

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL082026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2015
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NAME OF PROVIDER OR SUPPLIER CEDAR SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 670 CEDAR LAKE LANE CLINTON, NC 28328
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C 000	Initial Comments The Adult Care Licensure Section and the Sampson County Department of Social Services conducted an initial survey on 07/14/15.	C 000		
C 140	<p>10A NCAC 13G .0405(a)(b) Test For Tuberculosis</p> <p>10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 3 of 5 staff (C, D, E) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:</p> <p>1. Review of Staff D's personnel record revealed: - Staff D's hire date was 6/13/15. - Staff D was hired as a personal care aide and medication aide. - There was documentation of a negative</p>	C 140		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 140	<p>Continued From page 1</p> <p>tuberculosis (TB) skin test completed on 09/11/13.</p> <ul style="list-style-type: none"> - There was documentation of a negative TB skin test completed on 7/16/14. - There was no documentation of a TB skin test upon hire for Staff D. <p>Staff D was unavailable for interview at the facility on 07/14/15.</p> <p>Refer to interview with the Administrator /Owner on 07/14/15 at 4:00 p.m.</p> <p>2. Review of Staff E's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff E's hire date was 05/05/15. - Staff E was hired as a personal care aide and medication aide. - There was documentation of a negative tuberculosis (TB) skin test completed on 12/11/12. - There was documentation of a negative TB skin test completed on 02/10/15. - There was no documentation of a TB skin test upon hire for Staff E. <p>Staff E was unavailable for interview at the facility on 07/14/15.</p> <p>Refer to interview with the Administrator /Owner on 07/14/15 at 4:00 p.m.</p> <p>3. Review of Staff C's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff C was hired on 05/05/15 as a personal care aide and medication aide. - There was documentation of one step tuberculosis (TB) skin test documented as negative on 12/03/14. - There was no documentation of a TB skin test upon hire. 	C 140		

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C 140	<p>Continued From page 2</p> <p>Interview with the Administrator on 07/14/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> - She was unaware Staff C did not have a second step TB skin test. - She thought Staff C had a second step TB skin test. - She would contact Staff C via telephone. <p>Telephone interview with Staff C on 07/14/15 at 3:05 p.m. revealed she has not had a TB skin test since she was hired at the facility in May 2015.</p> <p>Refer to interview with the Administrator /Owner on 07/14/15 at 4:00 p.m.</p> <hr/> <p>Interview with the Administrator / Owner on 07/14/15 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - She was responsible for staff qualifications and maintaining personnel records. - She thought as long as staff had two TB skin tests it was okay. - She did not realize the two steps needed to be within 12 months of each other. - She did not realize even if staff had two TB skin tests prior to hire, they would still need another TB skin test upon hire. - She stated she would make sure the required TB skin tests were done for staff and maintained on file at the facility. 	C 140		
C 171	<p>10A NCAC 13G .0504(a) Competency Validation For Licensed Health</p> <p>10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks</p> <p>(a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as</p>	C 171		

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C 171	<p>Continued From page 3</p> <p>governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 5 of 5 facility non-licensed staff (A, B, C, D, E) sampled had been competency validated for personal care tasks specified as licensed health professional support (LHPS) tasks such as assistance with ambulation with assistive device, transfers, and applying and removing a leg/foot brace. The findings are:</p> <p>1. Review of Staff A's personnel record revealed: - Staff A was the Administrator / Owner. - There was no LHPS competency validation checklist for Staff A.</p> <p>Observations on 07/14/15 at 11:00 a.m. revealed: - Staff A provided assistance for Resident #2 with transferring from recliner to wheelchair. - Staff A provided assistance with pushing Resident #2's wheelchair into the bathroom.</p> <p>Refer to interview with Staff A (Administrator / Owner) on 07/14/15 at 4:00 p.m.</p> <p>2. Review of Staff B's personnel record revealed: - Staff B was hired on 05/04/15 as a personal care aide. - There was no LHPS competency validation checklist for Staff B.</p>	C 171		

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C 171	<p>Continued From page 4</p> <p>Interview with Staff B on 07/14/15 at 3:45 p.m. revealed:</p> <ul style="list-style-type: none"> - She assisted Resident #2 with ambulation. - She assisted Resident #2 with getting in and out of the wheelchair. - She assisted Resident #2 by taking the leg/foot brace on and off. <p>Refer to interview with Staff A (Administrator / Owner) on 07/14/15 at 4:00 p.m.</p> <p>3. Review of Staff C's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff C was hired on 05/05/15 as a personal care aide and medication aide. - There was no LHPS competency validation checklist for Staff C. <p>Staff C was unavailable for interview at the facility on 07/14/15.</p> <p>Refer to interview with Staff A (Administrator / Owner) on 07/14/15 at 4:00 p.m.</p> <p>4. Review of Staff D's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff D was hired on 06/13/15 as a personal care aide and medication aide. - There was no LHPS competency validation checklist for Staff D. <p>Staff D was unavailable for interview at the facility on 07/14/15.</p> <p>Refer to interview with Staff A (Administrator / Owner) on 07/14/15 at 4:00 p.m.</p> <p>5. Review of Staff E's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff E was hired on 05/05/15 as a personal care aide and medication aide. 	C 171		

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C 171	<p>Continued From page 5</p> <ul style="list-style-type: none"> - There was no LHPS competency validation checklist for Staff E. <p>Staff E was unavailable for interview at the facility on 07/14/15.</p> <p>Refer to interview with Staff A (Administrator / Owner) on 07/14/15 at 4:00 p.m.</p> <hr/> <p>Interview with Staff A (Administrator / Owner) on 07/14/15 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - She was unaware of a requirement for LHPS competency validation. - All staff assist Resident #2 with transferring, ambulation with wheelchair, and applying and removing leg/foot brace. - She would contact the facility's nurse to get the validations done. 	C 171		
C 230	<p>10A NCAC 13G .0801(a) Resident Assessment</p> <p>10A NCAC 13G .0801 Resident Assessment (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure that an initial assessment of each resident was completed within 72 hours of admission using the Resident Register for 2 of 2 residents (#1, #2) sampled. The findings are:</p> <ol style="list-style-type: none"> 1. Review of Resident #2's current FL-2 dated 04/23/15 revealed: -Diagnoses included cerebral vascular accident 	C 230		

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C 230	<p>Continued From page 6</p> <p>(CVA) with hemiplegia, hypertension, breast cancer with right mastectomy, seizure disorder, polycythemia vera, stress incontinence, and expressive aphasia.</p> <p>-The FL-2 did not contain documentation of Resident's #2's admission date to facility.</p> <p>Observation of Resident #2 at 10:12 a.m. on 07/14/15 revealed:</p> <p>-Resident was sitting in a recliner chair with feet elevated in the common area of the facility.</p> <p>-Resident was dressed appropriately for season.</p> <p>-Resident's right leg was elevated by one pillow.</p> <p>-There was a wheelchair sitting on the left side of the recliner.</p> <p>-There were a pair of shoes with a brace attached to the right shoe sitting on the floor beside the recliner.</p> <p>Interview with Resident #2 on 07/14/15 at 10:12 a.m. revealed:</p> <p>- The resident stated she was "sleepy" in a weak voice with slurred speech.</p> <p>- When asked if her swollen right leg hurt, the resident nodded her head up and down indicating yes.</p> <p>- When asked if she could walk, the resident moved her head from side to side indicating no.</p> <p>Interview with the Administrator / Owner at 10:15 a.m. on 07/14/15 revealed:</p> <p>-Resident #2 had a stroke.</p> <p>-Resident #2 has right sided weakness from stroke and requires assistance with activities of daily living (ADLs).</p> <p>-Resident has expressive aphasia and only responds verbally using very few words.</p> <p>-Resident had recently received a new brace.</p> <p>-Resident was getting physical therapy (PT) with most recent treatment on 07/13/15.</p>	C 230		

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C 230	<p>Continued From page 7</p> <p>Review of Resident #2's record revealed no documentation of a Resident Register with an initial assessment for Resident #2.</p> <p>Additional observation of Resident #2 11:00 a.m. on 07/14/15 revealed: -Resident was able to stand, pivot, and transfer to wheelchair with +1 assistance from facility staff. -Resident was able to shuffle her feet to self-propel her wheelchair.</p> <p>Interview with the Administrator / Owner on 07/14/15 at 11:41 a.m. revealed: -Resident #2 was admitted to the facility on 05/04/15. -The Resident Register had not been completed for Resident #2.</p> <p>Refer to interview with the Administrator / Owner on 07/14/15 at 11:41 a.m.</p> <p>2. Review of Resident #1's current FL-2 dated 06/02/15 revealed: - Diagnoses included dementia, depression, and seizures. - The admission date for Resident #1 was 06/01/15. - The resident was ambulatory. - The resident needed assistance with bathing and dressing.</p> <p>Observation of Resident #1 throughout the survey on 07/14/15 revealed the resident was ambulatory but required redirection due to cognitive impairment.</p> <p>Review of Resident #1's record revealed no documentation of a Resident Register with an initial assessment for Resident #1.</p>	C 230		

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C 230	<p>Continued From page 8</p> <p>Interview with the Administrator / Owner on 07/14/15 at 11:41 a.m. revealed a Resident Register had not been completed for Resident #1.</p> <p>Interview with the Administrator / Owner on 07/14/15 at 11:55 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #1 required supervision and prompting for bathing, dressing, grooming, toileting, and feeding. - The resident transferred and ambulated independently but required redirection because she was confused at times. <p>Refer to interview with the Administrator / Owner on 07/14/15 at 11:41 a.m.</p> <p>_____</p> <p>Interview with the Administrator / Owner on 07/14/15 at 11:41 a.m. revealed:</p> <ul style="list-style-type: none"> -She had no knowledge of the Resident Register requirement. -"I dropped the ball on that." 	C 230		
C 231	<p>10A NCAC 13G .0801(b) Resident Assessment</p> <p>10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include</p>	C 231		

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C 231	<p>Continued From page 9</p> <p>psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure an assessment was completed and an individualized, written care plan was developed for each resident within 30 days following admission to the facility for 2 of 2 residents (#1, #2) sampled. The findings are:</p> <p>1. Review of Resident #2's current FL-2 dated 04/23/15 revealed: -Diagnoses included cerebral vascular accident (CVA) with hemiplegia, hypertension, breast cancer with right mastectomy, seizure disorder, polycythemia vera, stress incontinence, and expressive aphasia. -There was no documentation on the FL-2 form regarding Resident #2's admission date to the facility.</p> <p>Review of Resident #2's record on 07/14/15 revealed: -There was no Resident Register documenting Resident #2's admission date to the facility. -There was no documented assessment and care plan for Resident #2.</p> <p>Observation of Resident #2 at 10:12 a.m. on</p>	C 231		

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C 231	<p>Continued From page 10</p> <p>07/14/2015 revealed:</p> <ul style="list-style-type: none"> -Resident was sitting in a reclined position in a recliner/ lift chair located in the common area of the facility. -Resident had her eyes closed. -Resident was dressed appropriately for season. -Resident had edema in bilateral lower extremities. -Resident #2's right leg had more edema than her left leg. -Resident's right lower leg was elevated higher than her left leg by a pillow which was lying on the foot piece of the chair. -There was a wheelchair sitting beside the resident on the left side of the chair. -A pair of shoes was sitting on the floor beside the resident. -The right shoe had a brace attached to it. -Resident opened her eyes when spoken to. <p>Interview with Resident #2 on 07/14/15 at 10:12 a.m. revealed:</p> <ul style="list-style-type: none"> - The resident stated she was "sleepy" in a weak voice with slurred speech. - When asked if her swollen right leg hurt, the resident nodded her head up and down indicating yes. - When asked if she could walk, the resident moved her head from side to side indicating no. <p>Observation of Resident #2 on 07/14/15 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident was able to operate remote control of reclining lift chair. -Resident was able to stand, pivot, and transfer to wheelchair using +1 assistance from Owner/Administrator. -Resident was able to shuffle feet to self-propel wheelchair around facility. -The Owner/Administrator entered the restroom 	C 231		

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C 231	<p>Continued From page 11</p> <p>with Resident #2 and closed the door.</p> <p>Interview with the Owner/Administrator on 07/14/15 revealed:</p> <ul style="list-style-type: none"> -Resident #2 was admitted to the facility on 05/04/15. -Resident has expressive aphasia which impacts her verbal communication abilities. -Resident #2 has right sided weakness. -Resident #2 requires assistance with bathing, toileting, dressing, and transferring. -Resident #2 can feed herself but occasionally needs assistance. -An assessment and care plan had not been done for Resident #2. <p>Refer to interview with the Administrator / Owner on 07/14/15 at 11:41 a.m.</p> <p>2. Review of Resident #1's current FL-2 dated 06/02/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included dementia, depression, and seizures. - The admission date for Resident #1 was 06/01/15. - The resident was ambulatory. - The resident needed assistance with bathing and dressing. <p>Observation of Resident #1 throughout the survey on 07/14/15 revealed the resident was ambulatory but required redirection due to cognitive impairment.</p> <p>Review of Resident #1's record revealed no documentation of an assessment and care plan for Resident #1.</p> <p>Interview with the Administrator / Owner on 07/14/15 at 11:41 a.m. revealed an assessment</p>	C 231		

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C 231	<p>Continued From page 12</p> <p>and care plan had not been completed for Resident #1.</p> <p>Interview with the Administrator / Owner on 07/14/15 at 11:55 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #1 required supervision and prompting for bathing, dressing, grooming, toileting, and feeding. - The resident transferred and ambulated independently but required redirection because she was confused at times. <p>Refer to interview with the Administrator / Owner on 07/14/15 at 11:41 a.m.</p> <hr/> <p>Interview with the Administrator / Owner on 07/14/15 at 11:41 a.m. revealed:</p> <ul style="list-style-type: none"> - She was unaware of the requirement for an assessment and care plan. - She would complete the assessment and care plan per the guidelines for both residents that evening. 	C 231		
C 249	<p>10A NCAC 13G .0902(c)(3)(4) Health Care</p> <p>10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:</p> <p>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</p> <p>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure</p>	C 249		

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C 249	<p>Continued From page 13</p> <p>implementation of physician orders for 1 of 1 resident sampled (#2) with health care orders including obtaining weekly measurement of blood pressure for resident with diagnosis of hypertension receiving two medications to lower blood pressure. The findings are:</p> <p>Review of Resident #2's current FL-2 dated 04/23/15 revealed:</p> <ul style="list-style-type: none"> -Diagnoses and health history included cerebral vascular accident (CVA) with hemiplegia, hypertension, breast cancer with right mastectomy, seizure disorder, polycythemia vera, stress incontinence, and expressive aphasia. -There was a physician's order to check Resident #2's blood pressure one time per week. -There was a physician's order for Metoprolol 50 mg. twice daily. (Metoprolol is a medication used to treat hypertension). -There was a physician's order for Lisinopril 20 mg. daily. (Lisinopril is a medication used to treat hypertension). <p>Interview with the Administrator / Owner at 11:41 a.m. on 07/14/15 revealed Resident #2 was admitted to facility 05/04/15.</p> <p>Review of Resident #2's record revealed no documentation of weekly blood pressure checks.</p> <p>Review of Resident #2's Medication Administration Records (MARs) for the months of May, June, and July 2015 revealed:</p> <ul style="list-style-type: none"> -There was no entry for blood pressure monitoring once a week on the May, June, or July 2015 MARs. -There was no documentation of Resident #2's weekly blood pressure measurement on the MARs. 	C 249		

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C 249	<p>Continued From page 14</p> <p>Interview at 12:40 p.m. on 07/14/15 with the Registered Nurse (RN)/Director of the contracted home health agency providing physical therapy (PT) services to Resident #2 revealed:</p> <ul style="list-style-type: none"> -It was procedure for the PT staff to assess client's vital signs at initiation of care to obtain baseline, re-certification of care, if patient was symptomatic, and per physician orders. -Resident's #2's physician had not written a specific order for PT to obtain Resident #2's vital signs or blood pressure at each visit. -Resident #2 first began PT on 05/11/15, but services were placed on hold for a while because Resident #2's plan of care required her to get a new foot/leg brace. -Resident #2 resumed PT 07/08/15, after receiving her new foot/leg brace. <p>Telephone interview with the Physical Therapy Assistant at 1:18 p.m. on 07/14/15 revealed:</p> <ul style="list-style-type: none"> -PT staff assess client's vital signs per physician order and if the client become symptomatic during treatment. -She saw Resident #2 last on 07/13/15. -Resident #2 did not have a physician order for PT to obtain vital signs at each visit. -The Physical Therapy Assistant had last obtained Resident #2's vital signs on 07/13/15 because the resident had more swelling than usual in her right lower leg and her leg brace would not fit due to the swelling. -Resident #2's blood pressure was 150/84 when obtained by PT Assistant on 07/13/15. -The Physical Therapy Assistant was not concerned about Resident #2's blood pressure because her baseline systolic blood pressure was in the 140's range and her diastolic blood pressure was in the 80's range and she checked with the facility staff who verified that the resident had received her blood pressure medication. 	C 249		

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C 249	<p>Continued From page 15</p> <p>-She normally would contact a physician if a client's systolic blood pressure is 180 or greater. -On 07/13/15, she educated the Owner/Administrator about signs and symptoms needing urgent medical evaluation.</p> <p>Review of clinical notes obtained from contracted agency from recent PT visits revealed: -07/13/15: Blood pressure documented as 150/84. "Pt. has taken her BP medication this morning." -07/10/15: Blood pressure documented as 142/84</p> <p>Interview with the Administrator / Owner at 3:00 p.m. on 07/14/15 revealed: -Documentation of resident's vital signs should be filed in the resident's record. -Resident #2's blood pressure had not been obtained weekly since she was admitted to the facility on 05/04/15. -She did not see the physician order for weekly blood pressure measurement on Resident #2's FL-2 form. -PT sometimes obtains Resident #2's blood pressure. -PT last checked Resident #2's blood pressure on 07/13/15. -The facility has a functioning blood pressure cuff on site that can be used for measurement of Resident #2's blood pressure per physician's order.</p> <p>Attempt to contact Resident #2's primary physician on 07/14/15 revealed the physician was unavailable due to the office being closed until 07/20/15.</p>	C 249		
C 330	10A NCAC 13G .1004(a) Medication Administration	C 330		

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C 330	<p>Continued From page 16</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure that administration of prescription and non-prescription medications (vitamin D3, multi-vitamin, and triple antibiotic ointment) were in accordance with orders by a licensed prescribing practitioner for 1 of 2 residents sampled (#2). The findings are:</p> <p>Review of Resident #2's current FL-2 dated 04/23/15 revealed: -Diagnoses included cerebral vascular accident (CVA) with hemiplegia, hypertension, breast cancer with right mastectomy, seizure disorder, polycythemia vera, stress incontinence, and expressive aphasia. -There was a physician order for Vitamin D3 2000 International Units (ius) daily. (Vitamin D3 is a supplement used to treat low vitamin D levels). -There was not a physician order for a multi-vitamin. (Multi-vitamin is a supplement with vitamins and minerals). -There was not a physician order for triple antibiotic ointment. (Triple antibiotic ointment is used to treat skin infections).</p> <p>Review of Resident #2's record revealed: -There was not a subsequent physician order for</p>	C 330		

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C 330	<p>Continued From page 17</p> <p>Vitamin D3. -There was not a physician order for a multi-vitamin. -There was not a physician order for triple antibiotic ointment.</p> <p>Review of facility staff note in Resident #2's record dated 05/12/15 revealed triple antibiotic ointment had been applied to Resident #2's left upper thigh.</p> <p>Review of Resident #2's Medication Administration Records (MARs) for May 2015 revealed: -Triple antibiotic ointment was not written on the May MARs. -Multi-vitamin was written on the May MARs as "Multi vitamin" with a dosing time of 8:00 a.m. -Vitamin D3 was written on the May MARs as "Vitamin D3 1000 ius" with a dosing time of 8:00 a.m., -Staff initialed Resident #2's May MARs documenting multivitamin was administered at 8:00 a.m. from 05/05/15-05/31/15. -Staff initialed Resident #2's May MARs documenting vitamin D3 1000 ius was administered at 8:00 a.m. from 05/05/15-05/31/15.</p> <p>Review of Resident #2's June 2015 MARs revealed: -Triple antibiotic ointment was not written on the June 2015 MARs. -Multi-vitamin was written on the June MARs as "Multi vitamin" with a dosing time of 8:00 a.m.. -Vitamin D3 was written on the June MARs as "Vitamin D3 1000 ius" with a dosing time of 8:00 a.m. -Staff initialed the June MARs documenting multi-vitamin was administered at 8:00 am. from</p>	C 330		

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C 330	<p>Continued From page 18</p> <p>06/01/15-06/30/15. -Staff initialed the June MARs documenting vitamin D3 1000 ius was administered at 8:00 a.m. from 06/01/15-06/18/15 and 06/20/15-06/30/15.</p> <p>Review of Resident #2's July 2015 MARs revealed: -Triple antibiotic ointment was not written on the July MARs. -Multi-vitamin was written on the July MARs as "Multi vitamin 1 tablet daily by mouth" with a dosing time of 8:00 a.m. -Vitamin D3 was written on the July MARs as "vitamin D3 1000 ius 1 tab daily by mouth" with a dosing time of 8:00 a.m. -Staff initialed the July MARs documenting multi-vitamin was administered at 8:00 a.m. from 07/01/15-07/14/15. -Staff initialed the July MARs documenting vitamin D3 1000 ius was administered at 8:00 a.m. from 07/01/15-07/14/15 instead of 2000 ius as ordered by physician.</p> <p>Observation and review of Resident #2's medication supply on hand revealed: -1 bottle of generic labeled multi-vitamins. -2 bottles of Vitamin D3 1000 ius. -There was no triple antibiotic ointment for Resident #2.</p> <p>Interview with the Administrator / Owner at 3:00 p.m. on 07/14/15 revealed: -Facility staff initial resident's MARs beside each medication entry for the corresponding date and time to document the medication has been administered. -Resident #2's family member had brought in the multi-vitamin and vitamin D3. -She did not verify that the dose on the vitamin</p>	C 330		

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C 330	<p>Continued From page 19</p> <p>D3 bottle matched the physician's order for vitamin D3 on the FL-2 form.</p> <ul style="list-style-type: none"> -Resident #2 had been receiving a total dose of one pill of vitamin D3 (1000 ius) daily since admission instead of 2000 ius as ordered. -When Resident #2 was admitted to the facility, the triple antibiotic ointment was in her belongings. -She had applied a one time dose of triple antibiotic ointment to a rash on Resident #2's leg on 05/12/15. -She was not aware that the triple antibiotic ointment required a physician's order. -She was not aware that a physician's order was required for the multi-vitamin. -She would notify Resident #2's physician and family that she had been receiving only 1000 ius of vitamin D3 since admission. -She would correct Resident #2's July 2015 MAR to reflect that 2 vitamin D3 pills (total dose of 2000 ius) would be administered daily in order to meet physician order and report change to all facility staff responsible for administering medications. -She would contact Resident #2's physician or ask the resident's family member to obtain orders for the multi-vitamin and triple antibiotic ointment. <p>Attempts to contact Resident #2's primary physician on 07/14/15 revealed the physician was unavailable and the office was closed until 07/20/15.</p>	C 330		
C935	<p>G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p>	C935		

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C935	<p>Continued From page 20</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ul style="list-style-type: none"> a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ul style="list-style-type: none"> a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ul style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. 	C935		

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C935	<p>Continued From page 21</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 5 staff (D, E) who performed medication aide duties met the requirements to administer medications including the medication aide clinical skills checklist (D) and the 5 hour, 10 hour, or 15 hour state approved medication aide training course (D, E). The findings are:</p> <p>1. Review of Staff D's personnel file revealed:</p> <ul style="list-style-type: none"> - Staff D's hire date was 06/13/15. - Staff D was hired as a personal care aide and medication aide. - There was no documentation of completion of the medication aide clinical skills checklist. - There was no documentation of completion of the 5 hour or 15 hour state medication aide training courses. <p>Review of the June 2015 and July 2015 medication administration records (MARS) revealed:</p> <ul style="list-style-type: none"> - Staff D started administering medications on 06/21/15. - Staff D administered medications in June and July 2015. <p>Staff D was unavailable for interview at the facility on 07/14/15.</p> <p>Refer to interview with the Administrator / Owner on 07/14/15 at 4:00 p.m.</p> <p>2. Review of Staff E's personnel file revealed:</p> <ul style="list-style-type: none"> - Staff E's hire date was 05/05/15. - Staff E was hired as a personal care aide and medication aide. 	C935		

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C935	<p>Continued From page 22</p> <ul style="list-style-type: none"> - There was no documentation of completion of the 5 hour, 10 hour, or 15 hour state medication aide training courses. <p>Review of the May 2015, June 2015, and July 2015 medication administration records (MARS) revealed:</p> <ul style="list-style-type: none"> - Staff E started administering medications on 05/16/15. - Staff E administered medications in May, June and July 2015. <p>Staff E was unavailable for interview at the facility on 07/14/15.</p> <p>Refer to interview with the Administrator / Owner on 07/14/15 at 4:00 p.m.</p> <p>_____</p> <p>Interview with the Administrator / Owner on 07/14/15 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - All of her staff administered medications to residents. - She thought she had 90 days to get the medication aide qualifications for staff completed. - She would get the qualifications for Staff D and Staff E completed. - Staff D and Staff E would not administer medications again until their qualifications were completed. 	C935		
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