

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 a follow up survey and complaint investigation on July 21 - 23, 2015.	D 000		
D 067	<p>10A NCAC 13F .0305(h)(4) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are:</p> <p>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure 1 of 4 exit doors, which exits the building to the designated smoking area, could be secured and had a sounding device for the 4 identified residents who wandered or were disoriented.</p> <p>The findings are:</p> <p>Observation of the facility's rear door on 7/21/15 at 11am which exits to the designated smoking area revealed: -No sounding device was activated when the door was opened.</p>	D 067		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 067	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-The door was not outfitted with a wandergard sensor.</li> <li>-The door was not alarmed.</li> <li>-The magnetic lock on top of the door was not locked.</li> </ul> <p>Observation of the facility's unsupervised outdoor smoking area on 7/21/15 at 11:05am revealed:</p> <ul style="list-style-type: none"> <li>-The gate had a locking metal latch in the open position on the inside of the gate door.</li> <li>-The gate had a latch with knob on the outside of the gate accessible by reaching thru a 4-inch gap in the door.</li> <li>-The gate exited to the grassy field at the back of the unfenced facility.</li> <li>-The smoking area was used by one resident who wandered (Resident #5) who was a smoker.</li> </ul> <p>Review of resident FL-2 forms revealed these 4 residents were listed as "intermittently disoriented" under the orientation category.</p> <p>Review of resident Care Plans revealed there were 4 residents of the facility that wore the wandergard bracelet monitoring system.</p> <p>Interview with Medication Aide (MA) on 7/20/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> <li>-The designated smoking area gate was supposed to be locked.</li> <li>-The exit door to the smoking area is never secured.</li> <li>-The exit door does not have an alarm because the residents can't get out of the facility from the smoking area.</li> <li>-None of the 4 residents who wandered at the facility had the dexterity to open the latch.</li> <li>-One of the residents who wandered (Resident #5) was a smoker who sat near the gate area.</li> <li>-Only 1 of 4 residents who wandered came</li> </ul>	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 067	<p>Continued From page 2</p> <p>outside to smoke.</p> <ul style="list-style-type: none"> <li>-The medication aide was able to open the wooden gate and walk outside.</li> <li>-She thought the smoking area exit gate was locked.</li> <li>-The exit door does not have a wandergard system.</li> </ul> <p>Interview with Administrator on 7/20/15 at 11:30 am revealed:</p> <ul style="list-style-type: none"> <li>-The designated smoking area gate was supposed to be locked.</li> <li>-None of the 4 wanderers at the facility had the ability to open the latch.</li> <li>-One of the residents who wanders (Resident #5) sat outside with other staff in the morning and evening.</li> <li>-The gate latch could be locked but she did not know the location of the key.</li> <li>-The administrator could open the gate herself and exit to the back of the facility.</li> <li>-There were no evaluations performed on the identified residents who wander to determine if they could open the gate.</li> <li>-The exit door to the smoking area was never locked because the smoking area was closed off.</li> </ul> <p>Interview with Resident Care Coordinator on 7/22/15 at 9:50am revealed:</p> <ul style="list-style-type: none"> <li>-The 4 residents who wander at the facility do not smoke.</li> <li>-Only one of the residents who wander (Resident #5) identified as a smoker sat out in the smoking area.</li> <li>-He never witnessed Resident #5 try to open the gate.</li> <li>-The smoking area is open 24-hours, 7-days a week.</li> <li>-None of the residents who wander have left the facility since installation of the wandergard</li> </ul>	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 067	<p>Continued From page 3</p> <p>system. -The gate did not have a wandergard alarm or sounding alarm.</p> <p>Interview with a Personal Care Aide on 7/22/15 at 10:10am revealed: -One resident who wandered (Resident #5) sat outside in the smoking area near the gate. -None of the residents who wander have the ability to open the latch of the gate.</p> <p>Interview with the facility's janitor on 7/22/15 at 10:25am revealed: -Only one of the 4 residents who wander (Resident #5) goes out to the smoking area. -He worked all 3 shifts as needed. -He had seen Resident #5 sitting in the smoking area at various times of the day. -The exit door to the designated smoking area is never locked. -The exit door to the designated smoking area does not sound.</p> <p>Interview with Administrator on 7/20/15 at 2:05pm revealed: -She had just received permission today to put up a board to cover the gap in the gate exposing the latch mechanism so it would not be visible to residents. -A call was placed to the Fire Marshall to request permission to lock the gate. -The DHSR construction section concurrently inspecting the facility on 7/20/15 identified the gate as a potential safety issue due to not opening easily and advised the facility to consult with the Fire Marshall. -There was no wandergard system on the facility exit door to the designated smoking area. -There were no elopements from the smoking area exit door or wooden gate.</p>	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (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 record review and interview, the facility failed to assure urine specimens were collected for 1 of 2 residents (Resident #4) as ordered by the physician following recent hospitalization.</p> <p>The findings are:</p> <p>Review of hospital discharge physician orders dated 05/25/2015 revealed an order for a "repeat ua(urinalysis)/urine cx(culture) in 1 week".</p> <p>Review of Resident #4's current FL-2 dated 05/26/2015 revealed: -Diagnoses included weakness, frequent falls, anemia, transient ischemic attack, depression, diverticulosis, parastomal hernia, gastroesophageal reflux disease, ischemic bowel, chronic dizziness, chronic pain secondary to fibromyalgia, osteoarthritis. -A physician's order for Amoxicillin (used to treat infections) 875mg two times daily for three days. -A physician's order for a routine urinalysis and urine culture in one week.</p> <p>Review of physician's orders dated 06/01/2015</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 276	<p>Continued From page 5</p> <p>for Resident #4 revealed:</p> <ul style="list-style-type: none"> <li>-On 06/01/2015, the Physician Assistant (PA) wrote an order for a urine sample by clean catch for UA/C&amp;S (urinalysis with culture and sensitivity).</li> <li>-The PA's order included instructions to "please collect this sample first thing Thursday (6/4/2015) in the morning" and "please store in a specimen cup labeled with patient's name and date of birth in the refrigerator until [name of lab] personnel picks it up".</li> </ul> <p>Record review of laboratory results revealed no results of a urinalysis ordered on 6/4/2015.</p> <p>Review of record revealed no documentation the PA was notified the urinalysis had not been collected.</p> <p>Review of a physician's orders dated 06/08/2015 for Resident #4 revealed the Physician Assistant (PA) provided a printed order to the facility to "please collect urine specimen and clearly label with ... . Call physician provider group when specimen is ready for pick up".</p> <p>Further review of physician orders dated 06/08/2015 for Resident #4 revealed:</p> <ul style="list-style-type: none"> <li>-An order by the PA documenting "re-ordering u/a pick up".</li> <li>-An order for "rest and push fluids".</li> <li>-An order to "start Bactrim DS (used to treat infections) 160/800mg (1 tab po [by mouth] bid [two times daily] x 10 days".</li> </ul> <p>Review of the PA's Visit Summary dated 06/08/2015 for Resident #4 revealed the PA documented "patient had UA ordered to reassess for UTI [Urinary Tract Infection] on 5/29. This has still not been collected. Left patient another urine</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 276	<p>Continued From page 6</p> <p>specimen cup today to obtain specimen. Contacted [lab provider group] to follow up on pick up".</p> <p>Record review for Resident #4 revealed no results of a urinalysis ordered on 06/08/2015.</p> <p>Review of record revealed no documentation the PA was notified the urinalysis had not been collected.</p> <p>Review of physician's orders dated 06/16/2015 for Resident #4 revealed: -On 06/16/2015, the Physician Assistant (PA) wrote an order to "please collect urine specimen by clean catch for a UA/C&amp;S". -The PA's order included instructions to "please ensure name and DOB are on cup. Please collect Thursday (6/18) in the morning when the phlebotomist arrives with specimen cup".</p> <p>Record review of laboratory results revealed: -No results of a urinalysis collected for 6/16/2015. -No results of any urinalysis results collected by the facility for Resident #4.</p> <p>Review of record revealed no documentation the PA was notified the urinalysis had not been collected.</p> <p>Review of a PA Visit Summary for Resident #4 dated 06/25/2015 revealed: -An order to obtain urine sample and take to hospital lab for urinalysis. -An order for Diflucan (used to treat yeast infections) 150mg take one tablet once.</p> <p>Review of hospital discharge instructions dated 06/25/2015 for Resident #4 revealed the resident</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 276	<p>Continued From page 7</p> <p>was seen in the emergency department with reason for visit including acute low back pain and " URINARY FREQUENCY".</p> <p>Further review of the hospital discharge instructions dated 06/26/2015 for Resident #4 revealed urinalysis results for 06/25/2105 at 23:50 (11:50pm) were negative.</p> <p>Review of physician orders for Resident #4 revealed: -A prescription was written on 06/26/2015 for Cipro (used to treat infections) 500mg one tablet every twelve hours for seven days. -An order dated 06/29/2015 to continue Cipro.</p> <p>Interview with the Administrator on 07/22/2015 at 11:15am revealed: -The Medication Aides (MA) were responsible to process new orders. -The facility had labwork collected at the facility. -Most of the time, the provider physician group came to the facility to collect lab specimens or the facility transporter would take the resident to the hospital for lab draws. -The provider physician group would have provided a specimen cup to the facility and the personal care aides (PCA) would have been responsible to assist with getting the urine specimen. -Once the urine specimen was obtained, the PCA would give the specimen to the MA or Resident Care Coordinator (RCC) until the specimen was taken to the lab by facility staff. -The Administrator did not know if urine specimen for urinalysis and culture for Resident #4 for 6/1/2015, 6/8/2015, and 6/16/2015 had been collected as ordered by the PA.</p> <p>Further interview with the Administrator on</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD</b> <b>NEW BERN, NC 28562</b>
---	--

(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 276	<p>Continued From page 8</p> <p>07/22/2015 at 1:00pm revealed: -When the PA wrote an order to obtain a urine specimen, the facility did not do anything because the PA wrote the order, faxed it along with blood lab orders to the provider group lab, the provider group lab then came to the facility to collect the lab. -The facility did not have the capability to keep urine specimens at the facility. -The facility only had the refrigerator in the medication room for medications and could not store urine specimens in the same refrigerator.</p> <p>Interview with the Administrator on 07/23/2015 at 11:05am revealed -The Administrator had not been able to locate urinalysis results for Resident #4 for dates of 6/1/2015, 6/8/2015, or 6/16/2015. -The PA said a UA had been collected but did not know what date.</p> <p>Review of lab reports from a medical center laboratory presented by the Administrator on 07/23/2015 revealed: -A urine specimen for urinalysis was collected on 06/26/2015 with a slightly cloudy appearance. -A urine specimen for culture was collected on 07/14/2015 which suggested contamination.</p> <p>Interview with the PA on 07/23/2015 between 11:45am and 1:00pm revealed: -There was an expectation for the facility to collect the urine specimen for urinalysis for Resident #4. -There had been issues with the resident providing the urine sample. -The PA had cancelled UA orders "on my end but not through the facility" and had re-ordered the urine specimen for UA. -The PA did not know if it was possible for the</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 276	<p>Continued From page 9</p> <p>facility to collect the urine specimen. -The PA did not think the facility had notified her by phone of the inability to collect the urine specimens but the facility staff did talk to her when she was on site. -The PA did not provide any specific dates when facility staff had talked to her about the inability to collect urine specimens for urinalysis with culture for Resident #4.</p> <p>Interview with Resident #4 on 07/22/2015 between 3:10pm and 4:00pm revealed: -Resident #4 did not have a problem providing a urine specimen when requested. -Resident #4 could provide the specimen in a cup. -Resident #4 did not provide an answer when asked if staff had assisted her with obtaining a urine specimen.</p>	D 276		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to medications not being administered timely and the manner in which staff speak to residents.</p> <p>The findings are:</p> <p>Confidential interview with a resident revealed:</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 338	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>-The resident was getting medication around 11:00pm.</li> <li>-Medications were supposed to be administered around 9:00pm and not later than 10:00pm.</li> <li>-It was 10:45pm on one night last week before the resident was administered his/her medications.</li> <li>-If the resident got his/her medications late, the resident would go to sleep late and felt "drained" and would "stumble around the next morning".</li> <li>-A Medication Aide (MA) said she was not going to give the resident medication because the MA and the resident "had words", but the MA did give the resident the medications late.</li> <li>-A MA told the resident that she (the MA) did not have to talk to the resident.</li> </ul> <p>Confidential interview with a second resident revealed medications on the 3-11pm shift were being administered late.</p> <p>Confidential interview with a third resident revealed:</p> <ul style="list-style-type: none"> <li>-Some of staff "answer me short".</li> <li>-Staff "tell me to go my room and wait, and she'll bring my meds to me. I don't know why I have to go to my room".</li> </ul> <p>Confidential interview with a fourth resident revealed:</p> <ul style="list-style-type: none"> <li>-Medication was not administered on time on 3-11pm shift.</li> <li>-A MA told the resident "you better believe you gonna be the last person to get medicine" after the resident and the MA "were going at each other fussing".</li> <li>-The medication was administered but not on time.</li> <li>-A MA said to the resident "oh you wanna get bougie with me".</li> </ul>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD</b> <b>NEW BERN, NC 28562</b>
---	--

(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 338	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-The resident did not remember what the resident said to the staff, but "understood the inclination of it" when asked what was meant by "bougie".</li> <li>-The resident took the medication being administered and left the medication room.</li> </ul> <p>Confidential interviews with staff revealed:</p> <ul style="list-style-type: none"> <li>-Residents complain to staff about not getting their medications on time.</li> <li>-Staff have seen medications administered to residents as late as 10:30pm.</li> <li>-Sometimes MA's are still administering medications when staff are ending the 3-11pm shift, about 15 minutes before end of shift.</li> <li>-One MA gave medications late and rushed before the oncoming medication aide came to work.</li> </ul> <p>Interview with the Administrator on 07/22/2015 at 8:30am revealed:</p> <ul style="list-style-type: none"> <li>-The facility's electronic medication administration records (EMAR) system allowed the Administrator and Resident Care Coordinator (RCC) to view EMAR's from home.</li> <li>-The EMAR system used at the facility gave the Administrator the capability to monitor "timeframes".</li> <li>-The Administrator "may not catch the day the resident actually complained about but can monitor that resident's med pass for the next couple of days".</li> </ul> <p>Interview with the Administrator on 07/22/2015 at 5:30pm revealed:</p> <ul style="list-style-type: none"> <li>-A resident complained to the Administrator two days ago about a Medication Aide being "ugly" to the resident in the way the MA administered a medication to the resident.</li> <li>-The Administrator called the staff in the office with the resident and talked to the staff.</li> </ul>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(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 338	<p>Continued From page 12</p> <p>-The Administrator did not document the discussion with the Medication Aide.</p> <p>Observation of an interaction between a MA and a resident on 07/23/2015 at 12:15pm revealed:</p> <p>-The resident initiated a inquiry about the status of her Tylenol (used to treat pain) dose and stated "because you're always out".</p> <p>-The MA responded in a stern tone "we got your Tylenol, no need to ask me about that, we got your Tylenol".</p> <p>Interview with the Medication Aide on 7/23/2015 at 12:20pm revealed:</p> <p>-The MA was short with the resident because the resident was short with her.</p> <p>-When the MA performed a medication pass, the MA was slow but precise.</p> <p>-Without interruptions, the medication pass could be finished between 10:15pm and 10:30pm, but most of the time the MA finished the medication pass by 10:30pm every shift worked.</p> <p>Review of four residents July 2015 medication administration records revealed:</p> <p>-Three of four residents last daily scheduled medication administration time was 9:00pm.</p> <p>-One of four residents last daily scheduled medication administration time was 9:00pm with the exception of one medication scheduled for 10:00pm.</p> <p>Interview with the Physician Assistant (PA) on 07/23/2015 at 12:55pm revealed:</p> <p>-Timeliness of medication administration would affect the ability to assess the effectiveness of the medications, especially for diabetics requiring blood sugars, as well as residents requiring pain management.</p> <p>-The PA was not aware of any real concerns</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD</b> <b>NEW BERN, NC 28562</b>
---	--

(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 338	Continued From page 13 regarding medication administration timeliness.	D 338		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure medications (Celexa, Oxycodone, Lorazepam, Fentanyl Patch) were administered as ordered by a licensed prescribing practitioner to 2 of 5 residents (Residents #2 and #4).</p> <p>The findings are:</p> <p>1. Review of Resident #4's current FL-2 dated 05/26/2015 revealed diagnoses included weakness, frequent falls, transient ischemic attacks, depression, diverticulosis, chronic dizziness, chronic pain secondary to fibromyalgia, and osteoarthritis.</p> <p>A. Review of physician orders for Resident #4 on the 05/26/2015 FL-2 revealed a physician's order for Lorazepam 0.5mg twice daily.</p> <p>Review of Electronic Medication Administration Records (EMARS) for May 2015 revealed:</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 14</p> <p>-There was no transcription entry to the EMAR for Lorazepam 0.5mg twice daily.</p> <p>-There was no documentation of administration for Lorazepam 0.5 mg twice daily.</p> <p>Review of Electronic Medication Administration Records (EMARS) for May 2015 revealed Lorazepam 0.5mg tablet was administered as a PRN (as needed) medication 5 times during the month on various dates and times.</p> <p>Review of Electronic Medication Administration Records (EMARS) for June 2015 revealed:</p> <p>-There was no transcription entry to the EMAR for Lorazepam 0.5mg twice daily.</p> <p>-There was no documentation of administration for scheduled Lorazepam 0.5 mg twice daily for 06/01/2015 through 06/10/2015, when a subsequent order dated 06/10/2015 was received and transcribed to the EMAR for Lorazepam 1mg take ½ tablet (0.5mg) daily at 5pm.</p> <p>Review of Electronic Medication Administration Records (EMARS) for June 2015 revealed Lorazepam 0.5mg tablet was administered on the following dates and times as a PRN (as needed) medication 17 times during the month on various dates and times.</p> <p>Further review of physician orders revealed there were no physician's order for Lorazepam to be administered as needed.</p> <p>Review of Electronic Medication Administration Records (EMARS) for July 2015 revealed Lorazepam 0.5mg tablet was administered on the following dates and times as a PRN (as needed) medication 16 times during the month on various dates and times.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 15</p> <p>Interview with Resident #4 on 07/22/2015 between 3:10pm and 4:00pm revealed: -Resident #4 did not remember any missed doses of the Lorazepam. -Resident #4 had no problems with the way the Lorazepam was administered. -When Resident #4's medication were administered, the resident would "take out the big vitamin and dump the rest down my throat".</p> <p>Refer to interview with the Administrator dated 07/22/2015 at 11:15am.</p> <p>Refer to interview with the Medication Aide (MA) dated 07/23/2015 at 1:20pm.</p> <p>Refer to interview with the Physician Assistant (PA) dated 07/23/2015 between 11:45am and 12:30pm.</p> <p>B. Review of physician orders for Resident #4 on the 05/26/2015 FL-2 revealed a physician's order for Fentanyl 50mcg one patch every 72 hours.</p> <p>Review of Electronic Medication Administration Records (EMARS) for July 2015 revealed: -There was a transcription entry to the EMAR for Fentanyl 50 mcg/hr Patch apply 1 patch to skin every 3 days and scheduled to be applied at 9:00am every 3 days. -There was no documentation of administration for the Fentanyl Patch on 07/02/2015. -There was no documentation of administration for the Fentanyl Patch on 07/05/2015.</p> <p>Review of the printed notes regarding reason for medication not administered on 07/02/2015 was "need a hardscript".</p> <p>Review of the printed notes regarding reason for</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 16</p> <p>medication not administered on 07/05/2015 was "wait on the pharmacy to send it".</p> <p>Interview with Resident #4 on 07/22/2015 between 3:10pm and 4:00pm revealed:                      -Resident #4 had missed 2 patches a couple weekends ago and "went through withdrawal".                      -Whoever was supposed to order resident #4's medication "is screwing it up .                      -Resident #4 had been through withdrawal and knew how it made her feel.                      -Resident #4 felt "horrible, creepy, cranky".                      -Resident #4 had a patch on her back, the patch had "no sticky on it, hadn't been changed for 6 days, no writing on the patch, had been through too many showers, staff always put the date on patch, staff always change location of patch, when [a new] patch put back on me I was very happy - hugh difference".</p> <p>Refer to interview with the Administrator dated 07/22/2015 at 11:15am.</p> <p>Refer to interview with the Medication Aide (MA) dated 07/23/2015 at 1:20pm.</p> <p>Refer to interview with the Physician Assistant (PA) dated 07/23/2015 between 11:45am and 12:30pm.</p> <p>C. Review of physician's orders for Resident #4 on the 05/26/2015 FL-2 revealed a physician's order for Oxycodone (a controlled narcotic used to treat pain) 5mg every six hours as needed for pain.</p> <p>Continued review of physician orders for Resident #4 revealed:                      -A subsequent order dated 06/01/2015 for Oxycodone 5mg one tablet every morning, one</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 17</p> <p>tablet every day at noon, one tablet every evening, and two tablets every night at bedtime. -A subsequent order dated 06/08/2015 to change Oxycodone 5mg two tablets dose to 6pm instead of at bedtime and replace bedtime dose with one tablet.</p> <p>Review of June 2015 Electronic Medication Administration Records (EMARs) revealed: -Oxycodone HCL 5mg tablet take one tablet by mouth three times daily scheduled at 8:00am, 12:00pm, and 6:00pm was transcribed to the EMAR with documentation of administration beginning at 6:00pm on 06/01/2015 and the last dose documented as administered at 12:00pm on 06/03/2015. - Oxycodone HCL 5mg tablet take two tablets by mouth at bedtime scheduled at 8:00pm, was transcribed to the EMAR with documentation of administration beginning on 06/01/2015 and the last dose documented as administered on 06/02/2015. -Oxycodone HCL 5mg tablet take one tablet by mouth three times daily scheduled at 8:00am, 1:00pm, and 6:00pm was transcribed to the EMAR with documentation of administration beginning at 1:00pm on 06/03/2015 and continued documentation of administration through 06/30/2015 at 8:00am, 1:00pm, and 6:00pm. - Oxycodone HCL 5mg tablet take two tablets by mouth at bedtime scheduled at 9:00pm, was printed to the EMAR with documentation of administration beginning on 06/03/2015 and continued documentation of administration through 06/30/2015 at 9:00pm. -No documentation of administration for Oxycodone 5mg two tablets at 6pm according to 06/08/2015 physicians order. -No documentation of administration for</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 18</p> <p>Oxycodone 5mg one tablet at bedtime according to 06/08/2015 physicians order.</p> <p>Continued review of the July 2015 EMAR for Resident #4 revealed on July 4, 2015 at 6:00pm, the Medication Aide documented Oxycodone 5mg tablet was not administered. Review of the documented medication notes for July 4, 2015 at 6:00pm revealed "waiting on pharmacy .</p> <p>Interview with Resident #4 on 07/22/2015 between 3:10pm and 4:00pm revealed: -Resident #4 was prescribed Oxycodone. -Resident #4 was getting Oxycodone 5mg three times a day and two tablets at night. -Resident #4 had "missed pill on a weekend, order didn't go through, wasn't delivered by pharmacy". -Resident #4 did not remember the date of missed doses of Oxycodone, but thought it "might have been two weeks ago".</p> <p>Refer to interview with the Administrator dated 07/22/2015 at 11:15am.</p> <p>Refer to interview with the Medication Aide (MA) dated 07/23/2015 at 1:20pm.</p> <p>Refer to interview with the Physician Assistant (PA) dated 07/23/2015 between 11:45am and 12:30pm.</p> <p>2. Review of Resident #2's current FL-2 dated 04/09/2015 revealed: - Diagnoses included schizophrenia, diabetes, hypertension, hypothyroidism, and hypercholesterolemia. -A physician's order dated 04/09/2015 for Celexa (used to treat depression) 10mg tablet daily.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 19</p> <p>Record review revealed a physician's order dated 06/29/2015 to discontinue Citalopram (generic for Celexa) 10mg tablet daily.</p> <p>Review of Electronic Medication Administration Records (EMARS) for June 2015 revealed: -Citalopram 10mg tablets take one tablet by mouth daily was transcribed to the EMAR and scheduled for administration daily at 8:00am. -Documentation of administration daily for Citalopram 10mg tablets, including 6/30/2015.</p> <p>Review of Electronic Medication Administration Records (EMARS) for July 2015 revealed: -Citalopram 10mg tablets take one tablet by mouth daily was transcribed to the EMAR and scheduled for administration daily at 8:00am. -Documentation of administration daily from 07/01/2015 through 07/21/2015 for Citalopram 10mg tablets, except 07/15/2015 which was documented as not administered with medication notes documenting patient refused medication.</p> <p>Review of medications on hand on 07/23/2015 at 1:15pm with the Medication Aide revealed Celexa 10mg tablets take one tablet daily, quantity 31 dispensed 07/01/2015 with quantity 8 on hand.</p> <p>Interview with the MA on 07/23/2015 at 1:15pm revealed: -The MA administered the Celexa 10mg tablet to Resident #2 on today (07/23/2015) and yesterday (07/22/2015). -The Celexa was discontinued on 07/22/2015 and was in a pending status until today. -The MA was not aware of the physician's order dated 06/29/2015 to discontinue the Celexa for Resident #2. -The MA stated she would remove the Celexa from Resident #2's medication storage area and</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 20</p> <p>place the Celexa in the medication tote to be returned to the pharmacy.</p> <p>Refer to interview with the Administrator dated 07/22/2015 at 11:15am.</p> <p>Refer to interview with the Medication Aide (MA) dated 07/23/2015 at 1:20pm.</p> <p>Refer to interview with the Physician Assistant (PA) dated 07/23/2015 between 11:45am and 12:30pm.</p> <p>Interview with the pharmacy provider on 07/23/2015 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy was responsible to input order changes into the EMAR system.</li> <li>-The pharmacy received a fax from the facility on 07/22/2015 at 8:41am of a 06/29/2015 physician visit form which included the Celexa discontinue order.</li> <li>-There was no documented return of Celexa to the pharmacy for Resident #2. Other medications had been returned on 06/30/2015, but not Celexa.</li> </ul> <p>Interview with a Medication Aide (MA) on 07/23/2015 at 1:20pm revealed:</p> <ul style="list-style-type: none"> <li>-MA's were responsible to fax new orders to the pharmacy.</li> <li>-New medication orders were placed on the EMAR by the pharmacy provider.</li> <li>-New medication orders were placed in a pending status on the EMAR until approved by the facility.</li> <li>-The MA was responsible to take the medication order out of pending status, once approved, before the medication could be administered according to the new order.</li> <li>-The MA administered medications according to</li> </ul>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 21</p> <p>the EMAR instructions when the medication popped up on the EMAR for administration.</p> <p>Interview with Administrator on 07/22/2015 at 11:15am revealed Medication Aides (MAs) were responsible to process new orders.</p> <p>Interview with the Physician Assistant (PA) on 07/23/2015 between 11:45am and 12:30pm revealed:</p> <ul style="list-style-type: none"> <li>-The facility staff were good about faxing orders to the pharmacy.</li> <li>-Orders had to be faxed to the pharmacy before 3pm to be delivered to the facility on the same day by 7pm.</li> <li>-The pharmacy provider does not deliver medications to the facility on the weekends.</li> <li>-The PA was not aware of any issues of residents running out of medications on the weekend.</li> <li>-The PA thought the facility could call another pharmacy on the weekend but the issue would be needing a prescription.</li> </ul> <p>_____</p> <p>The facility submitted the following Plan of Protection on 07/23/2015:</p> <ul style="list-style-type: none"> <li>-Effective immediately, the Resident Care Coordinator will contact the physician 7 days prior to the last dose regarding controlled substances as well as other medications.</li> <li>-The RCC will process and monitor all orders daily to ensure proper follow up and completion.</li> <li>-The Administrator will review all new orders weekly for proper follow up and completion.</li> <li>-The company Registered Nurse (RN) will be conducting a mandatory medication administration and documentation inservice on 07/27/2015 and 07/28/2015.</li> <li>-Residents will also be inserviced on both days.</li> </ul>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL025026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/23/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERSTONE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 EFIRD BOULEVARD NEW BERN, NC 28562</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 22  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2015.	D 358		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration.</p> <p>The findings are:</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure medications (Celexa, Oxycodone, Lorazepam, Fentanyl Patch) were administered as ordered by a licensed prescribing practitioner to 2 of 5 residents (Residents #2 and #4). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].</p>	D912		