 pm with the Medication Aide revealed: - The Medication Aides worked 12 hour shift. - One Medication Aide worked on each shift. - She was trained to compare the medications prepackaged by the pharmacy provider to the current MAR for accuracy. - She did not routinely enter medications on the MAR; the Administrator in Training (AIT) or the owner processed the medications orders and communicated with the pharmacy provider. - She administered medications according to the	D 358		

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D 358	Continued From page 58 MAR and prepackaged medications. - If a medication was not on the MAR or not in the prepackaged medication she would not have administered the medication. - She administered furosemide since it was on the MAR . Interview on 5/28/15 at 4:00 pm with AIT revealed: - All orders and FL-2s were supposed to be faxed to the pharmacy for their review. - She routinely processed all orders for residents. - She did not currently have a system in place to routinely audit resident ' s medication orders for comparing all the residents' current orders to the MAR. - She was responsible to audit the residents' month to month MARs at the beginning of each month for any medications that were added or discontinued to the previous month's MAR after the MAR was printed. - Medication aides occasionally processed new admissions if she was not at the facility, but that was not very often. - She had a plastic file holder on the wall in the medication room for medications aides to place in order they processed for her review the next day. - She was not aware the order for Resident #5's furosemide was not on the physician encounter form dated 03/30/15; she must have overlooked the medication not listed on the encounter form. - She would fax the encounter form to the pharmacy and the current Nurse Practitioner for review. Interview on 6/04/15 at 5:30 pm with the facility manager revealed: - The AIT was responsible for monitoring residents' health care and medications. - The AIT was assisted by the owner with	D 358		

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D 358	Continued From page 59 managing the resident's care and medications. - He spent most of his time with the managing the building and dealing with residents. 2. Review of Resident #4's current FL-2 dated 05/05/15 revealed diagnoses including hypoglycemia, Type I Diabetes, and chronic kidney disease. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 01/15/15. Review of Resident #4's record revealed a Hospital Discharge Summary dated 05/06/15 ordering insulin as follows: - Fingerstick blood glucose (FSBG) before meals and at bedtime. No bedtime insulin coverage. - Levemir insulin 6 units at 9 am. (Levemir is a long acting insulin analog.) - Novolog insulin (nutritional dose) scheduled dose of 2 units with breakfast, 2 units with lunch, and 2 units with dinner. (Novolog insulin is a rapid acting insulin analog.) - Novolog insulin sliding scale insulin (SSI) after each meal (correctional dose). No bedtime coverage. - Administer nutritional and correctional dose (scheduled and SSI) after meals if FSBG great than 70 mg/dl as follows: If patient does not eat any meal, do not give scheduled dose only give SSI dose; if patient eats less than half of meal, give half of schedules dose plus SSI dose; if patient eats greater than or equal to half of meal, give full scheduled dose plus SSI. - SSI dosing scale ordered was FSBG 200-300= 2 units, FSBG 301-375= 3 units, and FSBG 376-400= 4 units. a. Observation of the 11:00 a.m./12:00 noon	D 358		

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D 358	Continued From page 60 medication pass on 05/28/15 revealed: - The Medication Aide (MA) obtained a FSBG value for Resident #4 at 11:54 am. - The MA stated based on FSBG value of 198, scheduled dose of 2 units of Novolog insulin and FSBG value below the minimum value on Resident #4's SSI scale, the resident was to receive 2 units of insulin. - The MA was instructed to complete preparation of the insulin injection and when preparation was complete but prior to injecting the resident to allow the insulin syringe to be examined. - The MA obtained a 1cc 31guage 100 unit insulin syringe from the resident's zip-lock plastic bag, and prepared the insulin for injection. (The medication aide counted one, two out loud as she prepared the insulin injection.) - The MA then handed the insulin syringe to the surveyor for observation, stating she was ready to inject the resident. Observation of the syringe with insulin prepared by the medication aide revealed: - The syringe was calibrated in 10 unit increments; each 10 unit block had 4 hash marks (representing 2 units per hash mark) between the 10 unit increments. - The insulin dose was at the second hash mark representing 4 units of Novolog insulin to be administered. The surveyor returned the prepared insulin syringe to the MA but the MA stated she was not going to inject the resident until the Administrator in Training (AIT) was consulted because the surveyor looked at the syringe and she thought something must be wrong with the dose. The MA exited the room immediately and returned with the AIT.	D 358		

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D 358	Continued From page 61 Observation of the MA and AIT on 5/28/15 at 12:10 pm revealed: - The AIT examined the insulin syringe, consulted the MAR, questioned the MA how she obtained the dose, informed the MA that on this syringe each mark represented 2 units, and informed the MA she needed to adjust the dose to the first hash mark. - The AIT stopped the MA from reinserting the syringe into the insulin bottle to express 2 units, and told her she needed to use a fresh syringe and draw up the correct dosage of insulin. - The MA drew up 2 units of Novolog insulin, presented the syringe for observation, and administered the insulin in the resident's right arm.. Interview with Resident #4 at 12:00 noon, during insulin administration, revealed: - He was headed to lunch as soon as he received his insulin injection. (He had not gone to lunch yet.) - His blood sugars had been running better since he was in the hospital earlier this month (May 2015). - He routinely received his 2 units of insulin and any additional just before he was on the way to the dining room because his blood sugar could drop really fast. Interview on 5/28/15 at 12:12 pm with the MA revealed: - She had been working at the facility for a couple of months. - The MAs worked 12 hour shift and she routinely worked day shifts. - She had prepared Resident #4's insulin injection counting 2 hash marks for 2 units. - She stated the facility had been using a different type of syringe until about 2 weeks ago.	D 358		

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D 358	Continued From page 62 - Only after she presented the insulin syringe for observation did she begin to question the dose. - She was nervous during observation by the surveyor. - She did not realize, at the time, each hash mark on this syringe represented 2 units. - The MA stated the facility was not using the 100 unit insulin syringes until a couple of week ago. - She administered the insulin according to the times scheduled on the MAR. Observation of Resident #4 on 05/28/15 at 12:20 pm revealed the resident was eating his lunch in the dining room. Interview on 05/28/15 at 12:30 pm and 05/29/15 at 10:00 am with the AIT revealed: - The facility had been using the 50 unit syringes (each hash mark representing 1 unit) until about 2 weeks ago. - The AIT had trained the MA for insulin administration. - The contract facility Nurse completed the Medication Aides' Checklist and routinely went over insulin syringes during the checklist sign off. - She did not know why the MA prepared the incorrect dosage of Novolog for Resident #4. Interview on 06/03/15 at 12:45 pm with the AIT revealed: - She faxed Resident #4's current order for insulin to the pharmacy after 05/06/15. - The pharmacy had already prepared the MAR for May 2015. - Resident #4's current sliding scale was transcribed to the MAR correctly but the time of administration was not listed. - Medication aides had been administering Resident #4's SSI along with the fixed dosage just before the resident went to his meal.	D 358		

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D 358	Continued From page 63 Interview on 06/03/15 at 12:58 pm with Resident #4 revealed: - Staff administered his insulin just before he ate his meals. - He had been doing much better since he was in the hospital in early May 2015. - He was eating every meal and received extra food. - He had not experienced any really low blood sugars recently. Telephone interview on 06/03/15 at 1:00 pm with the facility Nurse Practitioner revealed: - Resident #4 was prone to hypoglycemia. - It was much safer for the resident to receive his insulin (Novolog) after he had eaten a meal. Interview on 6/04/15 at 5:30 pm with the facility manager revealed: - The AIT was responsible for monitoring residents' health care and medications. - The AIT was assisted by the owner with managing the resident's care and medications. - He spent most of his time with the managing the building and dealing with residents. b. Observation of Resident #4's insulin administration on 05/29/15 at 11:55 am by a second dayshift medication aide revealed: - MA obtained a fingerstick blood glucose (FSBG) value of 351. - MA consulted Resident #4's medication administration record (MAR) for the sliding scale insulin dose of Novolog and scheduled dose of Novolog. - MA stated based on FSBG value of 351, scheduled dose of 2 units of Novolog insulin and FSBG value below the minimum value on Resident #4's SSI scale, the resident was to	D 358		

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D 358	Continued From page 64 receive 2 plus 3 units of Novolog insulin. - MA was instructed to complete preparation of the insulin injection and when preparation was complete but prior to injecting the resident to allow the insulin syringe to be examined. - MA obtained a 1cc 31guage 100 unit insulin syringe from the resident's zip-lock plastic bag, and prepared the insulin for injection. - MA then handed the insulin syringe to the surveyor for observation, stating she was thought the dose was correct but she had to go half way between the 2 (4 units) and 3 (6 units) hash marks on the syringe because there was no line for 5 units. Interview at 11:58 am with the MA revealed: - She was not comfortable administering the insulin dose without having the Administrator in Training (AIT) check the dosage first. - This was her second day at work working the medication cart alone. - She had trained on the medication cart with the AIT and another MA. - She had worked as a medication aide at another facility before coming to this facility. - She had her Medication Aide Checklist done by the facility Nurse. - She was going to get the AIT to check the insulin dose before she was ready to give the insulin dose. Observation on 05/29/15 at 12:00 pm revealed: - The AIT came into the room with the MA. - MA explained to the AIT how she measured the 5 units of Novolog insulin for Resident #4. (Measure halfway between the 2nd and 3rd hash mark for 5 units). - The AIT checked the dosage and instructed the MA to administer the SSI.	D 358		

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D 358	Continued From page 65 Observation of Resident #4 on 05/28/15 at 12:20 pm revealed the resident was eating his lunch in the dining room. Interview on 05/28/15 at 12:30 pm and 05/29/15 at 10:00 am with the AIT revealed: - The facility had been using the 50 unit syringes (each hash mark representing 1 unit) until about 2 weeks ago. - The AIT had trained the MA for insulin administration. - The contract facility Nurse had checked the completed the Medication Aide Checklist and routinely goes over insulin syringes during the checklist sign off. Interview on 05/29/15 at 12:00 pm with the AIT revealed: - She was responsible for monitoring the medication aides for medication administration. - When the pharmacy provider started sending 100 unit insulin syringes about 2 weeks ago, she instructed staff to go half way between the hash marks to measure odd units of insulin. - She had contacted the pharmacy provider for insulin syringes that would measure odd units. - She was aware the medication aides were guessing for the halfway point for odd units of insulin. Interview on 06/03/15 at 12:45 pm with the AIT revealed: - She faxed Resident #4's current order for insulin to the pharmacy after 05/06/15. - The pharmacy had already prepared the MAR for May 2015. - Resident #4's current sliding scale was transcribed to the MAR correctly but the time of administration was not listed. - Medication aides had been administering	D 358		

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D 358	Continued From page 66 Resident #4's SSI along with the fixed dosage just before the resident went to his meal. Interview on 06/03/15 at 12:58 pm with Resident #4 revealed: - Staff administered his insulin just before he ate his meals. - He had been doing much better since he was in the hospital in early May 2015. - He was eating every meal and received extra food. - He had not experienced any really low blood sugars recently. Telephone interview on 06/03/15 at 1:00 pm with the facility Nurse Practitioner revealed: - Resident #4 was prone to hypoglycemia. - It was much safer for the resident to receive his insulin (Novolog) after he had eaten a meal. Interview on 6/04/15 at 5:30 pm with the facility manager revealed: - The AIT was responsible for monitoring residents' health care and medications. - The AIT was assisted by the owner with managing the resident's care and medications. - He spent most of his time with the managing the building and dealing with residents. B. Review of Resident #3's current FL-2 dated 03/09/15 revealed diagnoses included of schizophrenia and hypertension. 1. Review of the current FL-2 dated 03/09/15 revealed an order for potassium chloride 40 milliequivalents (meq) daily. (Potassium chloride is a potassium supplement to replace depleted potassium levels in the body. Potassium is essential for build proteins and muscles, break down fats and carbohydrates, and control the	D 358		

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D 358	Continued From page 67 electrical activity of the heart.) Review of Resident #3's record revealed: - Potassium chloride 20 meq daily was listed on current medications on physicians' encounter sheet dated 02/02/2015. - The resident was admitted to a local hospital psychiatric unit room 02/12/15 to 02/27/15. (The resident was admitted to the unit for behaviors and it was documented in the history that the resident was refusing all medications prior to admission.) - Potassium level was documented as 2.7 meq/liter on the discharge paperwork dated 02/24/15 (Normal range is 3.5 to 5.0 meq/liter). - Potassium chloride 40 meq daily was ordered on 02/27/15. - Potassium chloride 40 meq daily was ordered on the current FL-2 dated 03/09/15. - Potassium chloride 40 meq daily was discontinued on a telephone order to the pharmacy from the resident's primary care physician on 3/13/15 (with notation the resident (patient) has an appointment on 03/31/15). - Potassium chloride 20 meq daily was listed on current medications on the physician's encounter sheet dated 03/31/15. Review of Resident #3's Medication Administration Record (MAR) for February 2015 revealed: - Potassium chloride 20 meq daily was listed, scheduled for administration at 8:00 am daily. - Potassium chloride 20 meq was documented as refused from 02/01/15 to 02/12/15. (The resident was admitted to the unit for behaviors and it was documented in the history that the resident was refusing all medications prior to admission.) Review of Resident #3's MAR for March 2015	D 358		

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D 358	Continued From page 68 revealed potassium chloride 40 meq daily was transcribed on MAR, scheduled for administration at 8:00 am daily, and documented for administration from 03/01/15 to 03/22/15. Review of Resident #3's April 2015 and May 2015 MARs revealed potassium chloride 20 meq daily was not listed or transcribed on MARs. (No documentation for administration of potassium chloride was available. Interview on 5/28/15 at 4:00 pm with Administrator in Training (AIT) revealed: - All orders and FL-2s were supposed to be faxed to the pharmacy for their review. - She routinely processed all orders for residents. - She did not currently have a system in place to routinely audit residents' medication orders for comparing all the residents' current orders to the MAR. - She was responsible to audit the residents' month to month to MARs at the beginning of each month for any medications that were added or discontinued to the previous month's MAR after the MAR was printed. - Medication aides occasionally processed new admissions if she was not at the facility, but that was not very often. - She had a plastic file holder on the wall in the medication room for medications aides to place in order they processed for her review the next day. - She was not aware Resident #3's potassium chloride 20 meq was listed as current medications on the physician encounter form dated 03/31/15. - She was not aware the physician encounter form dated 03/31/15 had not been faxed to the pharmacy as was the policy. - She related it must have been overlooked.	D 358		

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	HAL035027		R 06/04/2015

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D 358	Continued From page 69 Observation of the medication on hand for administration for Resident #3 on 05/28/15 revealed: - The contract pharmacy prepackaged the residents' medications in plastic strips, with several medications in each package (labeled for the medication of each package), labeled with the times of administration. The packages were in a continuous strip, with repeated days. - Potassium chloride was not included in the medications dispensed for Resident #3. Interview on 05/28/15 at 6:15 pm with the medication aide (MA) revealed: - The medication aides worked 12 hour shift. - One medication aide worked on each shift. - She was trained to compare the medications prepackaged by the pharmacy provider to the current MAR for accuracy. - She did not routinely enter medications on the MAR; the Administrator in Training (AIT) or the owner processed the medications orders and communicated with the pharmacy provider. - She administered medications according to the MAR and prepackaged medications. - If a medication was not on the MAR or not in the prepackaged medication she would not have administered the medication. Telephone interview on 5/29/15 at 1:30 pm with a representative of the contract pharmacy revealed: - The facility was on 15 days cycle fills for residents' regular medications. - Routinely the pharmacy fills cycle medication orders for the facility for days 1-15 of the month and days 15-30 of the month. - The pharmacy filled the residents' medications in plastic prepackaged units. - The pharmacy received the physician's order for Resident #3's potassium 40 meq daily dated	D 358		

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D 358	Continued From page 70 02/27/15. - The pharmacy filled the potassium chloride 40 meq daily order until the discontinue order on 03/13/15. - The pharmacy did not have an order for potassium chloride for Resident #3 subsequent to 3/13/15. - The pharmacy had not dispensed potassium chloride for Resident #3 since the discontinue order on 03/13/15. Interview on 6/04/15 at 5:30 pm with the facility manager revealed: - The AIT was responsible for monitoring residents' health care and medications. - The AIT was assisted by the owner with managing the resident's care and medications. - He spent most of his time with the managing the building and dealing with residents. Interview on 06/02/15 at 5:20 pm with Resident #3's current general medicine Nurse Practitioner revealed: - She was aware Resident #3 had not been receiving Potassium chloride supplement. - She discovered the resident was not taking potassium during a visit in late May. - She stated she ordered a laboratory value for potassium to find out the level. - She stated the resident had told her he refused to take the potassium supplement when he was on it before because it made his stomach hurt and she advised the resident how important the medication was for his system. - She stated she restarted the potassium at 40 meq on 5/29/15 after she received the laboratory results. - She stated she was aware Resident #3 would not than likely not take the potassium regularly but she was going to try to get him to take it.	D 358		

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D 358	Continued From page 71 Observation on 6/04/15 at 4:30 pm of a conversation with the facility manager and Resident #3 revealed the facility manager was encouraging the resident that he should take potassium chloride because it was very important. Resident #3 refused interviews on 05/28/ 15 and 5/29/15 regarding his medications. 2. Review of Resident #3's record revealed: - Documentation on the physician's encounter forms (generated for facility visits by the primary care Nurse Practitioner) dated 02/02/15 and 3/31/15 ordering Terazosin 10 mg at bedtime as a current medication. (Terazosin is used to treat high blood pressure and enlarged prostate). - Review of the current FL-2 dated 03/09/15 revealed terazosin 10 mg was not included in the medications ordered for Resident #3. - A facility "Medication Clarification Form" dated 3/30/15 for Resident #3's terazosin dated 3/30/15 stating "Terazosin 10 mg 2 capsules at bedtime on the resident's MAR but isn't on the FL-2. Is this medication D/C [discontinued]. " - The response noted on the bottom of the facility "Medication Clarification Form" dated 3/30/15 was "Patient should be on terazosin 10 mg at bedtime. I will fax the last progress notes with order." (The form was date stamped as faxed on 3/31/15.) - Physician's orders for 6 months medication renewal (generated by the pharmacy provider) signed by the current Nurse Practitioner but not dated had terazosin 20 mg at bedtime listed. (The renewal was fax dated as received 05/28/15.) Telephone interview on 5/28/15 at 2:00 pm with a representative for the pharmacy provider	D 358		

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D 358	Continued From page 72 revealed: - The contract pharmacy prepackaged residents' medications in plastic strips, with several medications in each package (labeled for the medication of each package), labeled with the times of administration. - The pharmacy used the current orders on file at the pharmacy to dispense the residents' medications. - The facility was on 15 days cycle fills for residents' regular medications. - Routinely the pharmacy fills cycle medication orders for the facility for days 1-15 of the month and days 15-30 of the month. - The facility was responsible to fax all medication orders including, all discharge summaries, FL-2s, prescriptions and physicians' encounter forms to the pharmacy for maintaining current medication orders. - The pharmacy filled terazosin 20 mg at bedtime from an order on an FL-2 dated 10/08/14. - The pharmacy had not received subsequent orders for terazosin, including the clarification order dated 03/31/15. Review of Resident #3's April 2015 and May 2015 Medication Administration Records (MARs) revealed terazosin 10 mg 2 capsules (20 mg) at bedtime was listed and documented for administration from 04/01/15 to 5/28/15. Observation of the medication on hand for administration for Resident #3 on 05/28/15 revealed: - The contract pharmacy prepackaged the residents' medications in plastic strips, with several medications in each package (labeled for the medication of each package), labeled with the times of administration. The packages were in a continuous strip, with repeated days.	D 358		

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D 358	Continued From page 73 - Terazosin 10 mg 2 capsules (20 mg) at bedtime was included in the prepackaged medications labeled for administration at 8:00 pm. Interview on 06/02/15 with the facility's current Nurse Practitioner (NP) revealed: - The facility had recently switched to the current physician group. - The NP came to the facility every Tuesday to see residents' acute needs and was working her way through the residents for evaluations. - She had seen Resident #3 last week and referred him out for a minor surgery procedure. - She was not aware the previous general medicine practitioner had changed the Resident #3's terazosin from 20 mg at bedtime to 10 mg at bedtime when she signed the medication renewal. - She stated she would review the resident's record for the dose of the terazosin. - She was aware from documentation in the resident's record that the resident was very non-compliant with taking his medications and often refused medications. Interview on 5/28/15 at 4:00 pm with Administrator in Training (AIT) revealed: - All orders and FL-2s were supposed to be faxed to the pharmacy for their review. - She routinely processed all orders for residents. - She was responsible to audit the residents' month to MARs at the beginning of each month for any medications that were added or discontinued to the previous month's MAR after the MAR was printed. - Medication Aides occasionally processed new admissions if she was not at the facility, but that was not very often. - She had a plastic file holder on the wall in the medication room for medications aides to place in	D 358		

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D 358	Continued From page 74 order they processed for her review the next day. - She was not aware the physician encounter form dated 03/31/15 had not been faxed to the pharmacy as was the policy. (It must have been overlooked.) - She was not sure why she did not see the clarification in the resident's record. - She did not currently have a system in place to routinely audit resident's medication orders for comparing all the residents' current orders to the MAR. Interview on 6/04/15 at 5:30 pm with the Manager revealed: - The AIT was responsible for monitoring residents' health care and medications. - The AIT was assisted by the owner with managing the resident's care and medications. - He spent most of his time with the managing the building and dealing with residents. Resident #3 refused interviews on 05/28/ 15 and 5/29/15 regarding his medications. C. Review of Resident #11's current FL-2 dated 5/19/2015 revealed: - Diagnoses included depression, hypertension, and hyperlipidemia. - The resident was ambulatory. - An order for Tylenol 500 mg take 2 tablets every 4 hours as needed for pain or fever greater than 100. Observation on 5/27/15 at 10:30 am during the initial tour of the facility revealed Resident #11 was wearing a lace-up canvas boot with a hard bottom. The resident was ambulating around the facility without an assistive device. Interview on 5/27/15 at 11:30 am with Resident	D 358		

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D 358	Continued From page 75 #11 revealed: - He had fractured his foot outside the facility. - He was able to move around the facility if he took his time. Review of a discharge summary for Resident #11 from a local hospital emergency department dated 05/25/15 revealed: - Diagnosis of fracture mid metatarsal right foot. - Out of work for 3 days. - An order for Percocet 5/325 one tablet every 8to 12 hours for severe pain. (Percocet is a narcotic pain reliever.) - Order Tylenol 650 mg alternating with Aleve 200 mg every 12 hours for mild pain. (Tylenol is used to treat mild pain. Aleve is a non-steroidal anti-inflammatory drugs used to treat mild pain and inflammation.) Review of Resident #11's May 2015 Medication Administration Record (MAR) revealed: - Tylenol 650 mg alternating with Aleve 200 mg every 12 hours for mild pain was not listed on the MAR. - Percocet 5/325 one tablet every 8 to 12 hours was handwritten on the MAR. Review of the June 2015 MAR revealed: - "Tylenol 325 mg take 2 tablets every 12 hours for mild pain. Alternate with Aleve 220 mg." (Aleve contains 200 mg of Naproxen.) - Tylenol was scheduled for administration at 8:00 am and 8:00 pm. - "Aleve 220 mg take one tablet every twelve hours for mild pain. Alternate with Acetaminophen." (Acetaminophen is generic for Tylenol.) - Acetaminophen was scheduled for administration at 8:00 am and 8:00 pm. - Acetaminophen and Aleve were documented for	D 358		

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D 358	Continued From page 76 administration at 8:00 am and 8:00 pm daily on 06/01, 06/02, 06/03 and at 8:00 am on 06/04. Telephone interview on 06/04/15 at 4:15 pm with the Pharmacist at the contract pharmacy revealed: - The pharmacy received the order dated 05/25/15. - A staff pharmacist entered the order and scheduled both medications at 8:00 am and 8:00 pm. - The pharmacy did not send the medications because they were over the counter medications and the facility had house stock of the medications. - The Pharmacist stated she did not enter the order but it should have been scheduled as alternating; perhaps 8:00 am and 8:00 pm for one and 2:00 am and 2:00 pm for the other. Interview on 6/04/15 at 4:10 pm with the Administrator in Training (AIT) revealed: - Resident #11 had not asked for the Tylenol and Aleve in May 2015 because he had Percocet and the pain was worse the first few days. - She was responsible to review all orders compared to the MAR for residents. - She was not aware the pharmacy had entered the order for Resident #11's Aleve and Tylenol to be administered at the same times instead of alternating. - The order was not scheduled correctly. - She did not identify the order was correct when she did the audit of MARs prior to placing the MARs on the medication cart for the Medication Aides. - According to documentation on the MAR, Medication Aides had administered both medications together instead of alternating the medications.	D 358		

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D 358	Continued From page 77 - She would get a clarification from the contract Nurse Practitioner. Interview on 06/04/15 at 7:00 pm with a Medication Aide revealed: - She had been working at the facility for about 10 days. - She had administered Aleve and Tylenol to Resident #11 this morning at 8:00 am. - She stated she gave both at the same time according to the scheduled times on the MAR. - She did not read the directions for alternating the medications so she had not checked with the AIT for clarification. Interview on 06/04/15 at 7:45 pm with Resident #11 revealed: - He had been receiving the 2 new pain medications (not sure of the name) together at 8:00 am and 8:00 pm. - The medications helped his pain. - He had been to the doctor today and received a new walking boot for his foot. - He had not experienced of any negative side effects from any of his medications. _____ The Administer in Training provided a Plan of Protection dated 05/29/15 as follows: - All Medication Administration Records will be compared to the medications and all physicians' orders for accuracy. - Staff will be immediately in-serviced for administration of medications, including insulin and syringe doses. - The pharmacy will be contacted for any clarification. - The Executive Director will be responsible for monitoring on protocol. CORRECTION DATE FOR THE TYPE B	D 358		

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D 358	Continued From page 78 VIOLATION SHALL NOT EXCEED JULY 19, 2015.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record of controlled substances for the receipt, administration and disposition of the controlled substances for 3 of 5 sampled residents (#1, #7, and #10) with orders for narcotic pain medications. The findings are: A. Review of Resident #10's current FL-2 dated 05/29/15 revealed diagnoses including chronic obstructive pulmonary disease exacerbation. Previous FL-2 dated 01/29/15 revealed diagnoses including bipolar disorder. Review of Resident #10's record revealed a physician's order dated 04/13/15 prescribing Percocet 10/325 one tablet by mouth 4 times a day for 30 days. (Percocet is a combination narcotic pain reliever with acetaminophen used to treat severe pain.) Review of Resident #10's record revealed a	D 392		

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D 392	Continued From page 79 physician's order dated 4/13/15 prescribing Percocet 10/325 one tablet 4 times a day with a quantity of 120 tablets. Telephone interview on 06/01/15 at 11:38 am with the contract pharmacy representative revealed: - Resident #10 had Percocet 10/325 dispensed on 4/13/15 for a quantity of 120 tablets. - Percocet 10/325 for 120 tablets was dispensed on 05/11/15 for Resident #10. 1. Review of Resident #10's Medication Administration Record (MAR) and Controlled Drug Record (provided by the contract pharmacy along with the dispensed medication) for April 2015 and May 2015 revealed: - Percocet 10/325 mg was dispensed on 4/13/15 for a quantity of 120 tablets with instruction for one tablet 4 times a day. - Percocet 10/325 was scheduled for 6:00 am, 10:00 am, 2:00 pm and 6:00 pm daily and documented as administered at 6:00 am, 10:00 am, 2:00 pm and 6:00 pm on the MAR. - Documentation on the Controlled Drug Record (CDR) sheets from 4/14/15 to 5/12/15 for administration of 120 tablets. - Documentation for administration on the CDR sheets was inconsistent with the administration documented on the MARs. Examples of the inconsistency on the CDR sheets for Percocet 10/325 were as follows: - On 4/15/15 at 6:00 pm, one tablet documented as administered at 6:00 pm by one Medication Aide, and another tablet at 6 pm by a different Medication Aide. - On 4/20/15 at 6:00 pm, one tablet documented as administered (leaving a remainder of 31) tablets at the bottom of the first column on the last sheet; then one tablet documented as	D 392		

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D 392	Continued From page 80 administered at the same time on the top line of the second column (for a remainder of 30 tablets). - On 04/29/15, one tablet documented as administered at 6:00 am, 10:00 am, 2:00 pm and 6:00 pm; another tablet documented for administration at 6:00 am, and count adjusted (removing 3 tablets) with no time or reason entered. - On 05/01/15, one tablet documented as administered at 8:00 am, 12:00 noon, 2:00 pm, 4:00 pm, and at 6:00 pm. - On 05/04/15, one tablet documented as administered at 2:00 pm, 6:00 pm, and 8:00 pm (8:00 pm dose not on MAR). - On 05/11/15, one tablet documented as administered at 2:00 am, 10:00 am, 2:00 pm, and 5:55 pm. - On 05/12/15, one tablet was logged as administered at 6:00 am. - A total of 120 tablets were logged as administered from 04/14/15 to 05/12/15 at 6:00 am on the CDR sheets. A total of 116 tablets should have been used. Refer to telephone interview on 06/01/15 at 11:38 am with the contract pharmacy representative. Refer to interview on 06/04/15 at 6:00 pm with the AIT. 2. Review of Resident #10's Medication Administration Record (MAR) for May 2015 and June 2015 for Percocet 10/325 mg revealed: - Percocet 10/325 was scheduled for 6 am, 10 am, 2 pm and 6 pm daily and documented as administered at 6 am, 10 am, 2 pm and 6 pm from 05/11/15 to 5/23/15 at 6 am. - Resident #10 had documentation Percocet 10/325 mg was not administered from 05/23/15 to	D 392		

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D 392	Continued From page 81 5/29/15 (resident in hospital). - Resident #10 had documentation for administration of Percocet 10/325 mg from 05/01/15 to 05/22/15, 05/3015 and 05/31/15. Review of Resident 10's record on 06/01/15 revealed no log for documentation available for tracking the Percocet 10/325 dispensed on 05/11/15. On 06/01/15 at 9:50 am, a request was made to the Administrator in Training (AIT) for the Controlled Drug Record (CDR) sheets for Resident #10's Percocet 10/325 dispensed on 05/11/15. As of 5:00 pm on 06/01/15, the CDR sheets were not made available. On 6/02/15 at approximately 11:00 am, the AIT provided 2 handwritten CDR sheets for Resident #10's Percocet 10/325 dispensed on 05/11/15 for 120 tablets. (One sheet had documentation for 60 tablets logged out as administered; the other sheet was current with documentation for 45 tablets logged out as administered and matched the current medication on hand for administration quantity.) Review of the handwritten CDR sheet for the 60 Percocet 10/325 logged as administered from 05/11/15 through 05/23/15 at 6:00 am revealed: - The medication and directions were handwritten, which was inconsistent with the sheets provided to the facility as preprinted. - Most of the dates appeared to be in the same handwriting. - Documentation for administration on the CDR sheets was inconsistent with the administration documented on the MARs. Review of the CDR sheets for Resident #10's	D 392		

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D 392	Continued From page 82 documentation for administration of 120 tablets dispensed on 5/11/15 revealed examples of inconsistency as follows: - On 05/11/15, Percocet 5/325 was documented as administered at 6:00 am, 10:00 am, 2:00 pm, and 6:00 pm. (This was a duplicate of administration recorded on the CDR sheet for tablets dispensed on 04/13/15, when administration on 05/11/15 was documented as administered at 2:00 am, 10:00 am, 2:00 pm, and 5:55 pm also.) - On 05/12/15 at 6:00 am, administration was documented on both the CDR sheets for dispensing on 4/13/15 and on 5/11/15. - On 05/12/15 at 6:00 pm, two entries were logged on the CDR; each entry was by a different medication aide. - On 05/20/15, administration was documented on the CDR at 6:00 am, 10:00 am, 2:00 pm, 6:00 pm and an extra entry on 05/20/15 with no time entered. (The following entry was at 6:00 am on 05/21/15). Refer to telephone interview on 06/01/15 at 11:38 am with the contract pharmacy representative. Refer to interview on 06/04/15 at 6:00 pm with the AIT. B. Review of Resident #1 current FL-2 dated 01/24/15 revealed diagnoses including gastrointestinal bleeding secondary to diverticulosis, and episodes of hypertension from narcotic use. Review of Resident #1's record revealed previous diagnoses included major depressive disorder recurrent severe with psychotic feature, diabetes and congestive heart failure.	D 392		

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D 392	Continued From page 83 Review of Resident #1's record revealed a physician's order dated 04/02/15 for Norco 10/325 mg one every 4 hours, as needed for pain. (Norco is a combination narcotic pain reliever and acetaminophen used to treat severe pain.) 1. Review of Resident #1's Medication Administration Record (MAR) for April 2015 and Controlled Drug Record (provided by the contract pharmacy along with the dispensed medication) revealed: - Norco 10/325 mg was dispensed on 4/01/15 for a quantity of 120 tablets with instruction for one tablet 4 times a day. - A physician's order dated 04/02/15 to change the instructions to change to one tablet every 4 hours as needed for pain. - Norco 10/325 was listed for one tablet every 4 hours as needed for pain on the April 2015 MAR. - Documentation on the Controlled Drug Record (CDR) sheets from 04/02/15 to 04/19/15 for administration of 120 tablets. - Documentation for administration on the CDR sheets was inconsistent with the administration documented on the MARs. Review of the April 2015 MAR compared to the CDR sheets from 04/02/15 to 04/19/15 revealed 69 doses of Norco 10/325 mg documented on the MAR and 105 doses documented for administration on the CDR sheet. Examples of the inconsistency on the CDR sheets compared to the MAR were as follows: - Examples of administration documented on the CDR sheet but not on the MAR were: on 04/03 at 3:00 am, on 04/04 at 3:00 am, 04/04 at 7:00 pm and 11:00 pm, 04/05 at 3:00 am, 04/05 at 4:00 pm and 8:00 pm, 04/08 at 8:00 pm, 04/09 at 2:30	D 392		

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D 392	Continued From page 84 am and 6:30 am, 04/10 at 10:00 am, 04/11 at 12:00 am. - On 04/10/15 at 8 pm Norco 10/325 was signed out 2 times by the same medication aide. Interview on 06/01/15 at 2:00 pm with Resident #1 revealed: - She took her medication regularly. - She was not aware of how staff documented her medication. Refer to telephone interview on 06/01/15 at 11:38 am with the contract pharmacy representative. Refer to interview on 06/04/15 at 6:00 pm with the AIT. 2. Review of Resident #1's Control Drug Record(CDR) sheet for Norco 10/325 dispensed on 05/05/15 for 186 tablets revealed the Controlled Drug Record sheet sent from the pharmacy provider dated 05/05/15, documenting Norco 10/325 quantity of 186, had the quantity crossed out and 126 written. Interview during the initial tour on 05/28/15 at 11:30 am with Resident #1 revealed she had been on a leave of absence from the facility from 05/07/15 to 05/23/15. Interview on 06/02/15 at 1:50 pm with the facility Nurse Practitioner revealed: - She observed Resident #1's CDR sheet for Norco 10/325 dispensed on 05/05/15 had been changed from 186 to 126 tablets. - She stated she had called the pharmacy provider herself to ask how many Norco had been dispensed to Resident #1 on 05/05/15 and was informed 186 had been dispensed. - She was not aware of any explanation why the	D 392		

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D 392	Continued From page 85 facility changed the quantity. Review of Resident #1's Medication Administration Record(MAR) and CDR sheet for the Norco 10/325, quantity of 186 dispensed on 05/05/15 revealed: - The resident was documented out of the facility from 05/07/15 after 8:00 am to 5/23/15 at 2:00 pm. - Norco 10/325 was listed for one tablet every 4 hours as needed for pain on the May 2015 MAR. - Norco was documented as administered 22 times on the MAR from 05/23/15 to 05/31/15. - The CDR sheet listed 126 as the starting quantity on 05/07/15 and was signed on 05/07/15 by the Administrator in Training (AIT) - Documentation on the Controlled Drug Record (CDR) sheets on 05/07/15 for 2 tablets, and "Resident on LOA 60 tablets" was written on the MAR. - No documentation for administration, on the CDR sheet or the MAR, for Norco 10/325 from 05/07/15 until 05/23/15 at 11:00 am. - Documentation for administration on the CDR sheets was inconsistent with the administration documented on the MAR. Review of the resident's Medication Administration Record (MAR) for May 2015 revealed: - The resident was documented out of the facility from 05/07/15 after 8:00 am to 5/23/15 at 2:00 pm. - The May 2015 listed Norco 10/325 one tablet every 4 hours as needed for pain. - Norco was documented as administered 22 times on the MAR from 05/23/15 to 05/31/15. (No documentation for 05/07/15.) Interview on 06/01/15 at 2:00 pm with Resident	D 392		

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D 392	Continued From page 86 #1 revealed: - She had taken medications with her on her leave of absence. - She recalled signing for a bubble wrap card of 60 Norco 10/325 mg, when she left on leave. - She was not aware of signing for additional Norco 10/325 until 05/25/15 when she went out for a half day leave from the facilty. - She took her medication regularly. - She was not aware of how staff documented her medication. Interview on 06/02/15 at 10:00 am with the AIT revealed: - The facility had a binder for staff to place the residents' Medication Release/Receipt documentation and Medication Disposition Sheet for tracking the return or release of medications. - The binder was located in the medication room. - Information for any residents' medication that was signed out when going on leave or returned to the pharmacy should be in the book. - She remembered Resident #1 was going on a leave of absence on 05/07/15 and took medication with her when she left. - She stated the resident came back to the facility a couple of days later and requested an additional supply of her Norco so she gave her 60 more tablets. - She did not know what happened to the CDR sheet for the additional 60 signed out to the resident. - The facilty started documenting administration on the Norco on 05/23/15 when the resident returned to the facility. - She was not aware of any additional documentation for Resident #1's Norco. Review of the facility's Medication Release/Receipt documentation on 06/02/15	D 392		

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D 392	Continued From page 87 revealed no documentation for Norco 10 /325 for resident dated 05/07/15. Review of the facility's Medication Disposition Sheet on 06/02/15 revealed: - Two sheets with Resident #1's signature at the bottom, on the witnessed by line, and the AIT signature on the form completed by (person) line. - One sheet was clearly dated 05/07/15 and listed "Multi pack, hydrocodone 10 mg (60), and 2 other medications. The sheet was incomplete for any additional documentaion. - A second sheet was dated 05/07/15 or 05/09/15 (it was written over and the date could not be determined) and only had hydrocodone 10 mg 60 pills written on the sheet. - Both sheets were signed by the AIT and Resident #1. Refer to telephone interview on 06/01/15 at 11:38 am with the contract pharmacy representative. Refer to interview on 06/04/15 at 6:00 pm with the AIT. Based on record review and interview, it could not be determined if Resident #1 received 120 Norco 10/325 while on leave of absence from 05/07/15 to 05/23/15. The facility did not maintain a ready retrievable accounting for the Norco. C. Review of Resident #7's current FL-2 dated 12/30/14 revealed: - Diagnoses including hypertension and chronic pain syndrome. - A physician's order for Oxycodone 10 mg one tablet every 6 hours. (Oxycodone is a narcotic pain reliever.) Telephone interview on 06/01/15 at 11:00 am with	D 392		

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D 392	Continued From page 88 the contract pharmacy representative revealed: - The pharmacy received a physician's order dated 05/01/15 prescribing Oxycodone 10 mg one tablet every 6 hours as needed for Resident #7. - The pharmacy dispensed 120 Oxycodone 10 mg on 05/01/15. Review of Resident #7 record revealed a physician's order dated 05/25/15 from the facility's Nurse Practitioner to change the instructions for Resident #7's Oxycodone 10 mg to one tablet every 4 hours if needed, maximum of 4 tablets per day. Review of Resident #7's Medication Administration Record (MAR) for May 2015 and Controlled Drug Record (provided by the contract pharmacy along with the dispensed medication) revealed: - Oxycodone 10 mg was dispensed on 05/01/15 for a quantity of 120 tablets with instruction for one tablet every 6 hours, if needed for pain. - Oxycodone 10 mg was transcribed on the May 2015 MAR for one tablet every 6 hours as needed for pain from 05/01/15 to 05/24/15. - Oxycodone 10 mg was transcribed on the May 2015 MAR for one tablet every 4 hours as needed for pain beginning 05/25/15. - Documentation on the Controlled Drug Record (CDR) sheets from 05/01/15 to 06/01/15 for administration of 120 tablets. - Documentation for administration on the CDR sheets was inconsistent with the administration documented on the MAR. Review of the May 2015 MAR compared to the CDR sheets from 05/01/15 to 06/01/15 revealed 70 doses of Oxycodone 10 mg documented on the MAR and 120 doses documented for	D 392		

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D 392	Continued From page 89 administration on the CDR sheet (26 doses documented for leave of absence). Thirty-four doses were not documented on the MAR. Examples of the inconsistency on the CDR sheets compared to the MAR with administration documented on the CDR sheet but not on the MAR were as follows: - On 05/02 at 10:00 am and at 4:00 pm, - On 05/03 at 8:30 am, at 3:00 pm, and at 9:00 pm. - On 05/10 at 5:00 pm, and at 11:00 pm. - On 05/12 at 10:30 am, at no time listed, and at 8:00 pm. - On 05/17 at 3:00 am, and at 9:00 am. - On 05/26 at 3:00 am, at 9:00 am, at 3:00 pm, and at 8:00 pm. - On 05/30 at 3:00 pm. Interview on 06/01/15 at 11:55 am with Resident #7 revealed: - He took his medication regularly. - He was not aware of how staff documented his medication. Refer to telephone interview on 06/01/15 at 11:38 am with the contract pharmacy representative. Refer to interview on 06/04/15 at 6:00 pm with the AIT. _____ Telephone interview on 06/01/15 at 11:38 am with the contract pharmacy representative revealed: - The pharmacy provider dispensed a "Controlled Drug Record" sheet with each controlled medication sent to facilities. - The facility was responsible to use the Controlled Drug Record in conjunction with the Medication Administration Record (MAR) to have	D 392		

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D 392	Continued From page 90 an accounting for the disposition of the medication. Interview on 06/04/15 at 6:00 pm with the AIT revealed: - The pharmacy shipped controlled drugs by a commercial courier or by overnight mail as well as the cycle filled controlled drugs that were shipped with the regular orders (delivered by a pharmacy driver). - All controlled medications were stored in the locked controlled drug drawer in locked medication carts. - The facility received the medications and the CDR sheet rubber banded together. - The pharmacy did not routinely send an invoice for the controlled drugs with the packages that were shipped. - She and the facility owner were responsible to monitor medication aides and medication administration but did not currently have a system in place to monitor the control drugs other than the CDR sheet sent by the pharmacy.	D 392		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observation and interview, and record review, the facility failed to assure all 30 of 30 residents were treated with respect, consideration, and dignity related to the facility's negation to provide clean towels and wash cloths	D911		

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D911	Continued From page 91 to residents for bathing and showering. The findings are: Based on observation and interview, and record review, the facility failed to assure all 30 of 30 residents were treated with respect, consideration, and dignity related to the facility's negation to provide clean towels and wash cloths to residents for bathing and showering. [Refer to Tag 0338 10A NCAC 13F .0306(a)(6) Housekeeping and Furnishing (Type B Violation)]	D911		
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 observation, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with the rules and regulations as related to Housekeeping and Furnishings, Management of Facilities, Health Care, Medication Administration and Training on Cardio Pulmonary Resuscitation. The findings are: 1. Based on observation and interview, and record review, the facility failed to assure all 30 of 30 residents were treated with respect, consideration, and dignity related to the facility's negation to provide clean towels and wash cloths to residents for bathing and showering. [Refer to Tag 0338 10A NCAC 13F .0306(a)(6)	D912		

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D912	Continued From page 92 Housekeeping and Furnishing (Type B Violation)] 2. Based on observation and interview, the facility failed to assure an administrator or administrator in charge was responsible for the total operation of the facility, to meet and maintain the rules in rule areas of Housekeeping and Furnishings, Resident Rights, Health Care, Medication Administration, and Training on Cardio Pulmonary Resuscitation. [10A NCAC 13F .0601 (a) Management Of Facilites (Type B Violation)] 3. Based on interviews and record review, the facility failed to assure referral and follow up to meet the health care needs of 2 of 5 sampled residents (Resident #9, #11), failed to notify one resident's primary physician of the resident not having a walker after the resident fractured his foot and failed to have the resident seen for a follow-up by an orthopedic as ordered (#11) and failed to obtain an appointment with a nephrologist for bladder mass (Resident #9). [Refer to Tag 0273 10A NCAC 13F .0902 (b) Health Care (Type B Violation)]. 4. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 4 residents (# 4 and #5) observed during medication administration, and 2 of 4 sampled residents (#3 and #11) related to errors with administration. [Refer to tag 358 10A NCAC 13F .1004 (a) Medication Administration (Type B violation)]. 5. Based on interviews and record reviews, the facility failed to have at least one staff person on	D912		

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D912	Continued From page 93 the premises for 13 of 34 night shifts between 5/1/15 and 6/3/15 who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management. [Refer to tag 167 10A NCAC 13F .0507 Training on Cardio Pulmonary Resuscitation (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 substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or	D992		

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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
D992	Continued From page 94 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. 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 3 of 3 sampled employees (Staff A, B and C) hired after 10/1/13 before the employees began working. The findings are: A. Review of Staff A's Medication Aide employment record revealed: - Staff A was hired on 10/31/14. - Staff A was hired as a Medication Aide. - There was no documentation of completion of controlled substance examination and screening found in the record. Interview with Staff A on 5/29/15 at 9:40am revealed: - She was hired as MA in 2014 and left and came back as a Resident Care Coordinator in April 2015. - She had not been screened for controlled substances in 2014 or in 2015. Refer to interview with the Facility Manager on 5/28/15 at 2:30pmand 4:30pm. B. Review of Staff B's Medication Aide employment record revealed: - Staff B was hired on 3/23/15. - Staff B was hired as a Medication Aide. - There was no documentation of completion	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL035027		R 06/04/2015

NAME OF PROVIDER OR SUPPLIER
ESSEX MANOR ASSISTED LIVING FACILITY

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D992	Continued From page 95 of controlled substance examination and screening found in the record. Interview with Staff B on 5/28/15 at 10:05am revealed: - She was hired on 3/23/15 as a Medication Aide. - She was not screened was not screened for controlled substances. Refer to interview with the Facility Manager on 5/28/15 at 2:30pmand 4:30pm. C. Review of Staff C's Medication Aide employment record revealed: - No hire date was found in her record. - She was hired as a Medication Aide. - She received Licensed Health professional support training on 3/26/15. - She received medication clinical skills checklist on 3/26/15. - There was no documentation of completion of controlled substance examination and screening found in record. Staff C was not available for interview. Request for a hire date was given to the Facility Manager, no hire date was provided. Refer to interview with the Facility Manager on 5/28/15 at 2:30pm and 4:30Pm. _____ Interview with the Facility Manager on 5/28/15 at 2:30pm revealed: - None of the staff at the facility have been drug screened. - He did not know the staff was required to be tested for drugs.	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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D992	Continued From page 96 - He had not screened anyone for controlled substances for the 2 years he had been at the facility. - The previous employees that were already at the facility prior to his arrival had not been screened either. Interview with the Facility Manager on 5/28/15 at 4:30pm revealed: - It had been his interpretation that all he needed was to get staff consent to be tested and that would satisfy that rule area. - On the afternoon of 5/28/15 he ordered toxicology kits for all staff and would be screening all staff for controlled substances on 6/9/15.	D992		