

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL035017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE JORDAN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>90 COTTRELL ROAD</b> <b>LOUISBURG, NC 27549</b>
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C 000	Initial Comments  The Adult Care Licensures Section conducted a complaint investigation on December 30, 2015 with a telephone exit on January 7, 2016. The Wake County Department of Social Services initiated the complaint investigation on December 29, 2015.	C 000		
C 153	<p>10A NCAC 13G .0501 (a) Personal Care Training And Competency</p> <p>10A NCAC 13G .0501 Personal Care Training And Competency</p> <p>(a) The facility shall assure that personal care staff and those who directly supervise them in facilities without heavy care residents successfully complete a 25-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section. For the purposes of this Subchapter, heavy care residents are those for whom the facility is providing personal care tasks listed in Paragraph (i) of this Rule. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to assure 1 of 2 sampled staff (Staff B) successfully completed a 25 hour Personal Care and Training program.</p> <p>The findings are:</p> <p>Review of Staff B's personnel record revealed: -Staff B was hired 4/14/08.</p>	C 153		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 153	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-Staff B had a signed job description for a personal care aide.</li> <li>-Health Care Personal Registry check was completed 4/11/08.</li> <li>-No documentation of a 25 hour Personal Care and Training being completed.</li> </ul> <p>Attempted interview on 12/30/15 with Staff B was unsuccessful by exit.</p> <p>Interview on 12/30/15 at 3:10pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-Staff B had taken the training but she was unsure of the date.</li> <li>-She would fax a copy of the documents.</li> </ul> <p>The training documents were not recieved by exit.</p>	C 153		
C 234	<p>10A NCAC 13G .0801(d) Resident Assessment</p> <p>10A NCAC 13G .0801Resident Assessment (d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other appropriate licensed health professional such as a mental health professional, nurse practitioner, physician assistant or registered nurse in a timely manner consistent with the resident's condition but no longer than 10 days from the significant change, and document the referral in the resident's record. Referral shall be made immediately when significant changes are identified that pose an immediate risk to the health and safety of the resident, other residents or staff of the facility.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p>	C 234		

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C 234	<p>Continued From page 2</p> <p>Based on observations, record reviews and interviews the facility failed to assure an immediate referral was made for a significant change in 1 of 2 sampled residents (Resident #1) that posed an immediate risk to the health and safety of residents resulting in the death of a resident (Resident #2).</p> <p>The findings are:</p> <p>Interview with Staff B on 12/29/2015 at 12:05 pm revealed:</p> <ul style="list-style-type: none"> <li>-In the early morning hours on 12/29/15 at 2:00am he heard screaming, went to the room, and noticed the lights were off, so he turned the lights on. He observed Resident #2 lying on the floor next to the chair face down.</li> <li>-Resident #2 did not respond and he noticed 3 spots of blood on her back.</li> <li>-He stated Resident #1 was standing next to Resident #2, she (Resident #1) was holding something behind her back.</li> </ul> <p>Interview on 12/29/15 at 12:05pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-"I should have seen it, I should have seen it. I should have seen she wasn't handling it."</li> <li>-In the past Resident #1 had been hospitalized during this time of year for depression and "acting out", (agitation, anxiety).</li> <li>-The last 3 years Resident #1 had not been hospitalized, as she had no signs of depression or "acting out".</li> </ul> <p>Review of Resident #1's current FL2 dated 2/10/15 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 was admitted on 10/12/07.</li> <li>-Diagnoses included paranoid schizophrenia, bi-polar disorder, diabetes mellitus type 2, hypertension, hyperlipidemia, and</li> </ul>	C 234		

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C 234	<p>Continued From page 3</p> <p>hypercholesterolemia.</p> <p>-Resident #1 was ambulatory.</p> <p>-Medication orders included: Lexapro 10 mg daily Klonopin 1 mg twice daily Cogentin 1 mg three times daily</p> <p>Review of subsequent physician orders revealed: -A written order dated 9/17/15 for Risperidone 4 mg 2 tabs at bedtime. -A written order dated 12/22/15 to discontinue Clonazepam 1 mg twice daily routine and changed to Clonazepam 1 mg twice a day as needed for anxiety.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for December 2015 from 12/22/15 through 12/28/15 revealed: -Clonazepam was changed to twice daily as needed for anxiety on 12/22/15. -Clonazepam was documented as given twice daily from 12/22/15-12/25/15 at 8:00am and 8:00pm. -Clonazepam was not documented as administered from 12/25/15 to the date of discharge, 12/29/15.</p> <p>Review of Resident #1's care plans and assessment revealed: -There was a care plan dated 12/22/14. -The care plan noted that Resident #1 required no assistance with any activities of daily living. -There was no mental health services indicated.</p> <p>Review of Resident #1's medical record revealed: -There was no care plan completed in 2015. -There were no mental health referrals for Resident #1. -Resident #1 was seen by the primary care physician on 6/24/15 with a follow-up appointment</p>	C 234		

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C 234	<p>Continued From page 4</p> <p>scheduled for 9/24/15.</p> <p>-On 7/13/15, the primary care physician mailed a letter to Resident #1 that effective 8/14/14, the practice was no longer able to provide medical care to Resident #1.</p> <p>-On 8/31/15, Resident #1 was seen by a new primary care physician with a follow-up appointment scheduled for 11/30/15.</p> <p>-On 12/2/15, Resident #1 saw another new primary care physician, (due to the previous physician leaving)with a follow-up appointment on 12/22/15.</p> <p>Interview with one resident on 12/30/15 at 9:45am revealed:</p> <p>-Resident #2 had not been here that long.</p> <p>-Resident #2 did not like Resident #1.</p> <p>-Resident #1 would swing out and cry a lot.</p> <p>- "She (Resident #1) hit her (Resident #2) and she (Resident #2) died.</p> <p>-They (Resident #1 and #2) did not get along.</p> <p>-I don't know if they argued.</p> <p>-I did not hear them argue."</p> <p>Interview with a second resident on 12/30/15 at 9:55am revealed:</p> <p>-I did not hear nothing until the police got here.</p> <p>-They (Resident #1 and #2) did argue once in a while.</p> <p>-The staff was not aware of the arguing.</p> <p>-I could not hear them when they argued from my room."</p> <p>Interview with a third resident on 12/30/15 at 2:10pm revealed:</p> <p>-The resident never heard fighting or arguing between Resident #1 and #2.</p> <p>-None of the residents had been mean.</p> <p>- "I don't know them that good."</p>	C 234		

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C 234	<p>Continued From page 5</p> <p>Interview with the Administrator on 12/30/15 at 10:05am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had been living in the home for 7 or 8 years.</li> <li>-Resident #1 would get depressed around the holidays.</li> <li>- I tried to keep her [Resident #1] upbeat around this time of year.</li> <li>-I noticed in November 2015, she [Resident #1] was sad and sleeping a lot.</li> <li>-I tried to go ahead and get on top of it, so I called a hospital in another town to see if they had a bed to have Resident #1 admitted. They gave me the run around. The first time I called they did not have a bed and then the second time, they had closed the psych unit.</li> <li>-I thought I could handle it, (the depression).</li> <li>- I could talk to her [Resident #1] and she would be fine.</li> <li>-The primary physician office shut down and the new physician discontinued all Resident #1's psych (sic) medications.</li> <li>-The physician told the staff that, Klonopin, one of the medications Resident #1 was taking would cause dementia from taking it long-term.</li> <li>-After the medication change on 12/22/15, Resident #1 was irritable.</li> <li>-I feel like her system went into shock because of the medication change.</li> <li>-She seemed more depressed, irritable, aggressive, and argumentative.</li> <li>- I noticed a change in her [Resident #1's] voice; it didn't sound the same, more high-pitched.</li> <li>-Last week, it was like she (Resident #1) had a split personality, one minute she was talking fine and then the next her voice was real high pitched and "got to me."</li> <li>-The staff let the doctor know about Resident #1's change in her voice.</li> <li>-The staff got frustrated because the doctor did</li> </ul>	C 234		

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C 234	<p>Continued From page 6</p> <p>not get back with them.</p> <ul style="list-style-type: none"> <li>- Yesterday, one of the residents told me Resident #1 was fussing at her.</li> <li>-On Sunday (12/27/15), the staff at work called me and told me that Resident #1 had been fussing at her.</li> <li>-I had talked to Resident #1 before the staff called me at 10:12am, and Resident #1 told me the staff was in the room talking loud.</li> <li>-Resident #1 loved church, but did not go this past Sunday (12/27/15).</li> <li>-I saw her [Resident #1] Monday (12/28/15) evening, and she was wearing a wig and was happy, laughing.</li> <li>-Resident #1 was a good person, looked out for everyone else.</li> <li>-On 12/23/15, a church member took Resident #1 out to lunch and "that is where the knife came from Resident #1 used to stab Resident #2."</li> <li>- The knife was curved and I have never had knives like that here.</li> <li>- We keep scissors and knives locked in the office.</li> <li>-Resident #1 went home on Christmas with her family.</li> <li>- Resident #1's family member told me yesterday (12/29/15) that Resident #1 was on her cell phone when home for Christmas, but the family member did not know who it was. I think it was" them voices."</li> <li>-Resident #1 would hear voices during a crisis and the staff would notify mental health, but Resident #1 has not had a crisis in the last three years.</li> <li>-Resident #1 hadn't told me she was hearing voices."</li> </ul> <p>Interview with Staff A, Personal Care Aide, on 12/30/15 at 2:12pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff A started working at the home in 2014.</li> </ul>	C 234		

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C 234	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>- I was not here during those times between November-January in previous years when Resident #1 was taken to other facilities (hospitals).</li> <li>- "Resident #1 was a caring and good person, helped other residents.</li> <li>- This was not her [Resident #1].</li> <li>- I do not know what happened, why she did this.</li> <li>- She [Resident #1] had done her laundry and when I left at 4:30pm on 12/28/15, she was fine.</li> <li>- Resident #1 had not been angry or had any anxiety.</li> <li>- Resident #1 was not receiving mental health services, only seeing the primary care physician.</li> <li>- In August, the physician's office closed and Resident #1 was given to another physician.</li> <li>- That doctor left too and we got her a new one.</li> <li>- I was with her at the appointment on 12/22/15 when the doctor stopped the Klonopin (clonazepam). He said long-term use would cause dementia and Resident #1 said that is why she had been forgetting.</li> <li>- The doctor told me to watch out for anxiety, but nothing else.</li> <li>- Resident #1 saw this doctor for the first time on 12/2/15 and had lab work done.</li> <li>- The doctor changed the order (per the pharmacy) to take the Klonopin on a "as needed" basis on 12/2/15.</li> <li>- "I continued the twice daily order because I never got an order to discontinue the twice daily original order. I kept calling and left messages."</li> <li>- I finally made an appointment for 12/22/15 because I felt like that wasn't good for Resident #1 to come off it [Klonopin].</li> <li>- I questioned the doctor that Resident #1 had been taking Klonopin for so long and the doctor never said anything about tapering off.</li> <li>- Resident #1 had been excited about Christmas and going home.</li> </ul>	C 234		
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C 234	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-Resident #1 never threatened staff or residents.</li> <li>-Resident #1 did not act different other than being quieter after going home for Christmas.</li> <li>-When I came yesterday (12/29/15), Resident #1 was sitting here in shock. I heard Resident #1 talking to the police officer and "it didn't sound like her; her voice was different."</li> </ul> <p>Interview with Staff C, Personal Care Aide, on 12/30/15 at 4:06pm revealed:</p> <ul style="list-style-type: none"> <li>-If Resident #1 got upset, she would get quiet.</li> <li>-Resident #1 would get upset if she ran out of cigarettes or if her family did not come.</li> <li>-There would be a change in Resident #1's attitude, but never anger.</li> <li>- On Sunday (12/27/15) morning, Resident #1 told me I needed to go get the trash up out of the hall.</li> <li>-That same day, I was on the phone and Resident #1 told me I was too loud.</li> <li>-A cigarette got missing from the top of the radio where she had laid it and Resident #1 got mad about that. She thought I took it.</li> <li>- Resident #1 had never talked like that to me.</li> <li>-It seemed more like she was ordering me to do something.</li> <li>-I never noticed a change in Resident #1's voice.</li> <li>-Yesterday (12/29/15), it seemed like Resident #1 did not know what happened.</li> <li>-On Christmas Eve, Resident #1 was up a lot and could not sleep, because she was excited about the holiday.</li> <li>-The residents are only able to use forks, spoons, and butter knives. All sharp knives are kept locked up.</li> </ul> <p>Interview on 12/29/15 at 12:05pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had been there a long time, since 2007, and would have little spats with Resident</li> </ul>	C 234		

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C 234	<p>Continued From page 9</p> <p>#2, like taking things from each other or being on each other's side of the room.</p> <p>-Every year around this time, Resident #1 would act out, become irritable and easily agitated, and Resident #1 had previously been placed in the hospital for this, but not within the past 3 years.</p> <p>-Resident #1 had been up all night on Christmas Eve excited about her children coming.</p> <p>-Reported after stopping the Klonopin, Resident #1's voice changed, became higher sounding when Resident #1 talked.</p> <p>Interview on 12/29/15 at 12:05pm with Staff B , PCA revealed:</p> <p>-"It was a normal thing for Resident #1 and Resident #2 to argue over each other being on the wrong side of the room.</p> <p>-He was not sure what had upset Resident #1 on the night of the incident (12/28/15).</p> <p>-He had talked with Resident #1 when she got up for a drink of water, and Resident #1 calmed down, went to bed, and pulled the covers up.</p> <p>-About 2-3 minutes later, he heard screaming, went to the room, and noticed the lights were off, so he turned the lights on.</p> <p>-Resident #2 was lying on the floor next to the chair face down.</p> <p>-Resident #2 was not responding and he noticed 3 spots of blood on her back.</p> <p>-He stated Resident #1 was standing next to Resident #2 holding something behind her back. (Resident #1).</p> <p>-He ran to call 911 and came back to the bedroom to start Cardiopulmonary Resuscitation,(CPR).</p> <p>Observation on 11/29/15 at 12:05pm of Staff B revealed:</p> <p>-Staff B became visibly shaken and unable to talk further.</p>	C 234		

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C 234	<p>Continued From page 10</p> <p>-Staff B used his hands moving them back and forth rapidly to demonstrate that blood was gushing from Resident #2's neck area and coming out of Resident #2's mouth.</p> <p>Continued interview with Staff B revealed: -He did not attempt CPR, but did attempt to get Resident #1 to leave the room. Resident #1 had a blank look on her face did not respond to him or leave the room. -He left the room and went back to the staff breakroom and again called 911. While he was on the phone, Resident #1 walked past, shaking her head and saying, "Jesus, Jesus, Jesus."</p> <p>Telephone interview with the Pharmacy Manager on 12/31/15 at 9:23am revealed: -If Klonopin was stopped, the only thing you would see would be increased anxiety. - "We received an order on 12/8/15 to change the Klonopin to as needed. -I would be worried if the doctor had changed Risperdal or Lexapro. -With increased depression, any resident could experience increased anxiety or erratic behaviors. -Resident #1 was on a high dose of Risperdal which was why she was taking Cogentin, to counteract the side effects of the Risperdal."</p> <p>Attempted interview with the primary care physician or office staff were unsuccessful by exit.</p> <p>Attempted interview with Resident #1's family member were not successful by exit.</p> <p>Attempted interview with Staff B were not successful by exit.</p>	C 234		

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C 234	<p>Continued From page 11</p> <p>A Plan of Protection was submitted by the facility on 12/31/15 as follows: -Once a resident leaves the facility, upon return to facility the resident's bags and personal belongings need to be searched to make sure no weapons or any dangerous objects are being brought into the facility. -Putting a plan in place that ensures all materials entering the facility are properly searched so that no residents are at risk.</p> <p>An amended Plan of Protection requested from the facility on January 7, 2016.</p> <p>DATE OF CORRECTION FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 6, 2016.</p>	C 234		
C 247	<p>10A NCAC 13G .0902(c) Health Care</p> <p>10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care;</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure documentation of facility contacts and visits for 1 of 2 sampled residents (Resident #1) with a primary care providers.</p>	C 247		

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C 247	<p>Continued From page 12</p> <p>The findings are:</p> <p>Review of Resident #1's record revealed Resident #1 was admitted on 10/12/07.</p> <p>Review of Resident #1's current FL2 dated 10/12/15 revealed: -Diagnoses included paranoid schizophrenia, bi-polar disorder, diabetes mellitus type 2, hypertension, hyperlipidemia, and hypercholesterolemia. -No documentation of contacts with the primary care physician. -There was no progress notes in the medical record for Resident #1's physician visits on 12/2/15 or 12/22/15.</p> <p>Interview with the Administrator on 12/30/15 at 10:05am revealed: -Staff A went to the primary care physician appointments with the residents. -She didn't remember the date. "We would have to check with Staff A, as she keeps all that information. -I know staff calls the doctors about concerns because the staff complains the doctors never calls them back."</p> <p>Interview with Staff A, Personal Care Aide, on 12/30/15 at 2:12pm revealed: -"Resident #1 was not receiving any mental health services since she had been there, only the primary physician. -In August, the physician's office closed and Resident #1 was given to another physician. -That doctor left and we got her a new one. - She went to the new doctor on 12/2/15 and 12/22/15. That's when the doctor changed the Klonopin to as needed. I kept calling and leaving</p>	C 247		

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C 247	Continued From page 13  messages for them to call me back about the medication change. I finally made the appointment on the 22nd so I could talk to them. -I will look for my notes in the log book from where I called the doctor's office. -I will also look for the doctor's progress notes as well."  The telephone log book notes or the doctor's progress notes were not recieved by exit.  Attempted interviews with the primary care physican were not returned by exit.	C 247		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care  10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side	C 375		

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C 375	<p>Continued From page 14</p> <p>effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record;</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide quarterly pharmaceutical care and services for 5 of 6 residents.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 2/10/15 revealed: -Resident #1 was admitted on 10/12/07. -Diagnoses included paranoid schizophrenia, bi-polar disorder, Diabetes Mellitus Type 2, hypertension, hyperlipidemia, and hypercholesterolemia.</p> <p>Review of Resident #1's pharmacy review revealed the last pharmacy drug review was completed 2/5/15 with no recommendations or follow-up.</p> <p>Telephone interview with a Pharmacist for the facility's pharmacy provider on 12/31/15 at 8:25am revealed: - "I am not sure how often drug reviews are done. I would need to check with the pharmacy manager. -The physician can just stop Klonopin; it does not have to be tapered that I know of.</p>	C 375		

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C 375	<p>Continued From page 15</p> <p>-There are no side effects that I am aware of to watch for if Klonopin is stopped."</p> <p>Telephone interview with the Pharmacy Manager on 12/31/15 at 9:23am revealed:</p> <p>-If Klonopin was stopped, the only thing you would see would be increased anxiety.</p> <p>- "We received an order on 12/8/15 to change the Klonopin to as needed.</p> <p>-I would be worried if the doctor had changed Risperdal or Lexapro.</p> <p>-With increased depression, any resident could experience increased anxiety or erratic behaviors.</p> <p>-Resident #1 was on a high dose of Risperdal which was why she was taking Cogentin, to counteract the side effects of the Risperdal."</p> <p>-With family care homes, drug reviews are done every three months.</p> <p>-There is a schedule that the pharmacy goes by, but there is a charge for the service.</p> <p>-The service includes quarterly drug reviews, LHPS tasks, and Medication Aide evaluations and checklists.</p> <p>-The pharmacy staff will call the facility to remind them that reviews are due, and if the facility pays for the review, the pharmacy staff will set up a date to complete the services.</p> <p>-If not payment is received, then no services are scheduled and the pharmacist does not go out.</p> <p>Refer to interview with Staff A, Personal Care Aide, on 12/30/15 at 2:12pm.</p> <p>Refer to telephone interview with the pharmacy's clinical director on 12/31/15 at 11:01am .</p> <p>2. Review of Resident #2's current FL2 dated 3/17/15 revealed:</p> <p>-Diagnoses included Alzheimer's dementia, altered mental staus, hypertension, Diabetes</p>	C 375		

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C 375	<p>Continued From page 16</p> <p>Mellitus, osteoarthritis and gout.</p> <p>Review of Resident #2's record revealed an admission date of 4/15/15.</p> <p>Review of Resident #2's pharmacy review revealed the last pharmacy drug review was completed 2/5/15 with no recommendations or follow-up.</p> <p>Refer to interview with Staff A, Personal Care Aide, on 12/30/15 at 2:12pm.</p> <p>Refer to telephone interview with the pharmacy's clinical director on 12/31/15 at 11:01am .</p> <p>Refer to telephone interview with the pharmacy manager on 12/31/15 at 9:23am.</p> <p>3. Review of 4 non-sampled residents records revealed: -One resident was admitted on 11/3/15 and was not due for a pharmacy review. -Three residents pharmacy reviews were last completed on 2/5/15 with no recommendations or follow-up.</p> <p>Refer to interview with Staff A, Personal Care Aide, on 12/30/15 at 2:12pm.</p> <p>Refer to telephone interview with the pharmacy's clinical director on 12/31/15 at 11:01am .</p> <p>Refer to telephone interview with the pharmacy manager on 12/31/15 at 9:23am.</p> <p>_____ Interview with Staff A, Personal Care Aide, on 12/30/15 at 2:21pm revealed: -We have to call the pharmacy to schedule the</p>	C 375		

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C 375	Continued From page 17  drug reviews. -"I just called the to set up a time today for them to come out to do them."  Telephone interview with the pharmacy's clinical director on 12/31/15 at 11:01am revealed: -The facility had to payfor nursing services which included the drug reviews and LHPS tasks. -Once the facility pays for the service, we log the payment, and set up a time to come out to the home and complete the services due or needed. -On 9/8/15, the pharmacy manager e-mailed a staff at the home called to get drug reviews set up, but no payment was received, so the reviews have not been done. -The staff said at that time the drug reviews had not been done since February 2015. -It was identified in September 2015, the drug reviews had not been completed, but would not be done until the facility paid for the services.  Telephone interview with the Pharmacy Manager on 12/31/15 at 9:23am revealed: -With family care homes, drug reviews are done every three months. -There is a schedule that the pharmacy goes by, but there is a charge for the service. -The service includes quarterly drug reviews, LHPS tasks, and Medication Aide evaluations and checklists. -The pharmacy staff will call the facility to remind them that reviews are due, and if the facility pays for the review, the pharmacy staff will set up a date to complete the services. -If not payment is received, then no services are scheduled and the pharmacist does not go out.	C 375		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights	C 912		

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C 912	<p>Continued From page 18</p> <p>G.S. 131D-21 Declaration of Resident's 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 interviews and record reviews the facility failed to provide care and services which were adequate and appropriate resulting in the death of a resident (Resident #2) by another resident (Resident #1).</p> <p>The findings are:</p> <p>A. Based on observations, record reviews and interviews the facility failed to assure an immediate referral for a significant change in 1 of 2 sampled residents (Resident #1) that posed an immediate risk to the health and safety of residents resulting in the death of a resident (Resident #2). [Refer to Tag 0234, 10a NCAC 13G .0908 (d), Resident Assessment, (Type A1 Violation)].</p>	C 912		
C 934	<p>G.S. 131D-4.5B (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and</p>	C 934		

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C 934	<p>Continued From page 19</p> <p>glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 2 of 2 staff (Staff A and Staff B) completed an annual in-service training program on infection control.</p> <p>The findings are:</p> <p>1. Review of the personnel record for Staff A, Personal Care Aide, (PCA) on 12/30/15 revealed: -Staff A was hired as a PCA on 3/2/11. -Staff A completed the five hour Medication Training on 1/16/14 and the ten hour Medication Training on 1/21/14. Staff A completed a Medication Clinical Skills checklist on 2/4/14. -Staff A completed Medication Aide testing on 4/9/14. -Infection control training was last completed on 10/1/14.</p> <p>Interview with Staff A on 12/30/15 at 3:00pm revealed: - "I think I have had Infection Control training this year. -I will have to look in the folder to see if I can find the certificate."</p>	C 934		

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C 934	<p>Continued From page 20</p> <p>Review of information received from the facility via fax on 1/4/16 revealed Staff A completed Infection Control training on 1/4/16.</p> <p>2. Review of the personnel record for Staff B, PCA, on 12/30/15 revealed: -Staff B was hired as a PCA on 4/14/08. -Staff B completed the five hour Medication Training on 1/16/14 and the ten hour training on 1/21/14. -Staff B completed Medication Clinical Skills checklist on 2/4/14.</p> <p>Review of information recieved from the facility via fax on 1/4/4/16 revealed completed Infection Control training on 1/4/16.</p> <p>Attempted interview with Staff B was unsuccessful by exit.</p> <p>Interview on on 12/30/15 at 3:00pm with Staff A, PCA revealed that she thought Staff B had the Infection Training but she wasn't sure.</p> <p>Review of information received from the facility via fax on 1/4/16 revealed Staff B completed the Infection Control Training on 1/4/16.</p>	C 934		
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> <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</p>	C935		

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C935	<p>Continued From page 21</p> <p>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> <ol style="list-style-type: none"> <li>a. The key principles of medication administration.</li> <li>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.</li> </ol> <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> <ol style="list-style-type: none"> <li>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ol style="list-style-type: none"> <li>1. The key principles of medication administration.</li> <li>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.</li> </ol> </li> <li>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</li> </ol> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to assure 1 of 2 sampled staff (Staff B) had successfully completed the state approved</p>	C935		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C935	<p>Continued From page 22</p> <p>Medication Aide test.</p> <p>The findings are:</p> <p>Review of the personnel record for Staff B, Personal Care Aide, (PCA) on 12/30/15 revealed:</p> <ul style="list-style-type: none"> <li>-Staff B was hired as a PCA on 4/14/08.</li> <li>-No documentation of successful completion of the state Medication Aide testing.</li> <li>-Staff B completed the five hour Medication Training on 1/16/14 and the ten hour training on 1/21/14.</li> <li>-Staff B completed Medication Clinical Skills checklist on 2/4/14.</li> </ul> <p>Attempted interview with Staff B was unsuccessful by exit.</p> <p>Interview on 12/30/15 at 3:00pm with Staff A revealed:</p> <ul style="list-style-type: none"> <li>-Staff B worked alone on third shift.</li> <li>-She thought Staff B had completed the test.</li> <li>-She was unsure of the date of completion.</li> <li>-She was unsure where the documentation was.</li> <li>-She would find it and fax.</li> </ul> <p>Requested documentation was not received by exit.</p> <p>Review of the State Medication Testing site revealed Staff B completed the Medication exam on 4/19/14 unsuccessfully.</p> <p>Attempted interview with the Administrator was unsuccessful by exit.</p>	C935		