

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092177 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/11/2016 |
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| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE | STREET ADDRESS, CITY, STATE, ZIP CODE 300 KILDAIRE WOODS DRIVE CARY, NC 27511 |
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| D 000 | Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/08/16 - 03/11/16. | D 000 | | |
| D 234 | <p>10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio</p> <p>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 5 residents (#4) sampled was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:</p> <p>Review of Resident #4's current FL-2 dated 02/16/16 revealed the diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, osteoporosis, hypothyroidism, thyroidectomy, and bladder suspension.</p> <p>Review of Resident #4's Resident Register revealed an admission date of 08/26/13.</p> <p>Review of Resident #4's tuberculosis information in the record revealed: - One tuberculosis (TB) skin test placed on</p> | D 234 | | |

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

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| D 234 | <p>Continued From page 1</p> <p>08/01/13 and read as negative on 08/03/13.</p> <ul style="list-style-type: none"> - There was no documentation of any other TB skin test in the record. <p>Interview with the Assisted Living Director (ALD) on 03/10/16 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - The Special Care Coordinator (SCC), a nurse, would have been responsible for assuring a two-step TB skin test was completed for all residents in the Special Care Unit. - The SCC resigned in February 2016 and the position was currently vacant. - The ALD checked the facility's tickler system log for TB skin tests but it was incomplete. - She did not know why the ticker system was incomplete or who monitored the system. - The ALD would check in the SCU for any documentation of a TB skin test not filed in Resident #4's record. <p>Interview with the ALD on 03/11/16 at 10:50 a.m. revealed:</p> <ul style="list-style-type: none"> - She found a form in the SCU office that documented a TB skin test done for Resident #4 in June 2015. - It appeared the former SCC may have reviewed record and realized some residents only had one TB skin test on file in June 2015. - The SCC had placed TB skin tests for several residents in the SCU in June 2015 including Resident #4. - She was not able to locate any TB skin tests within 12 months of each other for Resident #4. - They planned to place another TB skin test for Resident #4 today. <p>Review of a TB form for Resident #4 revealed:</p> <ul style="list-style-type: none"> - The former SCC had placed a TB skin test for Resident #4 on 06/22/15 and read it as negative on 06/25/15. | D 234 | | |

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| D 234 | Continued From page 2 - No other TB skin tests were documented for Resident #4. | D 234 | | |
| D 273 | <p>10A NCAC 13F .0902(b) Health Care</p> <p>10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, record review, and interview, the facility failed to assure health care needs were met for 3 of 3 sampled residents (#3, #4, #5) as related to failure to obtain a gel overlay mattress for a resident who developed two stage II decubiti (#5), failure to obtain urinalysis and culture and sensitivity in a timely manner (#5), failure to obtain two urinalysis as ordered (#4), and failure to obtain a specialized wheelchair for a resident with special needs due to history of spinal injury/surgery (#3). The findings are:</p> <p>1. Review of Resident #5's current FL-2 dated 07/06/15 revealed the resident's diagnosis included memory loss.</p> <p>A. Review of a physician's order for Resident #5 dated 08/03/15 revealed there was an order for a gel pad overlay for the hospital bed of the resident.</p> <p>Review of Physician Visit Summary for Resident #5 dated 08/03/15 revealed Resident #5 had a Stage I pressure sore to his left shoulder and left</p> | D 273 | | |

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| D 273 | <p>Continued From page 3</p> <p>hip secondary to weight loss, poor nutritional status, and extended periods in bed.</p> <p>Review of Physician Visit Summary for Resident #5 dated 03/03/16 revealed Resident #5 had an open Stage II pressure sores to his left shoulder and left hip.</p> <p>Observation of Resident #5 on 03/08/16 at 12:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #5 was lying in bed asleep on his left side. - There was no gel pad overlay on the resident's bed. <p>Interview with Resident #5 on 03/08/16 at 12:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #5 was oriented to person only. - Resident #5 refused to come to dining area for lunch because he didn't feel well. - Resident #5 referred to dressings to his left hip and left shoulder as patches. - He didn't know why he had the dressings on his left hip or left shoulder. <p>Review of a physician's order for Resident #5 dated 03/10/16 revealed:</p> <ul style="list-style-type: none"> - There was a second order for a gel pad overlay for diagnosis of decubitus ulcers. <p>Observation of Resident #5 on 03/10/16 at 10:25 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #5 used a rolling walker. - He walked hunched over the walker. - Resident #5 walked with the left side of his body lower than his right side. - Resident #5 was able to walk independently with his rolling walker to his room for wound care. - Resident #5 had dressings that covered wound sites to his left hip and left shoulder. | D 273 | | |

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| D 273 | <p>Continued From page 4</p> <ul style="list-style-type: none"> - Both dressings were removed by the home health nurse. - There was slight redness to Resident #5's left shoulder that measured approximately a 3 inch diameter and 3 inch length. - There were 2 open areas to the center of the left shoulder wound sites that were both approximately 1½ inches wide and ½ inch long. - The wound site to left hip for Resident #5 was red and approximately 4 inches wide and 5 inches long. - Two opens areas were noted to Resident #5's left hip that were each approximately 1½ to 2 inches long and ½ to 1 inch wide with yellowed interiors. - There was no drainage or odor to wound sites of the left shoulder or left hip of Resident #5. <p>Interview with the Home Health Nurse for Resident #5 on 03/10/16 at 10:30 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #5 has had a steady decline over the last 2 or 3 months. - She was not sure what happened with Resident #5's left hip and left shoulder. - The wound sites initially looked like an extremely dry rash but then the areas opened on Resident #5's left hip and left shoulder. - Resident #5 liked to lie on his left side while he was in bed. - She did not know about previous order for gel pad overlay from August 2015. <p>Interview with Medication Aide (MA) on 03/10/16 at 10:50 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #5 did not have a gel pad overlay on his bed. - She remembered that Resident #5 was supposed to have gotten a physician's order for a gel pad overlay about 2 or 3 months ago. - She did not know why Resident #5 had not | D 273 | | |

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| D 273 | <p>Continued From page 5</p> <p>gotten the gel pad overlay.</p> <ul style="list-style-type: none"> - Resident #5 had to be seen by home health for wound care because he laid on his left side too much. <p>Interview with Physician Assistant (PA) for Resident #5 on 03/10/16 at 1:35 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not know what happened with the order for Resident #5 to have a gel pad overlay to his hospital bed back in August 2015. - She thought the home health nurse was supposed to have ordered the gel pad overlay for Resident #5. - She did not know the order for the gel pad overlay had not been done. - The PA had spoken to the home health nurse on 03/07/16 for a second order for the gel pad overlay for Resident #5 but she was not sure if the pad had been ordered yet. - She had ordered home health to provide wound care to pressure areas on Resident #5's left hip and left shoulder on 03/03/16. <p>Interview with the Assistant Living Director (ALD) on 03/10/16 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> - She was responsible for the care of the residents on the Special Care Unit since the SCC position had been vacant since February 2016. - She did not know what happened with the 08/04/15 order for the gel pad overlay for Resident #5. - Home health had ordered the gel pad overlay this week but the resident had not received it yet. - The resident's family member may have refused to order the gel pad overlay because of the cost but the ALD was not sure. <p>Interview with a family member of Resident #5 on 03/10/16 at 3:47 p.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware that a gel pad overlay had | D 273 | | |

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| D 273 | <p>Continued From page 6</p> <p>been ordered for Resident #5 in August 2015.</p> <ul style="list-style-type: none"> - She had not been contacted by any durable equipment supplier, home health agency, or the facility in August 2015 about the gel pad overlay. - Resident #5 liked to lie on his left side when he was in bed. - Resident #5 had problems with the skin on his left side for the last 3 to 5 months. - Resident #5's family member noticed the open areas to his left hip and left shoulder in mid to late February 2016 and notified the facility. <p>Interview with the Resident Care Coordinator (RCC) on 03/11/16 at 10:40 a.m. revealed:</p> <ul style="list-style-type: none"> - She did not know about the gel pad overlay order from August 2015. - The Special Care Coordinator (SCC) usually handled the orders for durable equipment. - The SCC had not longer worked with the facility since mid-February 2016. - It was the responsibility of the SCC to order durable equipment. - The SCC position was currently vacant. - The ALD was currently responsible for the care coordination for residents in the Special Care Unit. <p>Interview with ALD on 03/11/16 at 11:05 a.m. revealed:</p> <ul style="list-style-type: none"> - She didn't know what happened with the gel pad overlay order from August 2015. - It was the responsibility of the SCC to check the gel pad overlay order from August 2015. - The SCC no longer worked with the facility and the position was vacant. - She didn't know if the SCC had followed up on the gel pad overlay order in August 2015. - The family for Resident #5 did not know about the gel pad overlay order. - The family may have refused the gel pad | D 273 | | |

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| D 273 | <p>Continued From page 7</p> <p>overlay due to the cost.</p> <ul style="list-style-type: none"> - There was no documentation the resident's family was contacted to order the gel pad overlay or refused the gel pad overlay due to cost. <p>Interview with the Physician for Resident #5 on 03/11/16 at 12:40 p.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware of the gel pad overlay order written by the PA in August 2015. - She was not sure what happened with the gel pad overlay order or if the gel pad had been ordered. - It was in her electronic medical records on 02/18/16 that Resident #5 had Stage I pressure sores to his left shoulder and left hip. - On 03/03/16, Resident #5 had further skin breakdown that required wound care. - The areas to left shoulder and left hip were Stage II pressure sores. <p>Observation of Resident #5 on 03/11/16 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #5 was lying in bed on his left side. - There was a gel pad overlay on the mattress of Resident #5's bed. <p>B. Review of a physician's order for Resident #5 dated 03/03/16 revealed there was an order for Resident #5 to have a urinalysis and urine culture.</p> <p>Observation of Resident #5 on 03/08/16 at 12:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident was lying in bed asleep on his left side. - There was an empty urine sample cup on the side of the sink in the resident's room. <p>Confidential interview with a Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> - Resident #5 used incontinence briefs due to | D 273 | | |

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| D 273 | <p>Continued From page 8</p> <p>urinary incontinence.</p> <ul style="list-style-type: none"> - The staff had tried to catch the resident before he is incontinent to get the urine sample - Resident #5 doesn't let them know when he has to go to the bathroom to urinate. <p>Confidential interview with a Personal Care Aide revealed:</p> <ul style="list-style-type: none"> - Resident #5 would not cooperate to get urine sample for urinalysis or urine culture. - Resident #5 would not tell staff if he had to urinate. - Resident #5 wore adult incontinence briefs due to urinary incontinence. - She had reported to the Resident Care Coordinator (RCC) on 03/05/16 she had not been able to get a urine sample on Resident #5. - She had documented on the medication aide communication report that she was unable to collect the urine sample on Resident #5 on the shifts that she worked. <p>Review of the Medication Aide communication report revealed:</p> <ul style="list-style-type: none"> - There was no documentation staff was unable to collect urine sample on Resident #5 on 03/03/16 or 03/04/16. - Staff documented they were unable to collect the urine sample on Resident #5 on 03/05/16, 03/06/16, and 03/07/16. - There was no documentation the RCC or the Assistant Living Director (ALD) were notified the urine sample for Resident #5 was not obtained. - There was no documentation the physician for Resident #5 was notified the urine sample was not obtained for the urinalysis/urine culture. <p>Interview with the Physician Assistant (PA) for Resident #5 on 03/10/16 at 1:35 p.m. revealed:</p> | D 273 | | |

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| D 273 | <p>Continued From page 9</p> <ul style="list-style-type: none"> - She had given an order for a urinalysis and urine culture to be done for Resident #5 as part of a post fall assessment on 03/03/16. - The PA found out during a routine visit on 03/07/16 that the urinalysis and urine culture had not been done on Resident #5. - Staff appeared to have forgotten the urinalysis and urine culture had been ordered when she asked if it had been done yet on 03/07/16. - No one at the facility had notified her the urinalysis and urine culture had not been done. - She did not give any additional orders to assist with getting the urine sample from Resident #5. <p>Interview with the RCC on 03/11/16 at 10:40 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #5 could be difficult to handle sometimes. - When the physician gave an order for a urinalysis, the urine sample was supposed to be gotten before the physician's next visit which was usually about a week later. - No staff had reported to her that they were unable to get the urine sample from Resident #5. - Staff were supposed to contact the ALD if they were having problems with getting the urine sample for Resident #5. - She was only responsible for the residents who lived on the Assisted Living halls. <p>Interview with the ALD on 03/11/16 at 11:05 a.m. revealed:</p> <ul style="list-style-type: none"> - The ALD was not aware Resident #5 had refused to cooperate to give a urine sample. - If there were problems with getting the urine sample for Resident #5, it should be communicated in the Medication Aide communication report. - The Medication Aides were supposed to | D 273 | | |

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| D 273 | <p>Continued From page 10</p> <p>communicate with the physician if staff were having problems with getting the urine sample from Resident #5.</p> <ul style="list-style-type: none"> - It was difficult to get a urine sample from Resident #5 because of his urinary incontinence. - She was not aware of any communication with the physician that it was difficult to get a urine sample from Resident #5. - Staff was supposed to notify her if they were having problems getting the urine sample from Resident #5. - Staff could also contact the RCC if they were having problems with getting the urine sample for Resident #5. <p>Interview with the ALD on 03/11/16 at 12:30 p.m. revealed:</p> <ul style="list-style-type: none"> - There was no policy on notification of the physician when the resident refused or did not cooperate with testing or treatment. - There was no policy that addressed the time frame to obtain expected urine samples ordered by the physician. - She would make a flowchart to help the staff to understand when to notify the physician if there were problems in getting urine samples for residents. <p>Interview with the Physician for Resident #5 on 03/11/16 at 12:40 p.m. revealed:</p> <ul style="list-style-type: none"> - The orders for Resident #5 had been handled mostly by the Physician Assistant. - She reviewed the order for the urinalysis and urine culture for Resident #5. - No one from the facility had contacted her office and advised of problems getting a urine sample for Resident #5. - She did not have a time frame she expected the facility to get ordered urine samples. - The facility usually called and the physician | D 273 | | |

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| D 273 | <p>Continued From page 11</p> <p>would discontinue the order if the urine sample was not obtainable.</p> <ul style="list-style-type: none"> - The facility had not contacted her office and advised of their problems getting the urine sample for Resident #5. - Urine sample had been collected on 03/08/16 and it was negative for urinary tract infection. - No urine culture would be performed since the urinalysis was negative. <p>2. Review of the current FL-2 dated 10/08/15 for Resident #3 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included vascular dementia, chronic back pain, coronary artery disease with stents, insomnia, hypertension, hyperlipidemia, and osteoarthritis. - The resident was constantly disoriented and documented as a wanderer. - The resident was semi-ambulatory using a wheelchair. - The resident required assistance with bathing and dressing. <p>Review of resident notes for Resident #3 revealed the resident was admitted to the Special Care Unit (SCU) of the facility on 10/13/15.</p> <p>Review of Resident #3's assessment and care plan dated 10/20/15 revealed:</p> <ul style="list-style-type: none"> - The resident had severe memory loss. - The resident required two person assist for transfers. - The resident required total assistance with bathing. - The resident could ambulate independently using wheelchair. - The resident required reminders and/or assistance with toileting, dressing and grooming. - The resident was independent with eating. | D 273 | | |

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| D 273 | <p>Continued From page 12</p> <p>Review of a primary care visit note dated 10/22/15 for Resident #3 revealed:</p> <ul style="list-style-type: none"> - The resident had debility secondary to history of spinal methicillin resistant staphylococcus aureus (MRSA) and back pain status post two back surgeries. - The resident had been improving with physical therapy (PT) and occupational therapy (OT). - The physician's assistant (PA) noted to continue high back wheelchair. <p>Review of a primary care visit note dated 10/26/15 for Resident #3 revealed:</p> <ul style="list-style-type: none"> - The resident had been working with physical therapy at the facility. - The resident walked 25 feet on two separate occasions since moving to the facility. - The resident would be needing a replacement wheelchair. <p>Review of Resident #3's record revealed no documentation of a replacement wheelchair being obtained by the facility for Resident #3.</p> <p>Review of resident notes for Resident #3 revealed on 11/18/15, the resident was observed on the floor in his room with no injuries.</p> <p>Review of a physical therapy visit note dated 11/24/15 revealed:</p> <ul style="list-style-type: none"> - Resident #3 was not safe to ambulate without physical therapy at this point and does not have a safe wheelchair. - There was a note to follow-up with wheelchair needs. <p>Review of Resident #3's record revealed no documentation of the facility following up with the resident's wheelchair needs.</p> | D 273 | | |

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| D 273 | <p>Continued From page 13</p> <p>Review of a physical therapy visit note dated 12/18/15 revealed:</p> <ul style="list-style-type: none"> - Resident #3 has met all goals except knee and hip range of motion are still limited. - The resident was able to ambulate up to 75 - 80 feet with physical therapist only and the resident's family has chosen to continue with a maintenance program. - The resident was now safe with transfers and needed supervision only but no physical assistance. - The discharge plan and instructions section noted the family was to order new rock and go wheelchair. (A rock and go wheelchair has tilt and height adjustments for comfort and support.) <p>Review of a primary care visit note dated 12/21/15 for Resident #3 revealed:</p> <ul style="list-style-type: none"> - The resident had a mechanical fall with wheelchair malfunction. - No injuries or pain were reported. - A new wheelchair was ordered. - The resident was sent to the emergency room for altered mental status and new onset tremors and dysphagia. - There was a concern for a urinary tract infection. <p>Review of Resident #3's record revealed no documentation to indicate a new wheelchair was obtained for the resident.</p> <p>Review of resident notes for Resident #3 revealed:</p> <ul style="list-style-type: none"> - On 01/23/16, the resident was trying to transfer out of the wheelchair to another chair and slid on the floor. There was no injuries. - On 01/26/16, the resident was screaming from his room for help. The resident was observed on | D 273 | | |

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| D 273 | <p>Continued From page 14</p> <p>the floor beside his bed bleeding from the forehead. Emergency Medical Services and family were called. The family refused to have resident sent out.</p> <p>Review of a primary care visit note dated 01/28/16 for Resident #3 revealed:</p> <ul style="list-style-type: none"> - The resident recently had a fall or roll out of bed (01/26/16). - The resident hit his head on a nearby wheelchair and emergency medical services evaluated the resident but he did not go to the hospital. - The laceration was currently scabbed to his right forehead. - The physician noted, "We will also follow-up on new wheelchair that has been ordered". <p>Review of Resident #3's record revealed no documentation of a new wheelchair being obtained for the resident.</p> <p>Observation and interview of Resident #3 on 03/09/16 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> - The resident was in the dining room area sitting in a tilt in space wheelchair. - The resident was sitting upright and the back of the wheelchair was only slightly tilted back. - The wheels on the wheelchair were worn and did not appear new. - The arms of the wheelchair had some tears in the fabric. - The resident was unable to answer questions about his wheelchair. <p>Interview with a medication aide / personal care aide on 03/09/16 at 12:35 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident #3 could transfer himself with standby assistance. - Resident #3 used a rolling walker with the | D 273 | | |

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| D 273 | <p>Continued From page 15</p> <p>assistance of staff for toileting.</p> <ul style="list-style-type: none"> - Resident #3 used a wheelchair to go to the dining room and other common areas and he could self-propel the chair. - Resident #3 had no recent falls and had gotten stronger after he had physical therapy. - She thought the resident had gotten a new wheelchair a couple of months ago. - She was unsure if the wheelchair the resident was currently using was the new one. <p>Telephone interview with a family member of Resident #3 on 03/09/16 at 3:48 p.m. revealed:</p> <ul style="list-style-type: none"> - She had a meeting last week with the facility about the resident's plan of care. - The resident recently fell out of bed and hit his head either on a table or the wheelchair. - She was not sure why the resident had not received a new wheelchair yet. - The physical therapist had measured the resident for a new wheelchair not long after he was admitted to the facility. - She could not tell where the problem was occurring with getting the new wheelchair. - The durable medical equipment (DME) company said they had been waiting on the physician to fill out paperwork since 01/27/16. - The physician's office said they had signed off on the paperwork and did not know what happened. - The resident's current wheelchair was one the resident had at home prior to moving to the facility. - She met with the ALD last week and she thought the issue with the wheelchair was now in the hands of the insurance company. - She was not sure when he was supposed to get the new wheelchair. - The resident had a history of infection in his spine and a history of chronic back pain and | D 273 | | |

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| D 273 | <p>Continued From page 16</p> <p>needed a new chair to help relieve some of the pain.</p> <p>Interview with the Assisted Living Director (ALD) on 03/10/16 at 3:17 p.m. revealed:</p> <ul style="list-style-type: none"> - The Special Care Coordinator (SCC) would be responsible for following up on orders for any residents in the special care unit (SCU). - The SCC left employment with the facility on 02/12/16. - She was not sure what happened with a new wheelchair for Resident #3. - If they received orders for durable medical equipment (DME), they would contact one DME company. - She had become aware of the issue with Resident #3's wheelchair when the resident's family brought it to her attention on 03/03/16 during a care plan meeting. - She was in the process of contacting DME companies to find out the status of the wheelchair. <p>Telephone interview with a representative from a medical supply company on 03/10/16 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - They received an order for a standard wheelchair from Resident #3's primary care office on 01/29/16. - An 18 inch standard wheelchair was delivered to the facility on 02/01/16. - A medication aide had signed for the wheelchair when it was delivered. - She gave the serial number of the wheelchair and stated it could be found on the stickers on the crossbars of the wheelchair. - There was no record of the wheelchair being returned or exchanged. <p>Interview with a medication aide on 03/10/16 at</p> | D 273 | | |

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| D 273 | <p>Continued From page 17</p> <p>4:45 p.m. revealed:</p> <ul style="list-style-type: none"> - She recalled a new wheelchair being delivered for Resident #3 on 02/01/16. - She signed for the wheelchair when it was delivered. - The resident had a rock and go wheelchair when he was admitted but it was broken and being stored in a storage room. - She did not realize the resident was not using the standard wheelchair delivered on 02/01/16. - She did not know what happened to the new standard wheelchair. <p>Telephone interview with a representative from a specialty DME company on 03/10/16 at 4:20 p.m. revealed:</p> <ul style="list-style-type: none"> - They received some paperwork signed by a family member of Resident #3 in October 2015. - They received paperwork from the physical therapist dated 01/22/16. - She did not know who sent the paperwork to the company. - They need a seven element prescription for the wheelchair with tilt. - She was not sure the status of the wheelchair and referred to the vendor case manager. <p>Attempt to contact the vendor case manager for the specialty DME company on 03/11/16 was unsuccessful.</p> <p>Interview with the ALD on 03/11/16 at 10:40 a.m. revealed:</p> <ul style="list-style-type: none"> - She just talked with the vendor case manager for the specialty DME company. - The vendor was contacted by the PT and he came to the facility (not sure of date). - The vendor met with the resident, family, and PT and did measurements for the specialty wheelchair (not sure of date). | D 273 | | |

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| D 273 | <p>Continued From page 18</p> <ul style="list-style-type: none"> - The vendor brought two trial wheelchairs that did not work for the resident. - The family then called the vendor back and wanted to move forward with one of the trial chairs (not sure of date). - The PT wrote a letter on 01/22/16 for the wheelchair and sent it to the specialty DME company. - About 2 to 3 weeks ago, the vendor contacted the family and reported they were waiting on a form from the physician. - She was not aware a new standard wheelchair had been delivered by a different medical supply company. - She was going to check on it. <p>Interview with a family member of Resident #3 on 03/11/16 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - While the resident was receiving physical therapy at the facility, the specialty DME company loaned the resident two different wheelchairs to try. - One of the wheelchairs did not work and the other one caused sores on his hands because the wheels had treads. - The resident has never had a standard wheelchair because of his chronic back pain. - She thought the order for a new wheelchair was initiated in October 2015, shortly after the resident was admitted to the facility. - She did not know why there had been a delay and it was her understanding the facility or physical therapist were taking care of it. <p>Interview with the physical therapist (PT) on 03/11/16 at 12:00 noon revealed:</p> <ul style="list-style-type: none"> - The resident was in a rock and go wheelchair when he first came to the facility in October 2015. - She found a specialty DME company that sold specialty wheelchairs because of the resident's | D 273 | | |

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| D 273 | <p>Continued From page 19</p> <p>back problems.</p> <ul style="list-style-type: none"> - She worked with the DME company and they found a chair that had a spring to take the stress off of the back and they did a trial with that wheelchair. - The staff said the resident was not tolerating the wheelchair because he was getting agitated which they felt was caused by back pain. - The family decided they wanted the resident to have a new rock and go wheelchair in December 2015. - She thought the cost of the chair was a factor because it was too soon for insurance to pay for another wheelchair. - A family member contacted the PT around January 2016 and had been shopping around and found a chair at the specialty DME company. - The vendor for the DME company and the PT measured the resident for a new chair. - The vendor with the DME company had to send specifications to the PT. - The PT sent paperwork with justifications for the wheelchair back to the vendor. - At that point it was out of her hands. - There had been some verbal communication with the facility about the wheelchair but she could not recall with whom or the specifics. - She had a call from the resident's family member about two weeks ago asking about the wheelchair. - She told the family member to call the physician. - She was not aware the resident still did not have a new wheelchair. - She had no communications with any other medical supply company about the wheelchair. - She was not aware a standard wheelchair had been delivered for Resident #3. - Resident #3 would not be able to sit in a standard wheelchair due to the condition of his | D 273 | | |

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| D 273 | <p>Continued From page 20</p> <p>back.</p> <p>Review of a letter dated 01/22/16 written by the PT revealed:</p> <ul style="list-style-type: none"> - Resident #3 underwent physical therapy from 10/2015 - 12/2015. - During therapy, trial wheelchairs were attempted but the family did not feel they were suitable. - Since that time, the family has realized the wheelchair recommended was a valuable asset. - The resident would need a manual tilt wheelchair. - The resident's back pain requires that he remain in some sort of tilt throughout the day to relieve pressure on his back. - The resident uses a wheelchair for at least 12 hours a day and would also benefit from a deep back cushion to maintain back alignment. <p>Interview and observation of the ALD on 03/11/16 at 1:10 p.m. revealed:</p> <ul style="list-style-type: none"> - The ALD rolled a standard wheelchair into the room and stated she found it in a locked storage closet in the SCU. - The standard wheelchair had a small white stain on the left side of the seat and there was dust on the wheelchair. - The serial number matched the number provided by the medical supply company for the wheelchair delivered for Resident #3. - She did not know how the wheelchair got in the closet or why it was put there. - She would check with the medical supply company about returning the wheelchair. <p>Interview with the primary physician's assistant (PA) on 03/10/16 at 1:45 p.m. revealed:</p> <ul style="list-style-type: none"> - She thought Resident #3 already had a new wheelchair. | D 273 | | |

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| D 273 | <p>Continued From page 21</p> <ul style="list-style-type: none"> - She did not realize he did not have a new wheelchair. - She thought at some point cost may have been a factor. - The resident needed a new wheelchair because the one he had on admission was broken. - The wheelchair the resident was currently using looked safer than the first wheelchair when he was admitted. <p>Interview with the primary care physician (PCP) on 03/11/16 at 12:40 p.m. revealed:</p> <ul style="list-style-type: none"> - She recalled ordering a wheelchair for Resident #3 in January 2016. - She did not know what happened with the wheelchair. - She sent the paperwork to a medical supply company. - The facility did not contact her office about the wheelchair to her knowledge. - She found out from the ALD today that a standard wheelchair had been delivered to the facility at some point in January 2016. - They were trying to find out what happened. - They were trying to evaluate the resident for a specialty wheelchair. <p>3. Review of Resident #4's current FL-2 dated 02/16/16 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, osteoporosis, hypothyroidism, thyroidectomy, and bladder suspension. - The resident was constantly disoriented. - The resident was non-ambulatory and used a wheelchair. - The resident was incontinent of bowel and bladder. - The resident required assistance with bathing | D 273 | | |

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| D 273 | <p>Continued From page 22</p> <p>and dressing.</p> <p>Review of Resident #4's Resident Register revealed she was admitted to the facility on 08/26/13.</p> <p>Review of Resident #4's assessment and care plan dated 10/27/15 revealed:</p> <ul style="list-style-type: none"> - The resident had severe memory loss. - The resident required total assistance with toileting, bathing, and dressing. - The resident required assistance with ambulation and supervision with transfers. - The resident required reminders with grooming and was independent with eating. <p>Review of a physician's order dated 09/14/15 revealed an order to collect urine specimen for urinalysis and urine culture.</p> <p>Review of Resident #4's record revealed no documentation of urinalysis or urine culture being done as ordered on 09/14/15.</p> <p>Review of resident notes for Resident #4 revealed:</p> <ul style="list-style-type: none"> - On 12/14/15, the resident was observed lying on the floor in front of the wheelchair with no injuries. - On 01/19/16, the resident was observed on the floor in the living room with no injuries. <p>Review of notification of incident form dated 02/11/16 for Resident #4 revealed:</p> <ul style="list-style-type: none"> - Resident #4 had a fall on 02/11/16. - The resident lost balance and sat on the floor. <p>Review of a physician's visit summary dated 02/16/16 for Resident #4 revealed:</p> <ul style="list-style-type: none"> - The resident was declining from functional | D 273 | | |

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| D 273 | <p>Continued From page 23</p> <p>mobility.</p> <ul style="list-style-type: none"> - The resident was able to stand and transfer to wheelchair but no longer ambulatory according to staff. - The physician ordered a urinalysis and culture and sensitivity. <p>Review of Resident #4's record revealed no documentation of urinalysis or urine culture being done as ordered on 02/16/16.</p> <p>Interview with the Assisted Living Director (ALD) on 03/10/16 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - The Special Care Coordinator (SCC), a nurse, would have been responsible for assuring the orders for urinalysis and urine culture were done for any resident in the Special Care Unit (SCU). - The SCC resigned in February 2016 and the position was currently vacant. - The ALD would contact the lab company regarding the ordered urinalysis. <p>Interview with the ALD on 03/11/16 at 10:50 a.m. revealed:</p> <ul style="list-style-type: none"> - She contacted the lab company yesterday regarding urinalysis results for Resident #4. - The lab company only faxed one urinalysis done in March 2015. - It did not appear any urinalysis had been completed for Resident #4 since March 2015. - They only used this lab company and she would call them back to verify there was no urinalysis completed after March 2015. <p>Interview with a medication aide (MA) / personal care aide (PCA) on 03/11/16 at 3:12 p.m. revealed:</p> <ul style="list-style-type: none"> - The supervisor on duty would let the MAs know when a urine specimen needed to be collected. - MAs or PCAs could collect the urine specimen. | D 273 | | |

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| D 273 | <p>Continued From page 24</p> <ul style="list-style-type: none"> - Once the urine was collected, the supervisor on duty called the lab and the lab picked up the urine specimen. - She did not recall collecting a urine specimen for Resident #4 in February 2016. - Resident #4 was not experiencing any symptoms other than she had been sleepier for about a week. - The supervisor on duty just collected a urine specimen for Resident #4 today, 03/11/16. <p>Interview with the supervisor on duty on 03/11/16 at 3:19 p.m. revealed:</p> <ul style="list-style-type: none"> - She collected a urine specimen for Resident #4 today, 03/11/16. - She did not recall collecting a urine specimen for Resident #4 prior to today. - If a resident had symptoms like behaviors or if the resident was sleepy a lot, staff would let the physician know and get an order for a urinalysis. - They usually got orders for urinalysis on second shift and staff would try to collect the urine before 11:00 p.m. the same day. - If not, second shift would let third shift staff know so they could try to collect the urine. - If they could not collect the urine in 2 to 3 days, they would let the physician know. - She was not aware of Resident #4 having any symptoms other than she had been sleepy. <p>Interview with the ALD on 03/11/16 at 3:45 p.m. revealed:</p> <ul style="list-style-type: none"> - The urinalysis and urine cultures ordered on 09/14/15 and 02/16/16 were not done. - She checked the staff communication notes and there was no documentation that staff made any attempts to collect a urine specimen for Resident #4. - Staff had not reported that Resident #4 was currently having any symptoms of urinary tract | D 273 | | |

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| D 273 | <p>Continued From page 25</p> <p>infection.</p> <ul style="list-style-type: none"> - She had staff to collect urine from Resident #4 today, 03/11/16, for the order dated 02/16/16. <p>Interview with the primary care physician on 03/11/16 at 12:40 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not see a record of a urinalysis being done in September 2015 or February 2016. - She did not usually put a timeframe on when the urine specimens should be collected because they may have trouble collecting from the residents in the special care unit. - The facility would usually let her know within a day or two if they were having trouble collecting the urine and she would discontinue the order. - She did not see any documentation the facility had notified the physician's office of having trouble collecting urine in September 2015 or February 2016. - She did not write the order for the urinalysis and urine culture on 02/16/16. - The resident was seen by the physician's assistant on 02/16/16 and he may have more information. <p>Telephone interview with the physician's assistant (PA) on 03/11/16 at 3:28 p.m. revealed:</p> <ul style="list-style-type: none"> - He saw Resident #4 on 02/16/16 because she had a recent fall. - He would have ordered the urinalysis and urine culture because of the fall and her white blood cell count was elevated according to his records. - He was not aware the urinalysis and urine culture had not been done. - The resident had a wound that was being treated at a wound clinic. - She was started on an antibiotic on 03/03/16 for cellulitis and the antibiotic may helped with a urinary tract infection if she had one. | D 273 | | |

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| D 273 | <p>Continued From page 26</p> <p>Based on observation, interview, and record review, Resident #4 was not interviewable due to diagnoses of Alzheimer's dementia.</p> <hr/> <p>Review of the facility's plan of protection dated 03/11/16 revealed:</p> <ul style="list-style-type: none"> - The gel overlay for Resident #5 has been obtained and placed on the resident's bed. - Resident #3's standard wheelchair will be returned to the durable medical equipment (DME) on Monday, 03/14/16, as it was still in a rental phase and could be returned without charge. - The physician has signed the physical therapy statement of the need for a new tilt wheelchair for Resident #3 and the seven element prescription has been sent to the physician's office for completion. - The Assisted Living Director (ALD) will follow up with the physician on Monday, 03/14/16 to ensure the assessment is completed. - ALD will follow up on the status of the wheelchair at least twice a week and document until the wheelchair is delivered and resident in wheelchair. - The urinalysis for Resident #4 has been collected and picked up by the lab. - ALD or designee will follow up with the physician every 24 hours until results are received and any treatment orders processed and carried out. - Immediate staff training will take place for all new incoming DME and lab orders. - All medication aides will be trained within 72 hours. - DME/lab orders will be reviewed by the ALD or designee and routed appropriately. - Once they have been reviewed, orders will be placed in the hot box in the nurses' station until the order has been processed and completed. | D 273 | | |

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| D 273 | <p>Continued From page 27</p> <ul style="list-style-type: none"> - The order will be filed after the ALD or designee has signed off or stamped order completion. - Immediate staff training will take place for urine collection protocol. A flow chart will be used for guidelines. - All medication aides will be trained on flow chart and protocol within 72 hours. - All Special Care Unit charts will be audited to ensure orders have been followed and documentation is accurate. - An audit will be completed no later than Friday, 03/18/16. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 25, 2016.</p> | D 273 | | |
| D 283 | <p>10A NCAC 13F .0904(a)(2) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to protect food from contamination. The findings are:</p> <p>1. Observations made in the kitchen on 03/10/16 at 10:15 a.m. revealed: -A Kitchen Worker/Server was cutting and plating serving size pieces of cake. -Once a tray of cake was plated, the Kitchen Worker/Server would put the desserts, uncovered, into the walk-in-cooler.</p> | D 283 | | |

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| D 283 | <p>Continued From page 28</p> <p>-When asked if the individual servings were ever covered before refrigerated, the Kitchen Worker/Server looked confused but did not say anything.</p> <p>-The Kitchen Worker/Server removed the tray of cake slices and began wrapping them.</p> <p>Recheck of walk-in-cooler at 4:00 p.m. on revealed uncovered individual servings of fresh fruit and mixed salads.</p> <p>Refer to interview with the Dining Services Manager on 03/10/16 at 4:10 p.m.</p> <p>2. Observations of food service on 03/10/16 at 11:45 a.m. revealed:</p> <p>-Servers took individual resident's meal order at the dining room tables.</p> <p>-The written food order was given to the Cook who would plate the resident's selections from containers on the warming table.</p> <p>-A Server told the Cook that a resident wanted a cheeseburger for lunch.</p> <p>-The Cook, who was wearing gloves, took a frozen hamburger patty from the freezer and placed it in the oven.</p> <p>-The Cook returned to the warming table to continue filling lunch orders without changing gloves.</p> <p>-The Cook was stopped from touching serving implements by surveyor and reminded to change gloves before continuing to serve food.</p> <p>Interview with the Cook on 03/10/16 at 12:00 p.m. revealed:</p> <p>-The Cook was aware of the need to change gloves after handling raw meat to prevent cross contamination.</p> <p>-The presence of the surveyor made her nervous and she "forgot".</p> | D 283 | | |

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| D 283 | <p>Continued From page 29</p> <p>Refer to interview with the Dining Services Manager on 03/10/16 at 4:10 p.m.</p> <hr/> <p>Interview with the Dining Services Manager on 03/10/16 at 4:10 p.m. revealed:</p> <ul style="list-style-type: none"> -Training for the Kitchen Staff was tailored to each employee's need. -Training consisted of on-line classes and a checklist completed by a Trainer. -Food safety and safe food handling was covered in initial training and reinforced by the Dining Services Manger "continuously". -The Cook had worked at her current position for "several years" and "must have just gotten nervous and forgot to change gloves". -The Dining Services Manager attended the Serve Safe training annually and shared the information with the Kitchen Staff. | D 283 | | |
| 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: Based on observation, interview, and record review, the facility failed to administer a diabetes medication and an iron supplement as ordered for 1 of 7 residents (#6) observed during the</p> | D 358 | | |

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| D 358 | <p>Continued From page 30</p> <p>medication administration passes. The findings are:</p> <p>The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:30 a.m./9:00 a.m. and the 4:30 p.m./5:00 p.m. medication passes on 03/09/16.</p> <p>Review of Resident #6's current FL-2 dated 02/02/16 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included anxiety, depression, hypertension, Alzheimer's disease, hypothyroidism, arthropathy, and binaural disorder associated with dementia. <p>Review of a physician's order for Resident #6 dated 09/04/15 revealed:</p> <ul style="list-style-type: none"> - There was a medication order for Metformin 500 mg - 1 tablet by mouth twice a day with morning and evening meals. (Metformin is used to treat diabetes and lowers blood sugar.) <p>[Medications ordered with meals should be administered sometime after the resident has started eating up to 60 minutes after the resident has finished eating.]</p> <p>Review of a physician's order for Resident #6 dated 02/23/16 revealed:</p> <ul style="list-style-type: none"> - There was a medication order for Ferrous Sulfate 325mg - 1 tablet twice a day with food. (Ferrous Sulfate is a medication used to treat iron deficiency anemia.) <p>Review of the March 2016 medication administration record (MAR) on 03/09/16 revealed:</p> <ul style="list-style-type: none"> - Metformin was scheduled to be administered at 9:00 a.m. and 5:00 p.m. - Instructions for Metformin included, "Take with | D 358 | | |

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| D 358 | <p>Continued From page 31</p> <p>morning and evening meals".</p> <ul style="list-style-type: none"> - Ferrous Sulfate was scheduled to be administered at 9:00 a.m. and 5:00 p.m. - Instructions for Ferrous Sulfate included, "Take with food". <p>Observation of the 5:00 p.m. medication pass on 03/09/16 revealed:</p> <ul style="list-style-type: none"> - Resident #6 was observed sitting next to the nurses' station on the Assisted Living Hall at 4:20 p.m. - Ferrous Sulfate 325mg and Metformin 500mg were administered by mouth to Resident #6 at 4:23 p.m. by the Medication Aide (MA). - The MA did not offer any food to the resident during or after the administration of the Ferrous Sulfate or Metformin. - Resident #6 went in the dining room after she took her medication. <p>Observation of Resident #6 on 03/09/16 at 4:25 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff was serving food to the residents in the dining room. - Resident #6 sat at the table and she gave staff her food choices for dinner. - Resident #6 was served dinner at 4:43 p.m. and was observed eating her soup. <p>Interview with the Resident #6 on 03/09/16 at 4:25 p.m. revealed:</p> <ul style="list-style-type: none"> - The MA normally administered her medications scheduled for 5:00 p.m. before she came to the dining room for dinner. - She normally had to wait about 10-15 minutes for her dinner once she arrived in the dining room. - Resident #6 denied she felt any nausea or stomach irritation while she waited to be served. | D 358 | | |

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| D 358 | <p>Continued From page 32</p> <p>Interview with the MA on 03/09/16 at 4:50 p.m. revealed:</p> <ul style="list-style-type: none"> - The MA knew Resident #6 was supposed to have food with the medications, Ferrous Sulfate and Metformin. - She assumed since Resident #6 was going to dinner that was sufficient for food with medication administration. - She was not sure of the facility's policy on food with medication administration. - She usually started her 5:00 p.m. medication pass between 4:15 p.m. and 4:30 p.m. - Dinner normally started being served at 4:30 p.m. <p>Interview with the Resident Care Coordinator (RCC) on 03/09/16 at 4:50 p.m. revealed:</p> <ul style="list-style-type: none"> - The RCC was taught in nursing school medication administration with food meant the resident ate within 30 minutes of receiving the medication. - She had not noticed if Resident #6 had food with her Metformin or Ferrous Sulfate administration. - Snacks were available for the MAs to give to residents if needed with medication administration. - She would review the facility's medication administration policy. <p>Interview with the RCC on 03/10/16 at 9:00 a.m. revealed:</p> <ul style="list-style-type: none"> - It was the facility's policy that medications were not administered in the dining room and the medication cart was not allowed in the dining room area of the assisted living hall. - She learned in nursing school that as long as medications were given within 30 minutes of food/meal, then the medications were considered given with a meal. | D 358 | | |

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| D 358 | <p>Continued From page 33</p> <ul style="list-style-type: none"> - She was not sure what the facility's medication administration policy was about medications given with food and/or meals. - The RCC would try to contact the physician about the Metformin and Ferrous Sulfate <p>Review of the facility medication administration policies revealed:</p> <ul style="list-style-type: none"> - Medications ordered to be given before meals should be given approximately 30 minutes before mealtimes. - Medications ordered to be given after meals should be given 30 minutes after a meal had ended. - There was no policy to address medication administration timing for medications to be given with food or with meals. <p>Interview with a second MA for assisted living hall on 03/10/16 at 9:20 a.m. revealed:</p> <ul style="list-style-type: none"> - The MA first reported she sometimes gave Ferrous Sulfate and Metformin to Resident #6 before the Resident #6 had eaten her breakfast and sometimes after the resident had finished eating breakfast. - The MA reviewed the MAR for Resident #6. - The MA then said she always gave Resident #6 the Ferrous Sulfate and Metformin with breakfast because Resident #6 always had breakfast in her room. <p>Interview with Resident #6 on 03/10/16 at 9:30 a.m. revealed:</p> <ul style="list-style-type: none"> - She normally ate breakfast in her room. - The MA usually gave her morning medications before she ate her breakfast. - She was not offered any food or snacks when any of her medications were given. - She denied any recent episodes of nausea, vomiting, diarrhea, constipation, or stomach | D 358 | | |

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| D 358 | <p>Continued From page 34</p> <p>irritation.</p> <p>Interview with a third MA for the Memory Care Unit on 03/10/16 at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> - The MA did not have a problem with giving residents medications as ordered with food. - The MA was allowed to have the medication cart in dining room during meal times on the Memory Care Unit. <p>Interview with Assisted Living Director (ALD) on 03/10/16 at 10:25 a.m. revealed:</p> <ul style="list-style-type: none"> - The ALD was not aware there was an issue with medication administration being given as ordered with food and/or meal. - She would follow-up with Resident #6's physician. <p>Interview with Assisted Living Director (ALD) on 03/10/16 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - It was the policy of the facility that MAs were not supposed to administer medications from the dining room for the Assisted Living Hall. - She would check on the facility's medication administration policy. | D 358 | | |
| D 464 | <p>10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan</p> <p>10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan</p> <p>In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following:</p> <p>(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of</p> | D 464 | | |

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| D 464 | <p>Continued From page 35</p> <p>daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.</p> <p>(2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure a special care unit care plan profile and quarterly profile assessments were completed for 3 of 3 residents (#3, #4, #5) sampled for review in the special care unit. The findings are:</p> <p>1. Review of Resident #5's current FL-2 dated 07/06/15 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnosis included memory loss. - Resident #5's level of care was documented as Special Care Unit (SCU). <p>Review of the Resident Care Plan for Resident #5 on 03/09/16 revealed:</p> <ul style="list-style-type: none"> - The care plan was initiated on 07/22/15 for Resident #5. - The care plan was last updated on 10/27/15. - Resident #5 had severe memory loss. - Resident #5 exhibited no wandering behaviors. - He required no assistance with mobility and use a walker independently. - He required no assistance with transferring. - Resident #5 required total assistance with dressing and bathing. - Resident #5 required reminders for personal | D 464 | | |

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| D 464 | <p>Continued From page 36</p> <p>hygiene and toileting.</p> <ul style="list-style-type: none"> - There was no other updated dates or revision dates listed on the care plan. <p>Review of Resident #5's record revealed no documentation of a special care unit (SCU) quarterly profile and care plan.</p> <p>Interview with the Resident Care Coordinator (RCC) at 03/09/16 at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> - The RCC did not know the SCU quarterly profile and the care plan had not been done for Resident #5. - She would check for an updated SCU profile and care plan for Resident #5. <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/09/16 at 10:15 a.m.</p> <p>Refer to interview with the Assisted Living Director (ALD) on 03/09/16 at 3:10 p.m.</p> <p>Refer to interview with the Administrator on 03/09/16 at 5:15 p.m.</p> <p>2. Review of the current FL-2 dated 10/08/15 for Resident #3 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included vascular dementia, chronic back pain, coronary artery disease with stents, insomnia, hypertension, hyperlipidemia, and osteoarthritis. - The resident was constantly disoriented and documented as a wanderer. - The resident was semi-ambulatory using a wheelchair. - The resident required assistance with bathing and dressing. <p>Review of resident notes for Resident #3 revealed the resident was admitted to the Special</p> | D 464 | | |

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| D 464 | <p>Continued From page 37</p> <p>Care Unit (SCU) of the facility on 10/1315.</p> <p>Review of Resident #3's preadmission screening dated 07/08/15 revealed:</p> <ul style="list-style-type: none"> - The resident had obvious impairment of memory. - The resident had some disorientation and anxiety. - The resident was documented as a "wanderer". <p>Review of Resident #3's assessment and care plan dated 10/20/15 revealed:</p> <ul style="list-style-type: none"> - The form used for the assessment and care plan was called a service evaluation. - The resident had severe memory loss. - The resident required two person assist for transfers. - The resident required total assistance with bathing. - The resident could ambulate independently using a wheelchair. - The resident required reminders and/or assistance with toileting, dressing and grooming. - The resident was independent with eating. - The intervention section of the form had date initiated as 10/20/15. - There were no revision dates listed on the form. <p>Review of Resident #3's record revealed no documentation of a special care unit (SCU) quarterly profile and care plan.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/09/16 at 10:15 a.m.</p> <p>Refer to interview with the Assisted Living Director (ALD) on 03/09/16 at 3:10 p.m.</p> <p>Refer to interview with the Administrator on 03/09/16 at 5:15 p.m.</p> | D 464 | | |

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| D 464 | <p>Continued From page 38</p> <p>3. Review of Resident #4's current FL-2 dated 02/16/16 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, osteoporosis, hypothyroidism, thyroidectomy, and bladder suspension. - The resident was constantly disoriented. - The resident was non-ambulatory and used a wheelchair. - The resident was incontinent of bowel and bladder. - The resident required assistance with bathing and dressing. <p>Review of the Resident Register for Resident #4 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted to the Special Care Unit (SCU) of the facility on 08/26/13. - The resident had significant memory loss and must be redirected. <p>Review of Resident #4's preadmission screening dated 08/28/13 revealed:</p> <ul style="list-style-type: none"> - The resident had obvious impairment of memory. - The resident had occasional agitation and confusion. <p>Review of Resident #4's assessment and care plan dated 10/27/15 revealed:</p> <ul style="list-style-type: none"> - The form used for the assessment and care plan was called a service evaluation. - The resident had severe memory loss. - The resident required total assistance with toileting, bathing, and dressing. - The resident required assistance with ambulation and supervision with transfers. - The resident required reminders with grooming and was independent with eating. | D 464 | | |

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| D 464 | <p>Continued From page 39</p> <ul style="list-style-type: none"> - The intervention section of the form had date initiated as 08/24/15 and date revised as 10/27/15. - There were no other revision dates listed on the form. <p>Review of Resident #4's record revealed no documentation of a special care unit (SCU) quarterly profile and care plan.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/09/16 at 10:15 a.m.</p> <p>Refer to interview with the Assisted Living Director (ALD) on 03/09/16 at 3:10 p.m.</p> <p>Refer to interview with the Administrator on 03/09/16 at 5:15 p.m.</p> <hr/> <p>Interview with the Resident Care Coordinator (RCC) on 03/09/16 at 10:15 a.m. revealed:</p> <ul style="list-style-type: none"> - The Special Care Coordinator (SCC) was responsible for doing the quarterly profiles and care plans for the residents in the special care unit (SCU). - The SCC left employment with the facility in February 2016. - The RCC did not know if the SCC had done the quarterly profiles and care plans. <p>Interview with the Assisted Living Director (ALD) on 03/09/16 at 3:10 p.m. revealed:</p> <ul style="list-style-type: none"> - The facility was using a new computer system and they had just officially switched to the new system in January 2016. - The facility staff used the same services evaluation form for the SCU quarterly profiles and care plans as they do for the assessment and care plans since it included the required behavior | D 464 | | |

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| D 464 | <p>Continued From page 40</p> <p>information.</p> <ul style="list-style-type: none"> - The new system did not have a place for signing and dating on the forms generated for the resident care plans. - If no changes were made to the intervention section of the care plan, it would not show any reassessments and it would appear nothing was done. - The old system would show changes made and those changes would be dated. - The facility staff thought the new system was changing the dates for the reassessments as well but it was not. - A stamp has been ordered to use for the forms generated by the new system that will allow a specific place for signatures and dates. <p>Interview with the Administrator on 03/09/16 at 5:15 p.m. revealed:</p> <ul style="list-style-type: none"> - She checked with the computer software company and the forms only show the original date. - When a quarterly profile and care plan was updated on the computer, a copy of it should be printed, dated, and put in the resident's record. - She did not know if the former SCC had done the quarterly profiles and care plans due in January 2016 since there were no copies in the residents' records. - She planned to have the quarterly profiles and care plans for the residents in the SCU updated. - The facility management would work on putting an alternate system in place for documenting the quarterly SCU profiles and care plans until the new software system could be fixed. | D 464 | | |
| D912 | <p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights</p> | D912 | | |

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| D912 | <p>Continued From page 41</p> <p>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 every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are:</p> <p>Based on observation, record review, and interview, the facility failed to assure health care needs were met for 3 of 3 sampled residents (#3, #4, #5) as related to failure to obtain a gel overlay mattress for a resident who developed two stage II decubiti (#5), failure to obtain urinalysis and culture and sensitivity in a timely manner (#5), failure to obtain two urinalysis as ordered (#4), and failure to obtain a specialized wheelchair for a resident with special needs due to history of spinal injury/surgery (#3). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]</p> | D912 | | |
| D934 | <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</p> | D934 | | |

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| D934 | <p>Continued From page 42</p> <p>home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and 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 assure that 5 of 6 sampled medication aides (Staff A, B, D, E, F) completed the mandatory state infection control training annually. The findings are:</p> <p>1. Review of the personnel file for Staff A (Medication Aide) revealed: -Staff A was hired on 04/05/12 as a Personal Care Aide (PCA). -Staff A became a Medication Aide (MA) in May 2012. -The most recent certificate of completion of the State Infection Control training for Staff A was 07/29/14.</p> <p>Refer to interview with the Human Resources Manager (HRM) on 03/10/16 at 3:05 p.m.</p> <p>2. Review of the personnel file for Staff B (Medication Aide) revealed: -Staff B was hired as a Medication Aide (MA) on 03/21/13. -There was no documentation of the State Infection Control training for Staff B.</p> <p>Refer to interview with the Human Resources</p> | D934 | | |

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| D934 | <p>Continued From page 43</p> <p>Manager (HRM) on 03/10/16 at 3:05 p.m.</p> <p>3. Review of the personnel file for Staff D (Medication Aide) revealed: -Staff D was hired 03/18/04 as a Personal Care Aide (PCA). -Staff D became a Medication Aide (MA) on 10/03/05. - The most recent certificate for the State Infection Control training for Staff D was in 2013.</p> <p>Refer to interview with the Human Resources Manager (HRM) on 03/10/16 at 3:05 p.m.</p> <p>4. Review of the personnel file for Staff E (Medication Aide) revealed: -Staff E was hired as a Medication Aide (MA) on 07/06/05. -The most recent certificate of completion for the State Infection Control training for Staff E was 07/28/14.</p> <p>Refer to interview with the Human Resources Manager (HRM) on 03/10/16 at 3:05 p.m.</p> <p>5. The review of the personnel file for Staff F (Medication Aide) revealed: -Staff F was hired as a Medication Aide (MA) on 12/01/10. -The most recent certificate of completion for the State Infection Control training for Staff F was on 07/28/14.</p> <p>Refer to interview with the Human Resources Manager (HRM) on 03/10/16 at 3:05 p.m.</p> <p>_____</p> <p>Interview with the Human Resource Manager (HRM) on 03/10/16 at 3:05 p.m. revealed: -She was aware of the requirement for annual</p> | D934 | | |

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| D934 | <p>Continued From page 44</p> <p>State Infection Control training for Medication Aides (MA).</p> <ul style="list-style-type: none"> -She ran a computer report each month that revealed which staff needed required training. -She gave the training report to the Resident Care Coordinator (RCC) so the staff member could be enrolled in required class. -The 2015 State Infection Control training classes were filled by new employees. -The State Infection Control training classes have been scheduled for 04/04/16 and 04/08/16. -The MAs whose infection control training certificate had expired would be scheduled for the upcoming classes. | D934 | | |