

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2016
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NAME OF PROVIDER OR SUPPLIER ELM VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 1915 SOUTH ELM STREET HIGH POINT, NC 27260
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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
D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted an annual survey and complaint investigation on 04/20/16, 04/21/16, and 04/25/16 with an exit conference via telephone on 04/26/16.	D 000		
D 113	<p>10A NCAC 13F .0311(d) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to assure hot water temperatures were maintained between a minimum of 100 degrees Fahrenheit (F.) to a maximum of 116 degrees F. for 2 of 2 fixtures (sink and shower) located in the resident shared bathroom on 200 hall, 1 tub fixture located in a common bath on 200 hall, and 2 of 2 fixtures (1 sink and 1 tub) located in the women's ward room on 200 hall.</p> <p>The findings are:</p> <p>Observation on 04/20/16 of a 200 hall common bath revealed: -At 10:14 am, the shower hot water temperature in the common bathroom was 122 degrees F.</p>	D 113		

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D 113	<p>Continued From page 1</p> <p>-At 10:15 am, the sink hot water temperature in the common bathroom was 118 degrees F. -No steam was visible from either fixture.</p> <p>Observation on 04/20/16 at 10:20 am of a second 200 hall common bath revealed: -The tub hot water temperature in the common bathroom was 122 degrees F. -No steam was visible from the fixture.</p> <p>Observation on 04/20/16 at 11:05 am of the shared bathroom in the women's ward on the 200 hall revealed: -At 11:05 am, the sink hot water temperature in the shared bathroom was 122 degrees F. -At 11:06 am, the shower hot water temperature in the shared bathroom was 122 degrees F.</p> <p>Interview with a 200 hall resident on 04/20/15 at 10:17 am revealed: -The resident had never had a problem with the water temperature being too hot. -If the water temperature had gotten too hot, he mixed the hot water with cold water.</p> <p>On 04/20/16 at 10:28 am, a calibration of the surveyor's thermometer was performed using an ice-water slurry and the thermometer was determined to be reading accurately at 32 degrees F.</p> <p>On 04/20/16 at 11:00 am, the Administrator was informed that signs should be posted for the affected bathrooms informing residents and staff of elevated hot water temperatures and advising residents to have staff assist with running hot water.</p> <p>Interview on 4/20/16 at 10:40 am with the Administrator revealed:</p>	D 113		

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D 113	<p>Continued From page 2</p> <ul style="list-style-type: none"> -She was not aware of the hot water temperatures being above 116 degrees F. -The facility did not currently have a full time maintenance person. -The facility did not have a current hot water temperature log. -She checked water temperature about 5 weeks ago but did not log the temperatures because all the ones she checked were below 116 degrees F. -No residents had complained to her about the hot water temperature being elevated. -The maintenance staff member was responsible for monitoring hot water temperatures but that position had been vacant for 5 or more weeks. <p>Interview on 04/20/16 at 10:45 am with the first shift Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -No resident had informed her of the facility hot water temperature causing them to be burned. -Most of the residents were assisted with bathing, but 5 or 6 residents were independent with bathing. -She did not check hot water temperature. -The facility had a maintenance staff member who she had seen taking water temperature, but he was no longer employed by the facility. <p>Interview on 04/20/16 at 11:10 am with a first shift Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> -No resident had complained to her about the hot water temperature being too hot. -When she assisted residents with bathing, she always adjusted the water temperature before allowing the resident to bathe. -The shower in the common bathroom on 200 hall would get "pretty" hot. -She had not informed administrative staff. -She had never been assigned to check water temperatures. 	D 113		

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D 113	<p>Continued From page 3</p> <p>Interview on 04/20/16 at 11:18 am with a housekeeper revealed: -She had not been assigned to check hot water temperatures. -The regular maintenance person left the facility 5 to 6 weeks ago. -The hot water temperatures seemed to be about the same as they had been for several weeks. -No resident had complained to her about the hot water temperature being too hot.</p> <p>Second interview on 04/20/16 at 11:20 am with the Administrator revealed the Assistant Administrator (AA) knew how to adjust the hot water temperature in the boiler room and had done so a little while ago.</p> <p>Interview on 04/20/16 at 11:28 am with a 200 hall resident revealed: -He took showers without staff assistance. -He had not had any problem with the hot water being too hot. -He adjusted the temperature by adding cold water.</p> <p>Interview on 04/20/16 at 11:29 am with a second 200 hall resident revealed: -He took showers without staff assistance. -He was aware the hot water temperature for the 200 hall shared bathroom shower was very hot at times, but then at other times it was cold. -He had not gotten burned by the hot water but had been uncomfortably warm before.</p> <p>Interview on 04/20/16 at 11:32 am with the Assistant Administrator (AA) revealed: -She knew how to adjust the hot water temperature on the water heater for the 200 hall. -She had adjusted the water temperature up about 6 months when the residents complained</p>	D 113		

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D 113	<p>Continued From page 4</p> <p>of the hot water temperature being too cold. -She adjusted the hot water temperature down today but the water heater was not on the adjustment she had made 6 months ago, it was set higher. -The maintenance person must have adjusted the hot water temperature higher. -The maintenance staff would be responsible for checking hot water temperatures and maintaining the water temperature log. -She had not checked hot water temperatures. -No resident had complained to her about hot water temperatures being too hot. -She was not aware of any resident being burned from the hot water temperature.</p> <p>Recheck on 04/20/16 at 4:07 pm of a second 200 hall common bath revealed the tub hot water temperature in the common bathroom was 106 degrees F.</p> <p>Recheck on 04/20/16 at 4:27 pm and 4:28 pm of a 200 hall common bath revealed: -The sink hot water temperature in the common bathroom was 102 degrees F. -The shower hot water temperature in the common bathroom was 102 degrees F.</p> <p>Recheck on 04/20/16 at 4:22 pm of the shared bathroom in the women's ward on the 200 hall revealed: -The sink hot water temperature in the shared bathroom was 104 degrees F. -The shower hot water temperature in the shared bathroom was 106 degrees F.</p> <p>On 04/20/16 at 4:30 pm the Administrator was informed the signs posted regarding hot water could be removed. The Administrator stated the facility would monitor the hot water temperatures</p>	D 113		

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D 113	Continued From page 5 on a regular basis.	D 113		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medications (Oxycontin, oxycodone, diazepam, and clonazepam) were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Residents #2 and #3).</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL-2 dated 11/18/15 revealed diagnoses included paraplegic, chronic pain syndrome, pressure ulcer of hip, and anxiety.</p> <p>1. Further review of the current FL-2 dated 11/18/15 revealed a physician's order for Oxycontin 20 mg twice daily. (Oxycontin is a narcotic pain reliever.)</p> <p>Review of Resident #2's record revealed a physician's order dated 01/14/16 to decrease the</p>	D 358		

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D 358	<p>Continued From page 6</p> <p>Oxycontin 20 mg to once daily in the morning.</p> <p>Review of the Oxycontin 20 mg controlled substance count sheets from 12/13/15 through 04/20/16 revealed:</p> <ul style="list-style-type: none"> -Based on an ending count of 0 on 12/27/15 and the next dispense date of 01/14/16, there was no Oxycontin available for administration from 12/28/15 through 01/14/16; the resident missed 36 consecutive doses. -Based on an end count of 0 on 03/13/16 and the next dose signed out on 03/18/16, there was no Oxycontin available for administration from 03/14/16 through 03/17/16; the resident missed 4 consecutive doses. -Based on an ending count of 0 on 04/16/16 and the next dose signed out on 04/18/16, there was no Oxycontin administered on 04/17/16; the resident missed one dose. <p>Review of the December 2015 through April 2016 MARs revealed:</p> <ul style="list-style-type: none"> -The 8:00 pm dose of Oxycontin was documented as administered nightly from 12/28/15 through 01/01/16 when no Oxycontin was available for administration to the resident. -The 8:00 am dose of Oxycontin was documented as administered on 01/14/16 when no Oxycontin was available for administration to the resident. -The MAR was blank for the 8:00 am doses of Oxycontin on 01/01/16, 01/02/16, and 01/03/16. -The 8:00 am doses of Oxycontin was circled as not administered on 12/28/15, 01/05/16, 01/06/16, 01/07/16, 01/11/16, 01/12/16, and 01/13/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered. -The 8:00 pm doses of Oxycontin was circled as not administered from 01/02/16 through 01/13/16 	D 358		

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D 358	<p>Continued From page 7</p> <p>with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>-There were 7 doses of Oxycontin circled as not administered from 12/29/15 through 01/10/16 with corresponding documentation on the back of the MAR indicating "refill needed".</p> <p>-Oxycontin 20 mg was documented as administered on 01/14/16 when no Oxycontin was available for administration to the resident.</p> <p>-Oxycontin 20 mg was circled as not administered from 01/15/16 through 01/17/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>-Oxycontin 20 mg was documented as administered on 04/17/16 when none was signed out on the corresponding narcotic sign out sheet.</p> <p>Observation on 04/20/16 at 10:00 am of Resident #2's medications on hand revealed a bubble pack of Oxycontin 20 mg tablets dispensed on 04/15/16 with 26 of 30 tablets remaining in the pack.</p> <p>Review of facility staff notes revealed:</p> <p>-On 12/28/15, Resident #2 approached the Resident Care Director (RCD) to inquire about being out of Oxycontin and asked if the doctor would be at the facility that day. The RCD told the resident "the doctor will be here after the New Year".</p> <p>-On 01/04/16, Resident #2 reported to the RCD that he was out of Oxycontin 20 mg. The RCD called the Nurse Practitioner (NP) to request an order for the medication and was told the resident had to be seen by the NP before any additional narcotic medications.</p> <p>-On 01/06/16, Resident #2 asked the RCD if the doctor would be at the facility the next day, as</p>	D 358		

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D 358	<p>Continued From page 8</p> <p>was her usual schedule. The RCD told the resident she was not sure and would find out. The RCD called the NP and asked if she would be at the facility the next day. The NP said she would not be at the facility until 01/14/16. The RCD told the NP that Resident #2 was complaining about his medications. The NP said she could not prescribe any narcotic medications until the resident was seen.</p> <p>-On 01/11/16, Resident #2 "made the comment that he is dying". The RCD told the resident "can't be dying because you have been eating your meals and drinking plenty of fluids, so you're not dying. He stated, yes, I am cause I have been without my medications. I told him that's just an excuse. As long as you eat and drink, you're getting everything you need and you're not dying."</p> <p>Interview on 04/20/16 at 9:00 am with Resident #2 revealed:</p> <p>-He fell in 1993 and had been in a wheelchair for 23 years due to paralysis from the waist down.</p> <p>-The facility allowed him to run out of medications "every couple of weeks".</p> <p>-His medications ran out due to various reasons such as the facility not requesting a hard script before the medications were out, waiting on the doctor to write the hard script (prescription), and sometimes because the pharmacy was already closed when the hard script was obtained.</p> <p>-When he ran out of medications, he felt like he was "plugged into a wall socket from the waist down", his muscles "draw up", he saw red and blue flashes behind his eyes, and experienced severe diarrhea.</p> <p>-The pain medication made it bearable for him to perform other activities of daily living, such as showering.</p>	D 358		
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D 358	<p>Continued From page 9</p> <p>Interviews on 04/20/16 at 10:17 am and 04/21/16 at 2:15 pm with a representative from the facility's contracted pharmacy revealed the Oxycontin was dispensed as follows: 60 tablets on 12/03/15, 30 tablets on 01/14/16, 30 tablets on 02/09/16, 30 tablets on 03/17/16, and 30 tablets on 04/15/16.</p> <p>Telephone interview on 04/22/16 at 3:18 pm with the Nurse Practitioner (NP) revealed: -When informed by surveyor of the number of missed medications, the NP stated, "That's impossible". -She saw residents at least every 30 days and made sure prescriptions were written so there were enough medications to last until the next visit. -She did not know what they (the facility staff) did with the prescriptions, but she made "sure hard scripts are there". -She was on vacation during the holidays, but there was always people to cover for her who could see residents and write prescriptions. -She did not recall being told Resident #2 was out of medications.</p> <p>Refer to interviews on 04/20/16 at 10:17 am and 04/21/16 at 2:15 pm with a representative from the facility's contracted pharmacy.</p> <p>Refer to interview on 04/21/16 at 10:28 am with a Medication Aide.</p> <p>Refer to interviews on 04/20/16 at 11:10 am and 04/21/16 at 11:11 am with the Resident Care Director (RCD).</p> <p>Refer to telephone interview on 04/22/16 at 3:18 pm with the Nurse Practitioner (NP).</p> <p>2. Review of Resident #2's current FL-2 dated</p>	D 358		

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D 358	<p>Continued From page 10</p> <p>11/18/15 revealed a physician's order for diazepam 10 mg three times daily. (Diazepam is a sedative.)</p> <p>Review of the diazepam 10 mg controlled substance count sheets from 11/30/15 to 04/20/16 revealed:</p> <p>-Based on an ending count of 0 on 12/10/15 at 2:00 pm and the next dispense date of 12/14/15 with the next dose signed out on 12/15/16 at 8:00 am, there was no diazepam available for administration from 12/10/15 at 8:00 pm through 12/14/15 at 8:00 pm; the resident missed 13 consecutive doses.</p> <p>-Based on an ending count of 0 on 01/14/16 at 8:00 am and the next dispense date of 01/18/16 with the next dose signed out on 01/18/16 at 10:00 pm, there was no diazepam available for administration from 01/14/16 at 2:00 pm through 01/18/16 at 2:00 pm; the resident missed 12 consecutive doses.</p> <p>-Based on an ending count of 0 on 03/05/16 at 2:00 pm and the next dose signed out on 03/07/16 at 8:00 am, there was no diazepam administered from 03/05/16 at 8:00 pm through 03/06/16 at 8:00 pm; the resident missed four consecutive doses.</p> <p>-Based on an ending count of 0 on 03/16/16 at 2:00 pm and the next dispense date of 03/17/16 with the next dose signed out on 03/18/16 at 2:00 pm, there was no diazepam available for administration from 03/16/16 at 8:00 pm through 03/17/16 at 8:00 pm; the resident missed 4 consecutive doses.</p> <p>-Based on an ending count of 0 on 04/06/16 at 8:00 pm and the next dispense date of 04/11/16 with the next dose signed out on 04/12/16 at 7:00 am, there was no diazepam available for administration from 04/07/16 at 8:00 am through 04/11/16 at 8:00 pm; the resident missed 15</p>	D 358		

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D 358	<p>Continued From page 11</p> <p>consecutive doses.</p> <p>Review of the December 2015 through April 2016 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> -Diazepam 10 mg was documented as administered on 12/10/15 at 8:00 pm, 12/11/15 at 2:00 pm, and 12/11/15 at 8:00 pm when there was no diazepam available for administration to the resident. -Diazepam 10 mg was circled as not administered on 10 occasions from 12/10/15 through 12/14/15; there was no corresponding documentation on the back of the MAR to indicate why the medication was not administered for 9 of the 10 occasions. -The 8:00 pm dose of diazepam 10 mg was not documented as administered on 12/18/15 and was not documented as administered nightly from 12/22/15 through 12/31/15. -Diazepam 10 mg was documented as administered on 01/15/16 at 8:00 am and 8:00 pm when there was no diazepam available for administration to the resident. -Diazepam 10 mg was circled as not administered on 8 occasions from 01/14/16 through 01/18/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered. -The MAR was blank for the 01/15/16 2:00 pm dose and the 01/18/16 8:00 am and 2:00 pm doses. -The diazepam was circled as not administered from 8:00 pm on 03/05/16 through 8:00 pm on 03/06/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered. -The diazepam was circled as not administered from 8:00 pm on 03/16/16 through 8:00 pm on 	D 358		

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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
D 358	<p>Continued From page 12</p> <p>03/17/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>-The diazepam was documented as administered on six occasions between 04/07/16 and 04/11/16 when no diazepam was available to be administered to the resident.</p> <p>-The diazepam was circled as not administered on 9 occasions between 04/07/16 and 04/11/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>Observation on 04/20/16 at 10:00 am of Resident #2's medications on hand revealed:</p> <p>-A bubble pack of diazepam 10 mg tablets dispensed 04/11/16 with 5 of 30 tablets remaining in the pack.</p> <p>-A bubble pack of diazepam 10 mg tablets dispensed 04/11/16 with 30 of 30 tablets remaining, which was stored in a locker with some other overstock medications.</p> <p>-The pharmacy label for both packs of diazepam indicated 90 tablets were dispensed on 04/11/16.</p> <p>-The third bubble pack of diazepam 10 mg tablets was unable to be located.</p> <p>Review of a staff note dated 12/15/15 at 2:00 am revealed:</p> <p>-The resident approached the Medication Aide (MA) and asked her if it could be documented that he had not had his diazepam since 12/10/15 at 2:00 pm and that he had been taking this medication for "25 plus years".</p> <p>-"The resident is c/o (complaining of) withdrawal and believes he should be in the hospital. Will monitor resident through shift".</p> <p>-There was no further documentation regarding the diazepam, why the resident was out, or any communication with the pharmacy or physician</p>	D 358		

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D 358	<p>Continued From page 13 regarding the diazepam.</p> <p>Interview on 04/20/16 at 9:00 am with Resident #2 revealed: -He fell in 1993 and had been in a wheelchair for 23 years due to paralysis from the waist down. -The facility allowed him to run out of medications "every couple of weeks". -His medications ran out due to various reasons such as the facility not requesting a hard script before the medications were out, waiting on the doctor to write the hard script (prescription), and sometimes because the pharmacy was already closed when the hard script was obtained. -When he ran out of medications, he felt like he was "plugged into a wall socket from the waist down", his muscles "draw up", he saw red and blue flashes behind his eyes, and experienced severe diarrhea.</p> <p>Refer to interviews on 04/20/16 at 10:17 am and 04/21/16 at 2:15 pm with a representative from the facility's contracted pharmacy.</p> <p>Refer to interview on 04/21/16 at 10:28 am with a Medication Aide.</p> <p>Refer to interviews on 04/20/16 at 11:10 am and 04/21/16 at 11:11 am with the Resident Care Director (RCD).</p> <p>Refer to telephone interview on 04/22/16 at 3:18 pm with the Nurse Practitioner (NP).</p> <p>3. Review of Resident #2's current FL-2 dated 11/18/15 revealed an order for oxycodone-APAP 10/325 mg daily as needed for breakthrough pain, not to exceed three per week. (Oxycodone-APAP is a combination narcotic pain reliever with acetaminophen.)</p>	D 358		

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D 358	<p>Continued From page 14</p> <p>Review of the oxycodone-APAP controlled substance count sheets from 12/07/15 through 04/20/16 revealed:</p> <ul style="list-style-type: none"> -Based on an ending count of 0 on 12/31/15 and the next dispensing date of 01/14/16, there was no oxycodone-APAP available for administration from 12/31/15 through 01/14/16. -Based on an ending count of 0 on 03/06/15 and the next dispensing date of 03/16/16, there was no oxycodone-APAP available for administration from 03/06/16 through 03/16/16. -Based on an ending count of 0 on 04/11/16 and no subsequent dispensing of medication, there was no oxycodone-APAP available for administration after 04/11/16. <p>Review of the December 2015 through April 2016 MARs revealed:</p> <ul style="list-style-type: none"> -An entry for Oxycodone-APAP 10/325 mg once daily as needed for breakthrough pain was listed on the MARs for administration and scheduled as PRN. -The Oxycodone-APAP was documented as administered 13 times from 12/02/15 through 12/31/15, 4 times between 01/15/16 and 01/30/16, 7 times between 02/01/16 and 02/29/16, and 4 times from 04/04/16 through 04/11/16. -Oxycodone-APAP was signed out on 4 occasions from 01/18/16 to 01/28/16 with no corresponding documentation of administration to the resident on the MAR. -Oxycodone-APAP was signed out on 6 occasions from 02/05/16 through 02/25/16 with no corresponding documentation of administration to the resident on the MAR. -Oxycodone-APAP was signed out on 10 occasions from 03/02/16 through 03/30/16 with no corresponding documentation of 	D 358		

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D 358	<p>Continued From page 15</p> <p>administration to the resident on the MAR. -Oxycodone-APAP was signed out on 04/01/16 at 8:00 pm with no corresponding documentation of administration to the resident on the MAR.</p> <p>Observation on 04/20/16 at 10:00 am of Resident #2's medications on hand revealed there was currently no oxycodone-APAP available for administration to Resident #2.</p> <p>Review of a fax communication provided by the Resident Care Director (RCD) revealed the facility requested a refill of medications, including the oxycodone-APAP, on 04/14/16 and the pharmacy replied on 04/14/16 that new orders were needed for the oxycodone-APAP.</p> <p>Review of Resident #2's record revealed: -There was no documentation the facility contacted the physician for a new prescription for oxycodone-APAP. -There was no documentation of any further communication with the pharmacy regarding the oxycodone-APAP.</p> <p>Telephone interviews on 04/20/16 at 10:17 am and 04/21/16 at 2:15 pm with a representative from the facility's contracted pharmacy revealed: -The pharmacy did not fill prn (as needed) medications until requested by the facility. -The pharmacy had a "hard script" for the oxycodone-APAP on file dated 03/25/16, but it had not been filled yet because it had not been requested by the facility. -The pharmacy must have overlooked the 03/25/16 prescription for oxycodone-APAP when the facility requested it on 04/14/16. -The oxycodone-APAP dispensing records were as follows: 12 tablets were dispensed on 12/03/15, 12 tablets on 01/14/16, 12 tablets on</p>	D 358		

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D 358	<p>Continued From page 16</p> <p>02/08/16, and 12 tablets on 03/16/16.</p> <p>Interview on 04/20/16 at 9:00 am with Resident #2 revealed:</p> <ul style="list-style-type: none"> -He fell in 1993 and had been in a wheelchair for 23 years due to paralysis from the waist down. -The facility allowed him to run out of medications "every couple of weeks". -His medications ran out due to various reasons such as the facility not requesting a hard script before the medications were out, waiting on the doctor to write the "hard script", and sometimes because the pharmacy was already closed when the "hard script" was obtained. -When he ran out of medications, he felt like he was "plugged into a wall socket from the waist down", his muscles "draw up", he saw red and blue flashes behind his eyes, and experienced severe diarrhea. -The pain medication made it bearable for him to perform other activities of daily living, such as showering. <p>Refer to interviews on 04/20/16 at 10:17 am and 04/21/16 at 2:15 pm with a representative from the facility's contracted pharmacy.</p> <p>Refer to interview on 04/21/16 at 10:28 am with a Medication Aide.</p> <p>Refer to interviews on 04/20/16 at 11:10 am and 04/21/16 at 11:11 am with the Resident Care Director (RCD).</p> <p>Refer to telephone interview on 04/22/16 at 3:18 pm with the Nurse Practitioner (NP).</p> <p>B. Review of Resident #3's current FL-2 dated 02/25/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included alcohol abuse, 	D 358		

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D 358	<p>Continued From page 17</p> <p>hypertension, and schizoaffective disorder. -An order for Klonopin 1 mg, one and one-half tablets at bedtime. (Klonopin is used to treat mental disorders such as anxiety and panic attacks.</p> <p>Observation on 04/20/16 of the facility's controlled substance count sheet log book located on the medication cart revealed current controlled substance count sheets provided by the contract pharmacy provider were kept in the binder by resident name.</p> <p>Interview on 04/21/16 at 11:20 am with the Resident Care Director (RCD) revealed the completed controlled substance count sheets were stored in boxes in the RCD/Administrator's office.</p> <p>Review of the Klonopin (Clonazepam is the generic name) controlled substance count sheets for Resident #3 from 02/17/16 to through 04/20/16 revealed: -Clonazepam 1.5 mg was documented as administered (signed out on the controlled substance count sheet) from 02/17/16 to 03/16/16. The contract pharmacy dispensed a quantity of 44 clonazepam 1 mg tablets (29 doses) on 02/15/16. -Clonazepam 1.5 mg was documented as administered (signed out on the controlled substance count sheets) from 03/22/16 to 04/22/16. The contract pharmacy dispensed a quantity of 45 clonazepam 1 mg tablets (30 doses) on 03/21/16. -There was no Clonazepam 1.5 mg available for administration from 03/17/16 through 03/22/16; the resident missed 5 consecutive doses.</p> <p>Review of Resident #3's March 2016 Medication</p>	D 358		

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D 358	<p>Continued From page 18</p> <p>Administration Record(MAR) revealed: -Clonazepam 1.0 mg take 1 and ½ tablets at bedtime was listed and scheduled for bedtime. -Clonazepam 1.5 mg at bedtime was documented as administered daily from 03/01/16 to 03/31/16, except on 03/19/16 and 03/20/16 when it was not administered as indicated by initials circled but no explanation noted. -The clonazepam was documented as administered on 3 occasions between 03/17/16 and 03/21/16 when no clonazepam was available to be administered to the resident.</p> <p>Review on 04/25/16 at 10:30 am of Resident #3's medications on hand revealed a bubble pack of Clonazepam 1.0 mg tablets (45 tablets) dispensed on 04/21/16 with 30 of 30 doses remaining in the pack.</p> <p>Review of facility staff notes revealed: -No documentation regarding Resident #3 missing 5 doses of clonazepam 1.5 mg at bedtime from 03/17/16 to 03/22/16. -No documentation for behavioral changes noted from 03/17/16 to 03/22/16.</p> <p>Interview on 04/20/16 at 9:00 am with Resident #3 revealed: -He routinely received his medications as ordered except for one time, about a month ago, when he was out of his night-time "nerve" medication. -The facility had given him the medication routinely since that time.</p> <p>Telephone interview on 04/25/16 at 10:45 am with a Pharmacist for the contract pharmacy revealed: -The pharmacy records for Resident #3 for clonazepam 1.0 mg indicated dispensing on 02/15/16 for a quantity of 44 tablets, 03/21/16 for a quantity of 45 tablets, and on 04/21/16 for a</p>	D 358		

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D 358	<p>Continued From page 19</p> <p>quantity of 45 tablets.</p> <p>-Resident #3 should have received clonazepam 1.0 mg on 03/15/16 with the monthly "batch" fill.</p> <p>-The pharmacy had converted to a different computer system around 03/15/16 and the clonazepam may not have been sent in the "batch" fill.</p> <p>-The facility was responsible to notify the pharmacy for any resident needing medication.</p> <p>-Resident #3 had refills remaining on a physician's order dated 12/15/15 for the dispensing on 03/15/16.</p> <p>-The pharmacy had no documentation from the facility requesting clonazepam 1.0 mg for Resident #3 from 03/15/16 until 03/21/16.</p> <p>Interview on 04/25/16 at 11:54 am with the RCD revealed:</p> <p>-Staff routinely let her know when medications needed to be re-ordered.</p> <p>-She wrote down the medication refill information and called the pharmacy with the requested medications.</p> <p>-She did not routinely keep the documentation used to re-order medications, but disposed of the forms in the recycle bin.</p> <p>-Weekend staff often ordered the medications needed by faxing the pharmacy a request.</p> <p>-All records for residents' controlled substance administration would be documented on the narcotic count sheet (controlled substance count sheet).</p> <p>-Medication Aides were supposed to let the RCD know when a resident was getting low on controlled drugs and not wait until the resident ran out to reorder medication.</p> <p>-No staff member was assigned to routinely audit the medication carts for sufficient supply of medications for the residents.</p>	D 358		

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D 358	<p>Continued From page 20</p> <p>Telephone interview on 04/26/16 at 10:00 am with a second shift Medication Aide revealed: -She routinely documented administration of residents' controlled drugs (substances) on the MAR and on the controlled substance count sheets. -When a resident did not have a medication in the facility for administration, she documented on the MAR with her initials and circled the initials as not given. -She sometimes may have forgotten to document the reason the medication was not given on the back of the MAR. -If a resident did not have a controlled drug (substance) to administer then it would not be signed out on the controlled substance count sheet and should be initialed and circled on the resident's MAR.</p> <p>Telephone interview on 04/26/16 at 9:55 am with the Administrator revealed: -Staff routinely documented behavioral changes in the resident record. -Resident #3 had exhibited behavioral outburst on several occasions over the last 2 to 3 years. -There was no documentation for any behavioral changes in Resident #3's record for 03/17/16 to 03/22/16.</p> <p>Refer to interviews on 04/20/16 at 10:17 am and 04/21/16 at 2:15 pm with a representative from the facility's contracted pharmacy.</p> <p>Refer to interview on 04/21/16 at 10:28 am with a Medication Aide.</p> <p>Refer to interviews on 04/20/16 at 11:10 am and 04/21/16 at 11:11 am with the Resident Care Director (RCD).</p>	D 358		

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D 358	<p>Continued From page 21</p> <p>Refer to telephone interview on 04/22/16 at 3:18 pm with the Nurse Practitioner (NP).</p> <p>Interviews on 04/20/16 at 10:17 am and 04/21/16 at 2:15 pm with a representative from the facility's contracted pharmacy revealed:</p> <ul style="list-style-type: none"> -When the pharmacy received a "hard script" (prescription) for a narcotic, they routinely filled the prescription the same day. -The pharmacy courier delivered medications to the facility nightly, Monday through Friday. -The pharmacy relied on the facility staff to obtain any needed "hard scripts" from the physician prior to the depletion of the existing supply, and send the "hard script" to the pharmacy via the pharmacy courier. -The pharmacy had a back up system in place 24/7 in order to ensure residents' medications were available for administration at all times. -If a facility needed a narcotic medication requiring a "hard script" after routine pharmacy hours, the facility was supposed to notify the pharmacy, and the pharmacy would either direct them to take the "hard script" to the back up pharmacy, or the pharmacist could contact the physician to ask for a prescription for enough medication to get through until routine pharmacy hours. -In addition to the above, the pharmacy courier could take the "hard script" to the back up pharmacy to be filled. <p>Interview on 04/21/16 at 10:28 am with a Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -She did not recall specific reasons for the occasions when medications were out. -The MAs were supposed to let the Resident Care Director (RCD) know when narcotics were needed and the RCD "takes care of it". -Sometimes the pharmacy was "slow sending it", 	D 358		

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D 358	<p>Continued From page 22</p> <p>and sometimes the pharmacy said they did not receive the fax requesting the medication.</p> <ul style="list-style-type: none"> -When medications were ordered, sometimes they came that night and sometimes "it's a week". -When the medication did not arrive timely, the facility staff contacted the pharmacy to inquire about it, and were sometimes told it was not time to reorder or that a "hard script" was needed. <p>Interviews on 04/20/16 at 11:10 am and 04/21/16 at 11:11 am with the RCD revealed:</p> <ul style="list-style-type: none"> -She relied on the MAs to let her know when a resident's narcotic medications were low so she could obtain a "hard script" from the physician and/or call the pharmacy to reorder the medication. -Sometimes the "hard script" was already at the pharmacy, in which case she would contact the pharmacy to send the medication. -If a "hard script" was needed, she would obtain the "hard script" from the Nurse Practitioner (NP) when she was at the facility. -The NP came to the facility every other week. -She did not know why medications would be out unless it was because they were waiting for the NP to write a new prescription. <p>Telephone interview on 04/22/16 at 3:18 pm with the NP revealed:</p> <ul style="list-style-type: none"> -She routinely came to the facility every other week and routinely saw each resident "at least" every 30 days. -When she saw residents, it was part of her routine to ensure prescriptions were written for enough medications so that the resident did not run out between visits. -Sometimes she sent prescriptions directly to the pharmacy if needed, but usually wrote the prescriptions while at the facility seeing residents. -She did not know what they (the facility staff) did 	D 358		

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D 358	<p>Continued From page 23</p> <p>with the prescriptions, but she made "sure hard scripts are there".</p> <p>-If a prescription was needed between NP visits, the facility could call the physician's office and the needed "script" would be sent to the pharmacy.</p> <p>-If a pharmacy contacted the physician's office directly for a prescription, the physician's office could send the prescription directly to the pharmacy.</p> <p>-"We do not let patients do without medications".</p> <p>-In the event the NP was unavailable in the office, there was "always someone to cover" for her.</p> <p>-The NP was not aware there were blocks of time when medications were unavailable.</p> <p>-The facility should order or request the medications in time for them to be dispensed before the resident ran completely out.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JUNE 11, 2016.</p>	D 358		
D 367	<p>10A NCAC 13F .1004(j) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <p>(1) resident's name;</p> <p>(2) name of the medication or treatment order;</p> <p>(3) strength and dosage or quantity of medication administered;</p> <p>(4) instructions for administering the medication or treatment;</p> <p>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;</p> <p>(6) date and time of administration;</p>	D 367		

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NAME OF PROVIDER OR SUPPLIER ELM VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 1915 SOUTH ELM STREET HIGH POINT, NC 27260
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D 367	<p>Continued From page 24</p> <p>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,</p> <p>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the Medication Administration Records (MARs) were accurate and included documentation of omissions and the reason for the omission, and documentation of the reason for administration and resulting effect for PRN (as needed) medications for 2 of 3 sampled residents (Residents #2 and #3).</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL-2 dated 11/18/15 revealed diagnoses included paraplegic, chronic pain syndrome, pressure ulcer of hip, and anxiety.</p> <p>1. Review of the current FL-2 dated 11/18/15 revealed a physician's order for Oxycontin 20 mg twice daily. (Oxycontin is a narcotic pain reliever.)</p> <p>Review of Resident #2's record revealed a physician's order dated 01/14/16 to decrease the Oxycontin 20 mg to once daily in the morning.</p> <p>Review of the Oxycontin 20 mg narcotic sign out sheets from 12/13/15 through 04/20/16 revealed: -Based on an ending count of 0 on 12/27/15 and the next dispense date of 01/14/16, there was no</p>	D 367		

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D 367	<p>Continued From page 25</p> <p>Oxycontin available for administration from 12/28/15 through 01/14/16; the resident missed 36 consecutive doses.</p> <p>-Based on an end count of 0 on 03/13/16 and the next dose signed out on 03/18/16, there was no Oxycontin available for administration from 03/14/16 through 03/17/16; the resident missed 4 consecutive doses.</p> <p>-Based on an ending count of 0 on 04/16/16 and the next dose signed out on 04/18/16, there was no Oxycontin administered on 04/17/16; the resident missed one dose.</p> <p>Review of the December 2015 and January 2016 MARs revealed:</p> <p>-An entry for Oxycontin 20 mg scheduled twice daily at 8:00 am and 8:00 pm from 12/01/15 through 01/14/16.</p> <p>-The 8:00 pm dose of Oxycontin was documented as administered nightly from 12/28/15 through 01/01/16 when no Oxycontin was available for administration to the resident.</p> <p>-The 8:00 am dose of Oxycontin was documented as administered on 01/14/16 when no Oxycontin was available for administration to the resident.</p> <p>-The MAR was blank for the 8:00 am doses of Oxycontin on 01/01/16, 01/02/16, and 01/03/16.</p> <p>-The 8:00 am doses of Oxycontin was circled as not administered on 12/28/15, 01/05/16, 01/06/16, 01/07/16, 01/11/16, 01/12/16, and 01/13/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>-The 8:00 pm doses of Oxycontin was circled as not administered from 01/02/16 through 01/13/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>-There were 7 doses of Oxycontin circled as not</p>	D 367		

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D 367	<p>Continued From page 26</p> <p>administered from 12/29/15 through 01/10/16 with corresponding documentation on the back of the MAR indicating "refill needed".</p> <p>Review of the March 2016 MAR from 03/14/16 through 03/17/16 revealed: -An entry for Oxycontin 20 mg scheduled daily at 8:00 am. -Oxycontin 20 mg was documented as administered on 03/14/16 when no Oxycontin was available for administration to the resident. -Oxycontin 20 mg was circled as not administered from 03/15/16 through 03/17/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>Review of the April 2016 MAR revealed: -An entry for Oxycontin 20 mg scheduled for administration daily at 8:00 am. -Oxycontin 20 mg was documented as administered on 04/17/16 when none was signed out on the corresponding narcotic sign out sheet.</p> <p>Refer to interview on 04/20/16 at 11:00 am with a Medication Aide (MA).</p> <p>Refer to interviews on 04/20/16 at 11:10 am and 04/25/16 at 12:30 pm with the Resident Care Director (RCD).</p> <p>2. Review of Resident #2's current FL-2 dated 11/18/15 revealed a physician's order for diazepam 10 mg three times daily. (Diazepam is a sedative.)</p> <p>Review of the diazepam 10 mg narcotic sign out sheets from 11/30/15 to 04/20/16 revealed: -Based on an ending count of 0 on 12/10/15 at 2:00 pm and the next dispense date of 12/14/15</p>	D 367		

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D 367	<p>Continued From page 27</p> <p>with the next dose signed out on 12/15/16 at 8:00 am, there was no diazepam available for administration from 12/10/15 at 8:00 pm through 12/14/15 at 8:00 pm; the resident missed 13 consecutive doses.</p> <p>-Based on an ending count of 0 on 01/14/16 at 8:00 am and the next dispense date of 01/18/16 with the next dose signed out on 01/18/16 at 10:00 pm, there was no diazepam available for administration from 01/14/16 at 2:00 pm through 01/18/16 at 2:00 pm; the resident missed 12 consecutive doses.</p> <p>-Based on an ending count of 0 on 03/05/16 at 2:00 pm and the next dose signed out on 03/07/16 at 8:00 am, there was no diazepam administered from 03/05/16 at 8:00 pm through 03/06/16 at 8:00 pm; the resident missed four consecutive doses.</p> <p>-Based on an ending count of 0 on 03/16/16 at 2:00 pm and the next dispense date of 03/17/16 with the next dose signed out on 03/18/16 at 2:00 pm, there was no diazepam available for administration from 03/16/16 at 8:00 pm through 03/17/16 at 8:00 pm; the resident missed 4 consecutive doses.</p> <p>-Based on an ending count of 0 on 04/06/16 at 8:00 pm and the next dispense date of 04/11/16 with the next dose signed out on 04/12/16 at 7:00 am, there was no diazepam available for administration from 04/07/16 at 8:00 am through 04/11/16 at 8:00 pm; the resident missed 15 consecutive doses.</p> <p>Review of the December 2015 Medication Administration Record (MAR) revealed:</p> <p>-An entry for diazepam 10 mg scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily.</p> <p>-Diazepam 10 mg was documented as administered on 12/10/15 at 8:00 pm, 12/11/15 at</p>	D 367		

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D 367	<p>Continued From page 28</p> <p>2:00 pm, and 12/11/15 at 8:00 pm when there was no diazepam available for administration to the resident.</p> <p>-Diazepam 10 mg was circled as not administered on 10 occasions from 12/10/15 through 12/14/15; there was no corresponding documentation on the back of the MAR to indicate why the medication was not administered for 9 of the 10 occasions.</p> <p>-The 8:00 pm dose of diazepam 10 mg was not documented as administered on 12/18/15 and was not documented as administered nightly from 12/22/15 through 12/31/15.</p> <p>Review of the January 2016 MAR revealed:</p> <p>-An entry for diazepam 10 mg scheduled for administration daily at 8:00 am, 2:00 pm, and 8:00 pm daily.</p> <p>-Diazepam 10 mg was documented as administered on 01/15/16 at 8:00 am and 8:00 pm when there was no diazepam available for administration to the resident.</p> <p>-Diazepam 10 mg was circled as not administered on 8 occasions from 01/14/16 through 01/18/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>-The MAR was blank for the 01/15/16 2:00 pm dose and the 01/18/16 8:00 am and 2:00 pm doses.</p> <p>Review of the February 2016 MAR revealed:</p> <p>-An entry for diazepam 10 mg scheduled for administration daily at 8:00 am, 2:00 pm, and 8:00 pm daily.</p> <p>-The diazepam was circled as not administered from 8:00 pm on 03/05/16 through 8:00 pm on 03/06/16 with no corresponding documentation on the back of the MAR to indicate why the</p>	D 367		

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D 367	<p>Continued From page 29</p> <p>medication was not administered.</p> <p>-The diazepam was circled as not administered from 8:00 pm on 03/16/16 through 8:00 pm on 03/17/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>Review of the April 2016 MAR revealed:</p> <p>-An entry for diazepam 10 mg scheduled for administration daily at 8:00 am, 2:00 pm, and 8:00 pm daily.</p> <p>-The diazepam was documented as administered on six occasions between 04/07/16 and 04/11/16 when no diazepam was available to be administered to the resident.</p> <p>-The diazepam was circled as not administered on 9 occasions between 04/07/16 and 04/11/16 with no corresponding documentation on the back of the MAR to indicate why the medication was not administered.</p> <p>Refer to interview on 04/20/16 at 11:00 am with a Medication Aide (MA).</p> <p>Refer to interviews on 04/20/16 at 11:10 am and 04/25/16 at 12:30 pm with the Resident Care Director (RCD).</p> <p>3. Review of Resident #2's current FL-2 dated 11/18/15 revealed an order for oxycodone-APAP 10/325 mg daily as needed for breakthrough pain, not to exceed three per week. (Oxycodone-APAP is a combination narcotic pain reliever with acetaminophen.)</p> <p>Review of the December 2015 MAR revealed:</p> <p>-An entry for Oxycodone-APAP 10/325 mg once daily as needed for breakthrough pain was listed on the MAR for administration and scheduled as PRN.</p>	D 367		

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D 367	<p>Continued From page 30</p> <p>-The Oxycodone-APAP was administered 13 times from 12/02/15 through 12/31/15.</p> <p>-There was no corresponding documentation on the back of the MAR to indicate the time the medication was administered, the reason for administration, or the effectiveness of the medication for 12 of the 13 administered doses.</p> <p>Review of the January 2016 MAR revealed oxycodone-APAP was documented as administered on 4 occasions between 01/15/16 and 01/30/16 with no corresponding documentation on the back of the MAR to indicate the time the medication was administered, the reason for administration, or the effectiveness of the medication.</p> <p>Review of the narcotic sign out sheets revealed oxycodone-APAP was signed out on 4 occasions from 01/18/16 to 01/28/16 with no corresponding documentation of administration to the resident on the MAR.</p> <p>Review of the February 2016 MAR revealed oxycodone-APAP was documented as administered on 7 occasions between 02/01/16 and 02/29/16 with no corresponding documentation on the back of the MAR to indicate the time the medication was administered, the reason for administration, or the effectiveness of the medication.</p> <p>Review of the narcotic sign out sheets revealed oxycodone-APAP was signed out on 6 occasions from 02/05/16 through 02/25/16 with no corresponding documentation of administration to the resident on the MAR.</p> <p>Review of the March 2016 MAR revealed: -Oxycodone-APAP 10/325 mg once daily as</p>	D 367		

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D 367	<p>Continued From page 31</p> <p>needed for breakthrough pain was listed listed on the MAR for administration and scheduled as PRN.</p> <p>-There was no documentation of oxycodone-APAP administered to the resident during the month of March 2016.</p> <p>Review of the narcotic sign out sheets revealed oxycodone-APAP was signed out on 10 occasions from 03/02/16 through 03/30/16 with no corresponding documentation of administration to the resident on the MAR.</p> <p>Review of the April 2016 MAR revealed oxycodone-APAP 10/325 was administered on 4 occasions from 04/04/16 through 04/11/16 with no corresponding documentation on the back of the MAR to indicate the time the medication was administered, the reason for administration, or the effectiveness of the medication.</p> <p>Review of the narcotic sign out sheets revealed oxycodone-APAP was signed out on 04/01/16 at 8:00 pm with no corresponding documentation of administration to the resident on the MAR.</p> <p>Refer to interview on 04/20/16 at 11:00 am with a Medication Aide (MA).</p> <p>Refer to interviews on 04/20/16 at 11:10 am and 04/25/16 at 12:30 pm with the Resident Care Director (RCD).</p> <p>B. Review of Resident #3's current FL-2 dated 02/25/16 revealed: -Diagnoses included alcohol abuse, hypertension, and schizoaffective disorder. -An order for Klonopin 1 mg, one and one-half tablets at bedtime. (Klonopin is used to treat mental disorders such as anxiety and panic</p>	D 367		

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D 367	<p>Continued From page 32</p> <p>attacks.</p> <p>Observation on 04/20/16 of the facility's controlled drug sign-out log book located on the medication cart revealed current controlled substance count sheets provided by the contract pharmacy provider were kept in the binder by resident name.</p> <p>Review of the Klonopin (Clonazepam is the generic name) controlled substance count sheets for Resident #3 from 02/17/16 to through 04/20/16 revealed:</p> <ul style="list-style-type: none"> -Clonazepam 1.5 mg was documented as administered (signed out on the controlled substance count sheets) from 02/17/16 to 03/16/16. The contract pharmacy dispensed a quantity of 44 clonazepam 1 mg tablets (29 doses) on 02/15/16. -Clonazepam 1.5 mg was documented as administered (signed out on the controlled substance count sheets) from 03/22/16 to 04/22/16. The contract pharmacy dispensed a quantity of 45 clonazepam 1 mg tablets (30 doses) on 03/21/16. -There was no Clonazepam 1.5 mg available for administration from 03/17/16 through 03/22/16; the resident missed 5 consecutive doses.(was it doc. as not available?) <p>Review of Resident #3's March 2016 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> -An entry for Clonazepam 1.0 mg, take 1 and ½ tablets at bedtime was listed and scheduled for bedtime. -Clonazepam 1.5 mg at bedtime was documented as administered daily from 03/01/16 to 03/31/16, except on 03/19/16 and 03/20/16 when it was not administered as indicated by initials circled but no explanation noted on the 	D 367		

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D 367	Continued From page 33 back of the MAR. -The documentation of administration for 03/17/16, 03/18/16, and 03/21/16 on 3 occasions between 03/17/16 and 03/21/16 when no clonazepam was available to be administered to the resident. Interview on 04/20/16 at 9:00 am with Resident #3 revealed: -He routinely received his medications as ordered except for one time, about a month ago, when he was out of his night-time "nerve" medication. -The facility was giving him the medication routinely since that time. Telephone interview on 04/26/16 at 10.00 am with a second shift Medication Aide revealed: -She routinely documented administration of residents' controlled drugs on the MAR and on the controlled substance count sheets. -When a resident did not have a medication in the facility for administration, she documented on the MAR with her initials and circled the initials as not given. -She sometimes forgot to document the reason the medication was not given on back of the MAR. -If a resident did not have a controlled drug to administer then it would not be signed out on the controlled substance count sheets and should be initialed and circled on the resident's MAR. Refer to interview on 04/20/16 at 11:00 am with a Medication Aide (MA). Refer to interviews on 04/20/16 at 11:10 am and 04/25/16 at 12:30 pm with the Resident Care Director (RCD). Interview on 04/20/16 at 11:10 am with a	D 367		

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D 367	Continued From page 34 Medication Aide (MA) revealed: -She did not know why medications not available for administration had been documented as administered. -She thought the medications must have been "signed by mistake". -She knew medications circled as not administered and PRN medications were supposed to have corresponding documentation on the back of the MAR to indicate why they were or were not administered. -She did not know why there was no corresponding documentation on the back of the MARs. Interviews on 04/20/16 at 11:10 am and 04/25/16 at 12:30 pm with the Resident Care Director (RCD) revealed: -She was not aware medications had been documented as administered which were not available for administration. -She was not aware medications circled as not administered had no corresponding documentation to indicate why they were not administered. -She was responsible for ensuring the accuracy of the MARs. -She reviewed narcotic count sheets but only "glanced" at the sheets to be sure the count was correct. -She did not check the entries on the count sheets, but "only check that the narcotic sheet total matches what's in the drawer". -There was currently no system in place for monitoring to ensure accuracy of MAR documentation.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances	D 392		

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D 392	<p>Continued From page 35</p> <p>10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to accurately document the receipt, administration, and disposition of controlled substances (diazepam) for 1 of 3 sampled residents (Resident #2).</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 11/18/15 revealed: -Diagnoses included paraplegic, chronic pain syndrome, pressure ulcer of hip, and anxiety. -A physician's order for diazepam 10 mg three times daily. (Diazepam is a sedative.)</p> <p>1. Review of the diazepam controlled substance count sheet beginning on 02/15/16 and ending on 02/24/16 revealed: -There was a pharmacy label at the top of the sheet indicating 87 tablets of diazepam 10 mg dispensed on 02/15/16. -This count sheet sheet corresponded to a bubble package containing 29 tablets was began on 02/15/16 at 2:00 pm. -Five staff signatures on 02/16/16 at 8:00 pm through 02/18/16 at 8:00 am had been marked through with a line and other staff initials written in. -On 02/16/16, two 8:00 am doses had been signed out.</p>	D 392		

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D 392	<p>Continued From page 36</p> <ul style="list-style-type: none"> -On 02/17/16, no 8:00 am dose had been signed out. -On 02/18/16, two 8:00 am doses had been signed out. -On 02/23/16, one dose was signed out at 7:00 am and another dose at 8:00 am. -The last dose was signed out on 02/24/16 at 8:00 pm leaving a count of 0 of 29 (of 87 total) tablets. <p>Review of a diazepam controlled substance count sheet beginning on 02/25/16 and ending on 03/01/16 revealed:</p> <ul style="list-style-type: none"> -There was a pharmacy label at the top of the sheet indicating 87 tablets of diazepam 10 mg dispensed on 02/15/16. -This sign out sheet corresponded to a bubble pack containing 29 tablets which was begun on 02/25/16 at 8:00 am. -An entry on 03/01/16 at 7:00 am with 14 tablets remaining. -An entry on 03/01/16 at 8:00 pm with 13 tablets remaining. The 13 had a line drawn through it and 12 written in to the side. -An entry on 03/01/16 at 7:00 am with 11 tablets remaining and a note to the side "pill missing 12". The "11" had a line drawn through it and 11 written again to the side. -A line with an arrow had been drawn between the 7:00 am and 8:00 pm doses on 03/01/16 and a 2:00 pm dose was inserted at the arrow for 03/01/16. -There was no further documentation on the count sheet to indicate what happened to the remaining 11 tablets. <p>Review of additional diazepam controlled substance count information revealed:</p> <ul style="list-style-type: none"> -A different controlled substance count form with no pharmacy label at the top. 	D 392		

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D 392	<p>Continued From page 37</p> <p>- "Diazepam 10 mg tablets, Quantity 29, 02/15/16" and the resident's name was handwritten at the top of the sheet.</p> <p>- Entries three times daily from 02/25/16 at 8:00 am through 03/05/16 at 2:00 pm.</p> <p>- The first 20 entries were in the same handwriting with no staff signatures, but staff initials at each entry (02/25/16 through 03/02/16) and was duplication of documentation on the previous sheet.</p> <p>- The remaining 9 entries included staff signatures and documentation of the missing 11 tablets from the previous sheet.</p> <p>Review of another diazepam controlled substance count sheet beginning on 03/07/16 at 8:00 am revealed:</p> <p>- There was a pharmacy label at the top of the sheet indicating 87 tablets of diazepam 10 mg dispensed on 02/15/16.</p> <p>- This count sheet corresponded to a bubble pack containing 29 tablets which was begun on 03/07/16 at 8:00 am and included entries three times daily through 03/16/16 at 2:00 pm.</p> <p>Review of a diazepam controlled substance count sheet beginning on 03/18/16 at 8:00 am revealed:</p> <p>- There was a pharmacy label at the top of the sheet indicating 90 tablets of diazepam 10 mg were dispensed on 03/17/16.</p> <p>- The count sheet included documentation for diazepam 10 mg signed out three times daily from 03/18/16 at 8:00 am through 03/27/16 at 8:00 pm, leaving a final count of 0 of 30 tablets.</p> <p>A second diazepam control substance count sheet beginning on 03/28/16 at 8:00 am revealed:</p> <p>- There was a pharmacy label at the top of the sheet indicating 90 tablets of diazepam 10 mg were dispensed on 03/17/16.</p>	D 392		

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D 392	<p>Continued From page 38</p> <p>-The sheet included documentation for diazepam 10 mg signed out three times daily from 03/28/16 at 8:00 am through 04/06/16 at 8:00 pm, leaving a final count of 0 of 30 tablets.</p> <p>The third bubble pack containing 30 tablets of diazepam dispensed on 03/17/16 was not located and there was no controlled substance count sheet to indicate what happened to the remaining 30 tablets.</p> <p>Review of a diazepam controlled substance count sheet beginning 4/12/16 at 7:00 am revealed: -There was a pharmacy label indicating 90 tablets of diazepam 10 mg were dispensed on 04/11/16. -The count sheet included documentation of diazepam 10 mg signed out three times daily from 04/12/16 at 7:00 am through 04/20/16 at 8:00 am, leaving a final count of 5 of 30 tablets.</p> <p>Observation on 04/20/16 at 10:00 am of Resident #2's medications on hand revealed: -A bubble pack of diazepam 10 mg tablets dispensed on 04/12/16 with 5 of 30 tablets remaining. -A bubble pack of diazepam 10 mg tablets dispensed 04/11/16 with 30 of 30 tablets remaining, which was stored in a locker with some other overstock medications. -The pharmacy label for both packs of diazepam indicated 90 tablets were dispensed on 04/11/16. -The third bubble pack containing 30 diazepam 10 mg tablets not located.</p> <p>Interview on 04/21/16 at 10:28 am with one Medication Aide (MA) revealed: -She did not know anything about the 60 missing diazepam tablets. -She always counted the narcotics in the medication cart at the beginning of her shift with</p>	D 392		

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D 392	<p>Continued From page 39</p> <p>the offgoing MA, and at the end of her shift with the oncoming MA.</p> <ul style="list-style-type: none"> -Sometimes MAs "forget to sign out pills and have to catch it (narcotic sheet) up". -Sometimes the MAs forget to count the narcotics at the beginning or end of the shift. <p>Telephone interview on 04/26/16 at 9:30 am with a second MA revealed:</p> <ul style="list-style-type: none"> -When the narcotic sheets got "tacky" from corrections, no one could understand them, so either she or the RCD made a new sheet so people could understand. -Sometimes the MAs did not count the narcotics for "a couple of days", so when they did count them, the count was off. -When the narcotic count was off, the MA skipped a line so the person who forgot to sign out the narcotic could insert the information, but sometimes they signed on the wrong line. -The MA knew the narcotics were supposed to be counted every shift, but some MAs "bail out" as soon as they see the oncoming shift and she had to "find" someone to count the narcotics with her. <p>Interviews on 04/21/16 at 11:11 am and 3:03 pm with the Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> -The MAs were supposed to be counting the narcotics at every shift. -Sometimes if a MA had to leave early, the RCD might count the narcotics by herself. Then when the next MA came in, she just gave the keys to the oncoming MA and did not count the narcotics. -She was aware there were blocks of time when staff were not counting the narcotics at each shift because when the count was discovered to be off, the RCD would "have to go back and see who was working to fix" the count on the sheets. -It was part of the RCD's responsibility to ensure narcotics were documented accurately. 	D 392		

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D 392	Continued From page 40 -The only time she reviewed the narcotic sheets or narcotics was if a MA went home early and she took over the cart, or if someone reported to her that the narcotic count was off. -The RCD kept the extra cards of narcotics in a locker so the MAs did not have to count them every shift. -Only the RCD had a key to the locker and when the medications were needed, the RCD got them out of the locker to give to the MA. -She was not aware there were 60 tablets of diazepam unaccounted for.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding infection prevention requirements, and medication administration. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on	D912		

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D912	<p>Continued From page 41</p> <p>infection control regarding the sharing of glucometers and lancing pens between residents and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment for 4 of 4 sampled residents (Residents #4, #5, #6, #7). [Refer to Tag 0932, G.S. 131D-4.4A(b) (Type B Violation).]</p> <p>B. Based on observations, interviews, and record reviews, the facility failed to ensure medications (Oxycontin, oxycodone, diazepam, and clonazepam) were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Residents #2 and #3). [Refer to Tag 358, 10A NCAC 13F .1004(a) (Type B Violation).]</p> <p>C. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled medication aides had received annual inservice training on infection control, safe practices for injections, and glucose monitoring. [Refer to Tag 934, G.S. 131D-4.5B (Type B Violation).]</p>	D912		
D932	<p>G.S. 131D-4.4A (b) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements</p> <p>(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012:</p> <p>(1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following:</p> <p>a. Proper disposal of single-use equipment used</p>	D932		

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D932	<p>Continued From page 42</p> <p>to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents.</p> <p>b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.</p> <p>c. Accessibility of infection control devices and supplies.</p> <p>d. Blood and bodily fluid precautions.</p> <p>e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.</p> <p>f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.</p> <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers and lancing pens between residents and proper disinfection of fingerstick blood sugar</p>	D932		

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D932	<p>Continued From page 43</p> <p>(FSBS) monitoring equipment for 4 of 4 sampled residents (Residents #4, #5, #6, #7).</p> <p>The findings are:</p> <p>Interview on 04/20/16 at 10:30 am with the first shift Medication Aide (MA) and the Resident Care Director (RCD) revealed the facility had 5 residents receiving FSBS monitoring.</p> <p>Observation of blood glucose monitoring on 04/20/16 at 4:08 pm revealed:</p> <ul style="list-style-type: none"> -The second shift Medication Aide (MA) removed a black glucometer storage pouch from the top right hand drawer of the 200 Hall medication cart. -The pouch, labeled with a resident's name, contained a Brand A glucometer (not labeled with a resident's name), a bottle of test strips, lancets, and a lancing pen (not labeled with a resident's name). -The MA donned gloves, removed the Brand A glucometer and lancing pen from the resident's storage pouch; placed a test strip in the glucometer; wiped the tip on the lancing pen cap; removed the lancing pen cap; inserted a new lancet and recapped the lancing pen. -The MA wiped the resident's right index finger with a fresh alcohol wipe; pricked the finger with the lancing pen; obtained a blood sample; removed the lancet from the lancing pen; disposed of the lancet in the biohazard container; recapped the lancing pen; used a clean alcohol wipe to clean the outside of the lancing pen cap; and placed the lancing pen back in the storage pouch. -The MA placed the alcohol wipes inside one glove and disposed of the gloves in the medication cart trash container. <p>Observation on 04/21/16 at 8:05 am of the 100</p>	D932		

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D932	<p>Continued From page 44</p> <p>Hall medication cart revealed: -There was one glucometer storage pouch labeled with a resident's name located on the top right hand drawer of the medication cart. -The glucometer pouch contained diabetic test strips, lancets, a Brand A glucometer, not labeled with a resident's name, and a lancing pen, not labeled with a resident's name. -There were no Environmental Protection Agency (EPA) approved disinfectant wipes on the medication cart.</p> <p>Observation on 04/21/16 at 8:15 am of the 200 Hall medication cart revealed 4 glucometer storage pouches labeled with residents' names located on the top right hand drawer of the medication cart. The glucometer pouches were labeled with a resident's name and contained diabetic test strips, lancets, glucometers, and lancing pens as follows: -Two glucometer storage pouches each one containing a Brand A glucometer, not labeled with a resident's name, and a lancing pen, not labeled with a resident's name. -One glucometer storage pouches containing a Brand B glucometer, not labeled with a resident's name, and a lancing pen, not labeled with a resident's name. -One glucometer storage pouches containing a Brand C glucometer, not labeled with a resident's name, and a lancing pen, not labeled with a resident's name. -There were no EPA approved disinfectant wipes on the medication cart.</p> <p>Based on the Center for Disease Control (CDC) guidelines for infection control, the recommendations were: -Blood glucose monitoring devices (glucometers) should not be shared between residents.</p>	D932		

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D932	<p>Continued From page 45</p> <p>-If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions using an EPA approved disinfectant effective against blood borne infectious diseases, such as hepatitis or Human Immunodeficiency Virus (HIV), and tuberculosis. If the manufacturer does not list the disinfection information, the glucometer should not be shared between residents.</p> <p>-Diabetic lancing pens should never be used for more than one resident.</p> <p>Review of the manufacturer's User's Manual for the Brand A glucometer revealed the glucometer was recommended for use on a single person and should not be shared. The lancing pen should not be shared.</p> <p>Review of the manufacturer's User's Manual for the Brand B glucometer revealed the glucometer was recommended for use on a single person but the glucometer could be used by health care professionals in a clinical setting by following CDC guidelines for disinfecting in accordance to the instructions of the manufacturer of the disinfectant.</p> <p>Review of the manufacturer's product manual and telephone interview on 04/21/16 with a representative from glucometer Brand C's customer service department revealed:</p> <p>-This glucometer could be used on more than one person if proper disinfection protocols were adhered to.</p> <p>-The protocol for proper disinfection required the use of an Environmental Protection Agency (EPA) approved disinfectant effective against blood borne infectious diseases, such as hepatitis or Human Immunodeficiency Virus (HIV), and tuberculosis.</p>	D932		

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D932	<p>Continued From page 46</p> <p>-The manufacturer recommended (Brand name) wipe, used according to the directions on the (Brand Name) wipe, to clean and disinfect the glucometer. (Review of the ingredients of the recommended brand wipe revealed it contained water 70-80 percent (%), isopropanol 17.2%, ethylene glycol monobutyl ether (2-butoxyethanol) 1-5% and diisobutylphenoxyethoxyethyl dimethylbenzyl ammonium chloride 0.28%.</p> <p>-The lancing pen should not be shared.</p> <p>Interview on 04/21/16 at 2:30 pm with the Administrator revealed:</p> <p>-She was unable to locate an infection prevention policy for the use of glucometers in the facility.</p> <p>-She was certain the facility had a policy regarding the use of glucometers from the contract pharmacy, but she had recently relocated her office within the facility and she was not able to find a lot of the facility reference materials.</p> <p>-The facility's protocol was for each resident to have an assigned glucometer and lancing pen: only the assigned glucometer and lancing pen was to be used for FSBS checks on a resident.</p> <p>A. Review of Resident #4's current FL-2 dated 05/07/15 revealed:</p> <p>-Diagnoses included diabetes mellitus type 2.</p> <p>-An order for fingerstick blood sugar (FSBS) check two times a day on Monday, Wednesday, and Friday.</p> <p>Review of Resident #4's record revealed signed physician orders dated 04/07/16 ordering FSBS checks two times a day.</p> <p>Observation on 04/21/16 at 8:22 am of FSBS testing revealed:</p>	D932		

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D932	<p>Continued From page 47</p> <ul style="list-style-type: none"> -The Resident Care Director (RCD) removed a black glucometer storage pouch from the top right hand drawer of the 100 Hall medication cart. -The pouch, labeled with Resident #4 name, contained a Brand A glucometer (not labeled with a resident's name), a bottle of test strips, lancets, and a lancing pen (not labeled with a resident's name). -The RCD donned gloves; removed the Brand A glucometer and lancing pen from the resident's storage pouch; placed a test strip in the glucometer; wiped the tip on the lancing pen cap; removed the lancing pen cap; inserted a new lancet and recapped the lancing pen. -The MA wiped the resident's right index finger with a fresh alcohol wipe; pricked the finger with the lancing pen; obtained a blood sample; removed the lancet from the lancing pen; disposed of the lancet in the biohazard container; recapped the lancing pen; used a clean alcohol wipe to clean the outside of the lancing, including the pen cap; and placed the lancing pen back in the storage pouch. -The FSBS value obtained was 109. -The MA placed the alcohol wipes inside one glove and disposed of the gloves in the medication cart trash container. <p>Review of Resident #4's April 2016 Medication Administration Records (MAR) revealed:</p> <ul style="list-style-type: none"> -An entry to check FSBS twice a day was listed and scheduled for 7:00 am and 7:00 pm daily. -FSBS values were documented two times daily from 04/01/16 to 04/21/16. -FSBS value of 109 was documented for 04/21/16 at 7:00 am. <p>Observation of the Brand A glucometer used to obtain Resident #4's FSBS revealed:</p> <ul style="list-style-type: none"> -The glucometer was not labeled with Resident 	D932		

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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
D932	<p>Continued From page 48</p> <p>#4's name. -The lancing pen stored in the glucometer storage case, along with the glucometer, was not labeled with Resident #4's name.</p> <p>Review of the memory for the Brand A glucometer used to obtain Resident #4's FSBS revealed: -The date and time was accurately set. -The glucometer stored FSBS values starting with the most current and displaying progressively older. -The FSBS result for 04/20/16 at 4:30 pm of 127 was consistent with the result entered on the April 2016 MAR for 04/20/16.</p> <p>Review of the FSBS values recorded in the memory of the glucometer used for Resident #4 compared to the April 2016 MAR revealed: -There were no additional FSBS values recorded in the glucometer's memory from 04/01/16 to 04/20/16. -Values documented in the glucometer's memory were inconsistent with values documented on Resident #4's MAR for April 2016 for 7 of 21 FSBS values documented on the MAR at 7:00 am and 15 of 21 FSBS values documented on the MAR at 7:00 pm.</p> <p>Examples of FSBS values recorded in the glucometer's memory inconsistent with FSBS values documented on Resident #4's April 2016 MAR were as follows: -On 4/20/16, FSBS documented on MAR as 108 at 7:00 am and 145 at 7:00 pm; no FSBS value in the glucometer's memory. -On 4/19/16, FSBS documented on MAR as 110 at 7:00 am and 181 at 7:00 pm; no FSBS value in the glucometer's memory. -On 4/18/16, FSBS documented on MAR as 110 at 7:00 am and 145 at 7:00 pm; no FSBS value in</p>	D932		

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D932	<p>Continued From page 49</p> <p>the glucometer's memory.</p> <p>-On 4/17/16, FSBS documented on MAR as 119 at 7:00 am and 144 at 7:00 pm; no FSBS value in the glucometer's memory.</p> <p>-On 04/15/16, FSBS documented on MAR as 115 at 7:00 am; FSBS values recorded in the glucometer's memory were 115 at 7:36 am and 262 at 7:21 am (extra reading 15 minutes apart).</p> <p>-On 4/14/16, FSBS documented on MAR as 125 at 7:00 pm; no FSBS value in the glucometer's memory.</p> <p>-On 4/13/16, FSBS documented on MAR as 135 at 7:00 pm; no FSBS value in the glucometer's memory.</p> <p>-On 4/12/16, FSBS documented on MAR as 135 at 7:00 pm; no FSBS value in the glucometer's memory.</p> <p>-On 4/11/16, FSBS documented on MAR as 150 at 7:00 pm; no FSBS value in the glucometer's memory.</p> <p>-On 04/06/16, FSBS documented on MAR as 108 at 7:00 am; FSBS values recorded in the glucometer's memory were 108 at 7:53 am and 204 at 8:25 am (extra reading 35 minutes apart).</p> <p>Interview on 04/25/16 at 12:44 pm with Resident #4 revealed:</p> <p>-Staff checked his FSBS regularly.</p> <p>-He had never seen a name on the glucometer staff used to check his FSBS.</p> <p>-He was not sure what brand of glucometer staff used to check his FSBS.</p> <p>-Staff used a lancing pen to check his FSBS.</p> <p>-He could not say if the lancing pen was always the same type of lancing pen.</p> <p>Refer to interview on 04/21/16 at 3:00 pm with a third shift Medication Aide (MA).</p> <p>Refer to interview on 4/21/16 at 3:03 pm with the</p>	D932		

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D932	<p>Continued From page 50</p> <p>Assistant Administrator.</p> <p>Refer to interview on 04/21/16 at 3:07 pm with a first shift MA.</p> <p>Refer to interview on 04/21/16 at 3:45 pm with the Administrator.</p> <p>Refer to interview on 04/21/16 at 4:10 pm with the Resident Care Director (RCD).</p> <p>Refer to interview on 04/21/16 at 4:25 pm with a second shift MA.</p> <p>B. Review of Resident #5's current FL-2 dated 05/07/15 revealed: -Diagnoses included diabetes mellitus type 2. -An order for fingerstick blood sugar (FSBS) check two times a day on Monday, Wednesday, and Friday.</p> <p>Review of Resident #5's record revealed signed physician orders for June 2015 but no date signed ordering FSBS checks twice a day before breakfast and dinner, 3 times a week.</p> <p>Review of Resident #5's April 2016 Medication Administration Records (MAR) revealed: -An entry to check FSBS twice a day, before breakfast and dinner, 3 times a week was listed and scheduled for 7:30 am and 4:30 pm daily. -FSBS values were documented two times daily on 9 days from 04/01/16 to 04/21/16.</p> <p>Observation of the glucometer pouch labeled with Resident #5's name revealed: -The pouch contained a Brand A glucometer. -The glucometer was not labeled with a resident's name. -The lancing pen stored in the glucometer</p>	D932		

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D932	<p>Continued From page 51</p> <p>storage case, along with the glucometer was not labeled with Resident #5's name.</p> <p>Review of the FSBS values recorded in the memory of the glucometer used for Resident #5 compared to the April 2016 MAR revealed:</p> <ul style="list-style-type: none"> -The date and time was accurately set. -The FSBS result for 04/20/16 at 4:30 pm of 127 was consistent with the result entered on the April 2016 MAR for 04/20/16. -There were no FSBS values recorded in the glucometer's memory from 04/01/16 to 04/19/16. -Values documented in the glucometer's memory were inconsistent with values documented on Resident #5's MAR for April 2016 for 9 of 9 FSBS values documented on the MAR at 7:30 am and 8 of 9 FSBS values documented on the MAR at 4:30 pm. <p>Examples of FSBS values documented on Resident #5's April 2016 MAR inconsistent with FSBS values recorded in the glucometer's memory were as follows:</p> <ul style="list-style-type: none"> -On 04/20/16, FSBS documented on MAR was 102 at 7:30 am; no FSBS value in the glucometer's memory. -On 04/18/16, FSBSs documented on MAR were 111 at 7:30 am and 146 at 4:30 pm; no FSBS value in the glucometer's memory. -On 04/15/16, FSBSs documented on MAR were 115 at 7:30 am and 139 at 4:30 pm; no FSBS value in the glucometer's memory. -On 04/13/16, FSBSs documented on MAR were 115 at 7:30 am and 197 at 4:30 pm; no FSBS value in the glucometer's memory. -On 04/11/16, FSBSs documented on MAR were 121 at 7:30 am and 103 at 4:30 pm; no FSBS value in the glucometer's memory. <p>Review of Resident #5's March 2016 Medication</p>	D932		

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D932	<p>Continued From page 52</p> <p>Administration Records (MAR) revealed: -An entry to check FSBS twice a day, before breakfast and dinner, 3 times a week was listed and scheduled for 7:30 am and 4:30 pm daily. -FSBS values were documented two times daily on 13 days from 03/01/16 to 03/31/16.</p> <p>Review of the FSBS values recorded in the memory of the glucometer used for Resident #5 compared to the March 2016 MAR revealed values documented in the glucometer's memory were inconsistent with values documented on Resident #5's MAR for March 2016 for 7 of 13 FSBS values documented on the MAR at 7:30 am and 7 of 13 FSBS values documented on the MAR at 4:30 pm.</p> <p>Examples of FSBS values documented on Resident #5's March 2016 MAR inconsistent with FSBS values recorded in the glucometer's memory were as follows: -On 03/28/16, FSBS documented on MAR was 168 at 7:30 am; no FSBS value in the glucometer's memory. -On 03/25/16, FSBS documented on MAR was 151 at 4:30 pm; no FSBS value in the glucometer's memory. -On 03/23/16, FSBS documented on MAR was 135 at 4:30 pm; no FSBS value in the glucometer's memory. -On 03/18/16, FSBSs documented on MAR were 128 at 7:30 am and 199 at 4:30 pm; no FSBS value in the glucometer's memory.</p> <p>Examples of FSBS values recorded in the glucometer's memory but not documented on Resident #5's March 2016 MAR were as follows: -On 03/16/16, FSBS documented on MAR was 128 at 7:30 am; FSBS values recorded in the glucometers memory were 128 at 6:28 am and</p>	D932		

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D932	<p>Continued From page 53</p> <p>161 at 7:43 am (extra reading 15 minutes apart). -On 03/15/16, FSBS were not scheduled or documented on the MAR- FSBS values recorded in the glucometers memory were 283 at 5:38 am, 106 at 6:03 am, and 220 at 6:58 pm. -On 03/14/16, FSBSs documented on the MAR were 141 at 7:30 am; FSBS values recorded in the glucometers memory were 253 at 6:48 am, 141 at 7:02 am, and 108 at 7:08 am. FSBS documented on the MAR was 161 at 4:30 pm; FSBS values recorded in the glucometer's memory were 161 at 4:10 pm and 156 at 6:58 pm.</p> <p>Interview on 04/25/16 at 12:35 pm with Resident #5 revealed: -Staff used a glucometer from a black pouch to check her FSBS on Monday, Wednesday, and Friday. -She did not always see the name on the black pouch but had seen her name occasionally. -She thought staff used the same kind of glucometer to check her FSBS but he was not certain.</p> <p>Refer to interview on 04/21/16 at 3:00 pm with a third shift Medication Aide.</p> <p>Refer to interview on 4/21/16 at 3:03 pm with the Assistant Administrator.</p> <p>Refer to interview on 04/21/16 at 3:07 pm with the first shift MA.</p> <p>Refer to interview on 04/21/16 at 3:45 pm with the Administrator.</p> <p>Refer to interview on 04/21/16 at 4:10 pm with the Resident Care Director (RCD).</p>	D932		

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D932	<p>Continued From page 54</p> <p>Refer to interview on 04/21/16 at 4:25 pm with a second shift MA.</p> <p>C. Review of Resident #6's current FL-2 dated 05/07/15 revealed: -Diagnoses included diabetes. -An order for fingerstick blood sugar (FSBS) every morning.</p> <p>Observation of the glucometer pouch labeled with Resident #6's name revealed: -The pouch contained a Brand B glucometer. -The glucometer was not labeled with a resident's name. -The lancing pen stored in the glucometer storage case, along with the glucometer was not labeled with Resident #6's name.</p> <p>Review of Resident #6's April 2016 Medication Administration Records (MAR) revealed: -An entry to check FSBS every morning was listed and scheduled for 7:30 am. -FSBS values were documented daily from 04/01/16 to 04/21/16.</p> <p>Review of the memory for the Brand A glucometer used to obtain Resident #6's FSBS revealed the date and time was accurately set.</p> <p>Review of the FSBS values recorded in the memory of the glucometer used for Resident #6 compared to the April 2016 MAR revealed: -Values documented in the glucometer's memory were inconsistent with values documented on Resident #6's MAR for April 2016, from 04/01/16 to 04/21/16 at 7:30 am for 9 of 21 FSBS values documented on the MAR. -There were additional FSBS values recorded in the glucometer's memory from 04/20/16 to 04/01/16.</p>	D932		

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D932	<p>Continued From page 55</p> <p>Examples of FSBS values documented on Resident #6's April 2016 MAR inconsistent with FSBS values recorded in the glucometer's memory were as follows:</p> <ul style="list-style-type: none"> -On 4/20/16 at 7:30 am, FSBS-117; no corresponding FSBS value in the glucometer's memory. -On 4/16/16 at 7:30 am, FSBS-86 ; no corresponding FSBS value in the glucometer's memory. -On 4/15/16 at 7:30 am, FSBS-91; no corresponding FSBS value in the glucometer's memory. -On 4/11/16 at 7:30 am, FSBS-88; no corresponding FSBS value in the glucometer's memory. <p>Examples of FSBS values recorded in the glucometer's memory but not documented on Resident #6's April 2016 MAR, with a short time between FSBS, were as follows:</p> <ul style="list-style-type: none"> -On 04/20/16, at 7:37 am FSBS-102, at 7:31 am FSBS-102, at 7:24 am FSBS-126, and at 7:20 am FSBS-87. -On 04/19/16, at 6:47 pm FSBS-187, at 7:39 am FSBS-116, at 7:30 am FSBS-107, and at 7:16 am-115 (matching Resident #6's MAR for FSBS documentation for the same date and time). -On 04/18/16, at 6:57 am FSBS-166, at 6:47 am FSBS-110 (matching Resident #6's MAR for FSBS documentation for the same date and time), and at 6:13 am FSBS-111. -On 04/17/16, at 6:45 pm FSBS-144, at 6:13 pm FSBS-135, at 7:36 am FSBS-133, at 7:27 am FSBS-119, at 7:05 am FSBS-108, and at 7:02 am FSBS-85. -On 04/01/16, at 4:19 pm FSBS-169, at 4:17 pm FSBS-179, at 6:53 am FSBS-117, at 6:47 am FSBS-101 (matching Resident #6's MAR for 	D932		

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D932	<p>Continued From page 56</p> <p>FSBS documentation for the same date and time), and at 6:42 am FSBS-192.</p> <p>Interview on 04/25/16 at 12:40 pm with Resident #6 revealed: -He was aware Medication Aides checked his FSBS regularly. -He did not pay attention to the type of glucometer used to check his FSBS.</p> <p>Refer to interview on 04/21/16 at 3:00 pm with a third shift Medication Aide (MA).</p> <p>Refer to interview on 4/21/16 at 3:03 pm with the Assistant Administrator.</p> <p>Refer to interview on 04/21/16 at 3:07 pm with the first shift MA .</p> <p>Refer to interview on 04/21/16 at 3:45 pm with the Administrator.</p> <p>Refer to interview on 04/21/16 at 4:10 pm with the Resident Care Director (RCD).</p> <p>Refer to interview on 04/21/16 at 4:25 pm with a second shift MA.</p> <p>D. Review of Resident #7's current FL-2 dated 02/11/16 revealed: -Diagnoses included diabetes type 2. -An order for fingerstick blood sugar (FSBS) two times a day.</p> <p>Review of Resident #7's record revealed Signed Physician's orders dated 04/07/16 ordering FSBS two times a day.</p> <p>Observation of the glucometer pouch labeled with Resident #7's name revealed:</p>	D932		

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D932	<p>Continued From page 57</p> <ul style="list-style-type: none"> -The glucometer was a Brand A glucometer. -The glucometer was not labeled with a resident's name. -The lancing pen stored in the glucometer storage case, along with the glucometer was not labeled with Resident #7's name. <p>Review of the memory for the Brand A glucometer used to obtain Resident #7's FSBS revealed the date and time were accurately set.</p> <p>Review of Resident #7's April 2016 Medication Administration Records (MAR) revealed:</p> <ul style="list-style-type: none"> -An entry to check FSBS two times a day was listed and scheduled for 8:00 am and 8:00 pm daily. -FSBS values were documented two times daily from 04/01/16 to 04/21/16. <p>Review of the FSBS values recorded in the memory of the glucometer used for Resident #7 compared to the April 2016 MAR, from 04/01/16 to 04/21/16, revealed 41 out of 42 FSBS values documented on the MAR at 8:00 am and 8:00 pm were not recorded in the glucometer memory.</p> <p>Examples of FSBS values documented on Resident #7's April 2016 MAR inconsistent with FSBS values recorded in the glucometer's memory were as follows:</p> <ul style="list-style-type: none"> -On 4/20/16 at 8:00 am, FSBS-102; no corresponding FSBS value in the glucometer's memory. -On 4/20/16 at 8:00 pm, FSBS-166; no corresponding FSBS value in the glucometer's memory. -On 4/19/16 at 8:00 am, FSBS-114; no corresponding FSBS value in the glucometer's memory. -On 4/19/16 at 8:00 pm, FSBS-198; no 	D932		

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D932	<p>Continued From page 58</p> <p>corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/18/16 at 8:00 am, FSBS-108; no corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/18/16 at 8:00 pm, FSBS-166; no corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/17/16 at 8:00 am, FSBS-108; no corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/17/16 at 8:00 pm, FSBS-135; no corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/16/16 at 8:00 am, FSBS-109; no corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/16/16 at 8:00 pm, FSBS-199; no corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/15/16 at 8:00 am, FSBS-105; no corresponding FSBS value in the glucometer's memory.</p> <p>-On 4/15/16 at 8:00 pm, FSBS-135; no corresponding FSBS value in the glucometer's memory.</p> <p>Review of Resident #7's March 2016 MAR revealed: -An entry to check FSBS two times a day was listed and scheduled for 8:00 am and 8:00 pm daily. -FSBS values were documented two times daily from 03/20/16 to 03/31/16.</p> <p>Review of the FSBS values recorded in the memory of the glucometer used for Resident #7 compared to the March 2016 MAR, from 03/31/16 to 03/20/16, revealed: -Twelve out of 24 FSBS values documented on</p>	D932		

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D932	<p>Continued From page 59</p> <p>the MAR at 8:00 am and 8:00 pm were not recorded in the glucometer memory.</p> <p>-There were additional FSBS values recorded in the glucometer's memory from 03/20/16 to 03/31/16.</p> <p>Examples of FSBS values recorded in the glucometer's memory and documented on Resident #7's March 2016 MAR with additional FSBS recorded in a short period of time were as follows:</p> <p>-On 03/25/16, FSBS values recorded in the glucometers memory were 128 at 7:16 pm, 139 at 7:14 pm, and 104 at 5:05 pm.</p> <p>-On 03/24/16, FSBS documented on the MAR was 79 at 8:00 am; FSBS values recorded in the glucometer's memory were 140 at 6:46 am, and 79 at 6:46 am.</p> <p>-On 03/24/16, FSBS documented on the MAR was 145 at 8:00 pm; FSBS values recorded in the glucometer's memory were 146 at 7:22 pm and 140 at 6:46 pm.</p> <p>-On 03/23/16, FSBS documented on the MAR was 92 at 8:00 am; FSBS values recorded in the glucometers memory were 92 at 7:45 am, and 162 at 6:42 am.</p> <p>-On 03/23/16, FSBS documented on the MAR was 192 at 8:00 pm; FSBS values recorded in the glucometer's memory were 132 at 7:41 pm and 121 at 6:55 pm.</p> <p>Interview on 4/25/16 at 12:38 pm with Resident #7 revealed he was not aware of the type of glucometer used to test his FSBS.</p> <p>Refer to interview on 04/21/16 at 3:00 pm with a third shift Medication Aide.</p> <p>Refer to interview on 4/21/16 at 3:03 pm with the Assistant Administrator.</p>	D932		

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D932	<p>Continued From page 60</p> <p>Refer to interview on 04/21/16 at 3:07 pm with the first shift MA.</p> <p>Refer to interview on 04/21/16 at 3:45 pm with the Administrator.</p> <p>Refer to interview on 04/21/16 at 4:10 pm with the Resident Care Director (RCD).</p> <p>Refer to interview on 04/21/16 at 4:25 pm with a second shift MA.</p> <p>Interview on 04/21/16 at 3:00 pm with a third shift Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -She routinely worked 3 nights a week and every other weekend. -She routinely did FSBS checks for residents scheduled for FSBS before or at 7:00 am before she left at the end of her shift (7:00 am). -She was aware the glucometers and lancing pens were not labeled for the residents. -The facility policy was for each resident to have a their own glucometer and lancing pen assigned to each resident. Staff were supposed to use the assigned glucometer to check FSBS. -She routinely used both the lancing pen and glucometer in the storage pouch labeled with residents' names to check FSBSs. -Staff were trained to check one resident's FSBS at a time with the glucometer in the resident's assigned glucometer storage pouch and to return all the resident's supplies to the storage pouch before moving on to the next resident. -She used alcohol wipes to clean the glucometer and lancing pen before and after each use. -She had never had to use a glucometer to check a FSBS other than the one assigned to the resident. -She was aware alcohol was not a disinfectant. 	D932		

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D932	<p>Continued From page 61</p> <ul style="list-style-type: none"> -She had a training in infection control in February 2016 and was instructed staff should not share glucometers or lancing pens. -She would not use a lancing pen if it became separated from the storage case, but would discard the lancing pen in the biohazard waste container. -She would notify the Resident Care Director (RCD) if she needed supplies or if a glucometer was not working properly. <p>Interview on 4/21/16 at 3:03 pm with the Assistant Administrator revealed:</p> <ul style="list-style-type: none"> -The facility policy was residents had glucometers assigned to each resident. -Staff were not supposed to share glucometers or lancing pens between residents. -The lancing pens and the glucometers for each resident stayed together in the storage pouch labeled with a resident's name. -She was not aware of any system currently in place to routinely audit the use of glucometers used for checking FSBS. She did not routinely compare glucometer's memory to residents' corresponding MARs for accuracy or to rule out sharing glucometers between residents. -No MA staff had informed her that a resident's glucometer was not working properly. -She was not aware that MA staff were sharing glucometers and/or lancing pens between residents. -Alcohol was used by MA staff to wipe the glucometer and lancing pen before and after each use. -The facility did not have a system in place to routinely disinfect glucometers. <p>Interview on 04/21/16 at 3:07 pm with the first shift MA revealed:</p> <ul style="list-style-type: none"> -The facility only had 5 residents currently 	D932		

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D932	<p>Continued From page 62</p> <p>receiving FSBS and not all them had a FSBS checks scheduled every day.</p> <ul style="list-style-type: none"> -All residents had a glucometer storage pouch labeled with the resident's name and an assigned glucometer. -The facility protocol was to use only the glucometer and lancing pen assigned to a resident to check the resident's FSBS. -She was not aware of an instance when a resident did not have diabetic supplies for their assigned glucometer. -The MA stated her routine for checking FSBS was to retrieve the glucometer and lancing pen labeled for a resident from the medication cart; wipe the glucometer and the lancing pen (inside and outside) with an alcohol swab before and after using the glucometer and lancing pen. -She routinely returned the glucometer and lancing pen to the labeled storage pouch before she moved to the next resident. -She had not used any cleaner other than alcohol to clean the glucometers or lancing pens. -She thought alcohol would clean and disinfect glucometers and lancing pens. -She completed the 15 hours medication aide training course within the last year and had infection prevention training as part of the 15 hours of Medication Aide training. -She did not remember a time when she used a glucometer or lancing pen on a resident other than the resident for which the storage pouch was labeled for. -She received her Medication Aide check-off by the contract pharmacy Nurse. <p>Interview on 04/21/16 at 3:45 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -The facility protocol was to have a glucometer and lancing pen assigned to each resident for FSBS checks and both to be used for the 	D932		

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D932	<p>Continued From page 63</p> <p>assigned resident only.</p> <ul style="list-style-type: none"> -She was unable to locate the facility policy and procedure manual. -Her office had recently been relocated within the building and she had not located most of the facility reference books. -The contract pharmacy had provided the facility with their policy and procedures regarding glucometer and lancing pen usage, but she could not locate the manual. -The facility did not have a system currently in place to routinely monitor or audit the use of glucometers for assuring accuracy of the glucometers' memory compared to the FSBS values documented on residents' MARs. -She did not know how residents had FSBS values documented on the MAR if the FSBS reading was not in the glucometer. -The Administrator confirmed no diabetic resident currently receiving FSBS checks had a diagnosis of a blood borne disease. -The Administrator was not familiar with the "Clinical Laboratory Improvements Amendments" (CLIA) waiver and stated she was certain the facility did not have the waiver. <p>Interview on 04/21/16 at 4:10 pm with the Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> -She was responsible for ordering diabetic residents' supplies. -The facility did not have an Environmental Protection Agency (EPA) approved disinfectant agent effective against blood borne infectious diseases, such as hepatitis or Human Immunodeficiency Virus (HIV), and tuberculosis. -Staff were trained not to share glucometers of lancing pens between residents. -No staff member had informed her that a resident was short on supplies or had a glucometer that did not work. 	D932		

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D932	<p>Continued From page 64</p> <ul style="list-style-type: none"> -She did not have a system in place to monitor glucometers compared to residents' MARs for accuracy or evidence of glucometer sharing. -She did not label the glucometers or the lancing pens because they were supposed to be used for the resident assigned to the storage pouch and returned to the medication cart before checking a FSBS on another resident. <p>Interview on 04/21/16 at 4:25 pm with a second shift MA revealed:</p> <ul style="list-style-type: none"> -The facility protocol was all diabetic residents receiving FSBS checks had an assigned glucometer and lancing pen to be used to check their FSBS. -Staff were not supposed to share glucometers or lancing pens between residents. -She did not know how residents had FSBS values documented on the MAR if the FSBS reading was not in the glucometer memory. -She always used alcohol to clean the glucometers and lancing pens after each use. -The facility did not have any other type of cleaner for the glucometers or lancing pens. -She had used a glucometer assigned to one resident to check another resident's FSBS when she ran out of diabetic supplies, but she always used the lancing pen from the storage pouch of the resident receiving the FSBS. It had been a long time since she shared a glucometer between residents. -She had not observed a staff member sharing glucometers between residents. <hr/> <p>The facility provided a Plan of Protection on 04/21/16 as follows:</p> <ul style="list-style-type: none"> -Immediately the facility will obtain new glucometers for each resident. -Glucometers, pouches, and lancing pens will all be labeled correctly for each resident. 	D932		

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D932	Continued From page 65 -Staff will be in-serviced on using each residents' devices on the assigned resident only. -The RCD, Administrator or Co-Administrator will develop a system for monitoring glucometers to assure they are not shared between residents. -This will be implemented immediately. -All medication Aides will be in-serviced before obtaining next scheduled blood sugar test. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, June 11, 2016.	D932		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (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 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 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2	D934		

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D934	<p>Continued From page 66</p> <p>sampled Medication Aides (Staff A and C) had received annual inservice training on infection control, safe practices for injections, and glucose monitoring.</p> <p>The findings are:</p> <p>A. Review of Staff A's personnel record revealed: -A hire date of 11/26/003 as a Resident Care Assistant. -Staff A became a Medication Aide (MA) in 2004 and was currently the Resident Care Director (RCD). -Documentation Staff A completed the annual infection control training on 06/18/13. -No documentation of infection control training after 06/18/13.</p> <p>Interview on 04/25/16 at 12:30 pm with Staff A revealed: -A Registered Nurse (RN) taught the infection control course in 2013. -She had not completed the infection control training since 2013. -She did not know the training was supposed to be completed by Medication Aides (MAs) annually.</p> <p>Interview on 04/25/16 at 11:34 am with the Administrator revealed she did not know the infection control training was supposed to be completed annually by the MAs.</p> <p>B. Review of Staff C's personnel record revealed: -A hire date of 09/11/14 as a Medication Aide (MA). -Documentation Staff C completed annual infection control training on 10/21/14. -Documentation the 10/21/14 infection control training was taught by the Resident Care Director</p>	D934		

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D934	<p>Continued From page 67</p> <p>(RCD), who was a Medication Aide (MA), and not an appropriately licensed health professional.</p> <p>Interview on 04/25/16 at 12:30 pm with the RCD revealed:</p> <ul style="list-style-type: none"> -A Registered Nurse (RN) taught the infection control training in 2013 and told the RCD at that time that she had to appoint someone to teach the class. -The RN gave the RCD a copy of the course, copies of the test, copies of the certificate of completion, and an answer key. -The RCD taught the class to newly hired MAs. -The RCD did not know MAs were supposed to complete the training annually. <p>Interview on 04/25/16 at 11:34 am with the Administrator revealed:</p> <ul style="list-style-type: none"> -An RN from the facility's previously contracted pharmacy came to the facility in 2013 and taught the infection control class. -The RN "left the course" and told the RCD she could teach it and fill out the certificates of completion. -The Administrator did not know MAs were supposed to complete the training annually. <p>Staff C was unavailable for interview.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 11, 2016.</p>	D934		
D935	<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>	D935		

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D935	<p>Continued From page 68</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ol style="list-style-type: none"> a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ol style="list-style-type: none"> a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ol style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. 	D935		

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D935	<p>Continued From page 69</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled Medication Aides (Staff C) hired after October 2013 had worked as a Medication Aide (MA) during the previous 24 months in an adult care home or successfully completed the 15-hour MA training.</p> <p>The findings are:</p> <p>Review of Staff C's personnel record revealed: -A hire date of 09/11/14 as a MA. -Documentation Staff C passed the written Medication Aide exam on 08/17/04. -Documentation of a Medication Clinical Skills validation dated 10/21/14. -No documentation of an employment verification that Staff C had worked as a MA during the previous 24 months. -No documentation of the 5-10-15 hour MA training.</p> <p>Interview on 04/25/16 at 11:34 am with the Administrator revealed: -She knew Staff C had previously worked as a MA. -She did not know she had to complete a MA verification form or provide the 5-10-15 hour training.</p> <p>Staff C was unavailable for interview.</p>	D935		
D992	<p>G.S. § 131D-45 (a) Examination and screening</p> <p>G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care</p>	D992		

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D992	<p>Continued From page 70</p> <p>homes.</p> <p>(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete an examination and screening for the presence of controlled</p>	D992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2016
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NAME OF PROVIDER OR SUPPLIER ELM VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 1915 SOUTH ELM STREET HIGH POINT, NC 27260
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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
D992	<p>Continued From page 71</p> <p>substances prior to hire for 1 of 1 sampled staff member (Staff C) hired after October 2013.</p> <p>The findings are:</p> <p>Review of Staff C's personnel record revealed: -A hire date of 09/11/14 as a Medication Aide (MA). -No documentation of a drug screen.</p> <p>Interview on 04/25/16 at 11:34 am with the Administrator revealed she did not perform drug screening for Staff C prior to hire because she did not know it was mandatory.</p> <p>Staff C was unavailable for interview.</p>	D992		