

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092124	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/20/2015
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NAME OF PROVIDER OR SUPPLIER ELMCROFT OF NORTH RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NEWTON ROAD RALEIGH, NC 27609
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a Follow Up Survey on 1/18/15, 11/19/15, and 11/20/15.	{D 000}		
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 administer triamcinolone 0.1% cream to 1 of 4 residents sampled in the Special Care Unit by the documentation of 110 applications to over half of the resident's body from 6 ounces of the cream (Resident #6).</p> <p>The findings are:</p> <p>Observations of Resident #6 with the personal care aide (PCA) on 11/18/15 at 2:58pm revealed:</p> <ul style="list-style-type: none"> -The resident was lying on her bed and appeared to be scratching her abdomen. -The resident's entire torso, arms, back and upper buttocks and thighs were covered in small, flat and raised, reddened areas appearing to be 1 to 2 cm. in size. 	D 358		

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

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D 358	<p>Continued From page 1</p> <p>Interview with the PCA on 11/18/15 at 3:00pm revealed: -The rash had been on the resident for about a month. -The PCA did not know what was causing the rash. -The medication aides (MA) have a cream they are putting on it.</p> <p>Review of Resident #6's current FL2 dated 2/16/15 revealed: -Diagnoses included moderate to advanced Dementia, Urinary Tract Infection, Hypertension, diabetes Mellitus and History of Cardiovascular Disease. -For personal care assistance, Resident #6 required total care. -"Wanderer" was indicated as inappropriate behavior.</p> <p>Review of Resident Notes for Resident #6 revealed: -On 9/18/15, a medication aide (MA) documented the resident was seen by the primary care provider (PCP) for red areas on both arms and abdomen. The resident refused for skin to be scraped. The PCP will follow up and advise very soon. The resident keeps scratching these areas. -On 9/19/15, an MA documented the PCP stated they will not provide any prophylactic treatment for the resident until other residents in the facility have a positive result for scabies. -On 9/20/15, the MA working second shift documented the resident had red spots on her right chest and both arms.</p> <p>Review of a physician's order dated 9/21/15 revealed: -Apply Elimite Cream 5% head to toe (Elimite cream is a topical scabidical agent for the</p>	D 358		

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D 358	<p>Continued From page 2</p> <p>treatment of infestation with scabies). -Keep on 8-12 hours, then wash off. -May repeat after one week.</p> <p>Review of Resident #6's September 2015 medication Administration Record (MAR) revealed documentation of the application of the cream on 9/22/15 at 8:00am.</p> <p>Review of the September 2015 and October 2015 MARs revealed there was no documentation of a repeat application in a week.</p> <p>Interview with the Memory Care Clinical Leader on 11/19/15 at 4:25pm revealed if an order states "may repeat", we should call the doctor to clarify.</p> <p>Review of a medical encounter note dated 10/12/15 revealed: -The resident has diffuse papular rash on abdomen, upper back and axilla areas. -The rash was noted to be, "erythema with scabs in areas", no blisters or pustules. -The resident had been seen the month before for similar symptoms, at which time the resident was treated for scabies. -The resident has had no significant improvement in rash since being treated for scabies. -Start Triamcinolone cream 0.1% to affected areas three times a day (60grams plus 1 refill). Notify if symptoms are not improving. -Start Benadryl 25mg every six hours as needed [no indication documented].</p> <p>Interview with the pharmacy provider on 11/19/15 at 4:47pm revealed: -Triamcinolone cream 0.1% for Resident #6 had been dispensed on 10/12/15, 11/4/15 and 11/11/15. -The pharmacy provider could not state how long</p>	D 358		

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D 358	<p>Continued From page 3</p> <p>60gms of the medication should last if being applied 3 times a day because it depended on how much each individual uses and how many affected areas.</p> <ul style="list-style-type: none"> -They usually try to dispense a 10-15 day supply of creams and liquids. -The medication is not on an automatic refill; the facility has to request it. <p>Review of the October 2015 MAR revealed:</p> <ul style="list-style-type: none"> -There was documentation of the application of triamcinolone cream at 8:00am, 2:00pm and 8:00pm from 10/13/15 through 10/31/15 (57 applications). -According to documentation on 10/28/15 at 10:01pm, the resident was administered Benadryl 25 mg only one time for itching. <p>Review of the November 2015 MAR on 11/19/15 revealed:</p> <ul style="list-style-type: none"> -There was documentation of the application of triamcinolone cream at 8:00am on 11/2/15 and 11/4/15 -11/1915. -On 11/1/15 the medication was documented as not given at 8:00am due to the medication had been reordered and staff was awaiting delivery. -On 11/3/15 the medication was documented as not given at 8:00am due to the medication being unavailable and will arrive on 11/4/15. -There was documentation of the application of triamcinolone cream at 2:00pm on 11/2/15, and 11/4/15 -11/10/15 and 11/12/15 -11/18/15. -On 11/1/15 the medication was documented as not given at 2:00pm due to the medication had been reordered and staff was awaiting delivery. -On 11/3/15 the medication was documented as not given at 2:00pm due to the medication being unavailable and will arrive on 11/4/15. -On 11/11/15 the medication was documented as not given at 2:00pm due to the medication being 	D 358		

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D 358	<p>Continued From page 4</p> <p>refilled.</p> <p>-There was documentation of the application of triamcinolone cream at 8:00pm from 11/1/15 through 11/18/15.</p> <p>Review of Resident Notes for Resident #6 revealed:</p> <p>-On 10/15/15, the MA documented the resident had red spots on chest, shoulder, back and arm areas and cream was applied.</p> <p>-On 10/19/15, the MA documented the resident had no itching to red spots on body area; cream was applied.</p> <p>-On 10/21/15, the MA documented the resident had red spots on body, chest, back and arms; cream was applied.</p> <p>-On 10/26/15, the MA documented the resident had a rash on body area; no itching was noted; cream was applied.</p> <p>-On 10 28/15, the MA documented the resident had red spots that had spread more on body area; cream applied to entire body; Benadryl was administered for itching. MD on call was notified.</p> <p>-On 10/29/15, the MA documented the resident had red spots on chest, back, arms, shoulders and stomach. No itching was noted. Cream was applied and the MD will see on next visit.</p> <p>On 10/30/15, a different MA documented the resident was seen by the PCP for red spots on back, abdomen and chest. A new order was for prednisone was written.</p> <p>Review of physician's order dated 10/30/15 revealed an order to start Prednisone 20mg every day for 3 days, then 10mg for 2 days.</p> <p>Observations on 11/18/15 at 9:43am of Resident #6 revealed the resident was ambulating in her wheelchair independently in the memory care unit</p>	D 358		

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D 358	<p>Continued From page 5</p> <p>scratching her right fore arm.</p> <p>Observations on 11/19/15 at 5:30pm of the container of Triamcinolone cream 0.1% for Resident #6 revealed: -Sixty grams of the cream had been dispensed on 11/11/15. -The container appeared to be the size of a regular prescription tablet bottle. -The container was approximately ¾ full.</p> <p>Interview on 11/18/15 at 5:30pm with MA working the second shift revealed she would be applying the cream at 8:00pm.</p> <p>Observations on 11/20/15 at 9:45am revealed: -The MA went to apply the triamcinolone 0.1% to resident #6 's affected areas. -The container was about ½ full of cream. -Resident #6 was fighting the MA and the personal care aide who assisted. -The resident had a red rash that appeared flat in some areas and raised in others which covered her entire upper body torso, arms, back, upper thighs and upper buttocks. -The MA applied the cream to the resident's arms, shoulders, chest, abdomen and sides. The MA needed the entire half container of cream for the application. -There was not enough to cover the resident's thighs and buttocks</p> <p>Review of the October 2015 and November 2015 MARs revealed: -A single container of 60gms of triamcinolone 0.1% lasted the staff for a total of 62 applications from 10/12/15 through 10/31/15 and 11/1/15 through 11/3/15. - A single container of 60gms of triamcinolone 0.1% lasted the staff for a total of 22 applications</p>	D 358		

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D 358	Continued From page 6 from 11/4/15 through 11/11/15. - A single container of 60gms of triamcinolone 0.1% lasted the staff for a total of 26 applications from 11/11/15 through 11/20/15. Review of the Plan of Protection submitted by the facility on 11/20/15 revealed the facility will ensure doctors' orders for administration are followed. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 4, 2016.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on interviews, review of staff time records, and review of staff scheduling ; the facility failed to properly staff 5 of 14 reviewed (3rd shifts) in the Special Care Unit to meet the minimum staffing requirement. The findings are:	D 465		

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D 465	<p>Continued From page 7</p> <p>Interview with the Administrator on 11/20/15 at 6PM confirmed there were 47 residents in the Special Care Unit on Sunday September 27, 2015, Wednesday September 30, 2015 and Friday October 2, 2015.</p> <p>Based on the requirement for staffing a special care unit with 47 as a census; the minimum requirement should have been 37.6 hours of staffing for third shift.</p> <p>Review of third shift time records for September 27, 2015 to October 3, 2015 revealed the following days were short staffed: -September 27,2015 there were 31.25 staffed hours for the unit on third shift. -September 30, 2015 there were 31 staffed hours for the unit on third shift. -October 2, 2015 there were 26.25 staffed hours for the unit for third shift.</p> <p>Interview with the Administrator on 11/20/15 at 6PM confirmed there were 46 residents in the special care unit on Thursday October 29,2015, and Friday October 30, 2015.</p> <p>Based on the requirement for staffing a special care unit with 46 as a census; the minimum requirement should have been 36.8 hours of staffing for third shift.</p> <p>Review of third shift time records for October 25, 2015 to October 31, 2015 revealed the following days were short staffed: -October 29, 2015 there were 32.5 staffed hours for the unit for third shift. -October 30, 2015 there were 23.5 staffed hours for the unit for third shift.</p>	D 465		

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{D914}	Continued From page 8	{D914}		
{D914}	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer a medication as ordered by the prescribing practitioner to 1 of 4 residents sampled in the Special Care Unit by documenting 62, 26 and 22 applications of triamcinolone 0.1% cream from a 60gms containers (Resident #6).[Refer to Tag D 358, 10A NCAC 13F .1004 (a)(1) (Type B Violation)].</p>	{D914}		