

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2016
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NAME OF PROVIDER OR SUPPLIER SHERWOOD MANOR REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1605 ROBINHOOD ROAD WILMINGTON, NC 28401
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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover Department of Social Services conducted an annual survey and a complaint investigation on April 12-14, 2016.	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 observation, interview, and record review, the facility failed to assure hot water temperatures were maintained between 100 and 116 degrees for 2 of 13 fixtures used by residents.</p> <p>The findings are:</p> <p>Observation of a sink in a shared bathroom for resident rooms #1 and #2 on 04/12/16 at 10:40 AM revealed: -The water temperature was 122 degrees Fahrenheit. -The faucet to the sink was continuously running with water and would not shut off.</p> <p>Observation of a second sink in a shared bathroom for resident rooms #3 and #4 on</p>	D 113		

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

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D 113	<p>Continued From page 1</p> <p>04/12/16 at 10:50 AM revealed a water temperature of 118 degrees Fahrenheit.</p> <p>Review of logs for water temperature checks revealed: -The last check of the water temperatures was dated 04/01/16. -There was only two different temperatures logged in the log book, but there was no description of which fixtures were checked.</p> <p>Observation of the recheck for the sink in the shared bathroom for resident rooms #1 and #2 on 04/13/16 at 8:50 AM revealed a water temperature of 124 degrees Fahrenheit.</p> <p>Observation of the recheck for the sink in the shared bathroom for resident rooms #3 and #4 on 04/13/16 at 8:55 AM revealed a water temperature of 122 degrees Fahrenheit.</p> <p>Interview with one of the Administrators on 04/12/16 at 11:45 AM revealed: -She was the one who did the checks on the water temperatures for the facility. -She kept a log of the water temperatures. -She was aware that the faucet in the shared bathroom between room #1 and #2 was continuously running. -She had already contacted the plumbing company this morning to come and repair the fixture. -She was not aware that the water temperatures were too high in any of the bathrooms.</p> <p>Interview with one of the Administrators on 04/13/16 at 9:11 AM revealed: -She had called a plumber yesterday to come and fix the plumbing but no one ever showed up. -She would call the plumber again this morning to</p>	D 113		

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D 113	<p>Continued From page 2</p> <p>see if she could get them out there today to look at the plumbing issues.</p> <p>Interview with a second Administrator on 04/13/16 at 9:30 AM revealed:</p> <ul style="list-style-type: none"> -She said that the other Administrator of the building is responsible for checking the water temperatures. -She believes that the other Administrator is checking the water temperatures every day. -She was not sure if the other Administrator checked all the sinks or just random sink when she was checking water temperatures. -The facility has had several issues in the past with the water temperature fluctuating up and down. -There is no maintenance person on staff. -The other Administrator called in a contracted person to fix any problems and repairs they need done to the facility. <p>Telephone interview with a plumber on 04/13/16 at 10:05 AM revealed:</p> <ul style="list-style-type: none"> -He was the usual plumber that came from his company to work on plumbing issues at the facility. -He has been servicing this facility for the last 10 years. -The last time there was a problem with the temperatures in the building he had to replace stem in the sink in the kitchen area. -Most of the time the mixing valve gets dirty and he has to take it off and clean the valve so that the water will mix correctly. -He feels that if the water temperature are off then it is related to a mixing issue with the mixing valve. -He does not do water temperature checks at the facility. -The Administrator is responsible for checking the 	D 113		

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D 113	<p>Continued From page 3</p> <p>water temperatures.</p> <p>-The Administrator did call in a service call on 04/12/16 but he was not able to get by on that day.</p> <p>-He plans on coming by today to look at the problem and see if he can get the problem fixed.</p> <p>-If it is not a mixing valve problem then it may be related to the pipes and how they were placed when the building was built.</p> <p>Observation of the plumber and the Administrator checking the water temperatures on 04/13/16 at 10:53 AM revealed:</p> <p>-The plumber was using a cooking thermometer to check the water temperatures.</p> <p>-The Administrator was using a cooking thermometer to check the water temperatures.</p> <p>Review of the packaging for the thermometer that the Administrator was using on 04/13/16 revealed:</p> <p>-The thermometer is a probe for measuring internal meat temperatures.</p> <p>-It can also be used to check the temperature of foods from the refrigerator and freezer to determine cooking times.</p> <p>-The packaging does not specify a use for measuring water temperatures.</p> <p>Interview with a second Plumber on 04/13/16 at 11:20 AM revealed:</p> <p>-He has attempted to adjust the temperature at the hot water tank, but was unable to get the temperatures to adjust properly.</p> <p>-He was going to add a mixing valve to each of the sinks that were not at the right temperature too see if that would fix the problem.</p>	D 113		

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D 358 D 358	<p>Continued From page 4</p> <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: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer medications to 2 of 3 residents (Resident #2 and Resident #5) including administering the wrong dosage and omitting medications ordered.</p> <p>The findings are:</p> <p>The medication error rate was 13% as evidence by observation of 4 errors out of 30 opportunities during the 7:00/8:00 AM medication pass on 04/13/16 and the 12:00 PM pass on the 04/13/16.</p> <p>1.Review of Resident #2's current FL2 dated 03/03/16 revealed diagnoses of shortness of breath, diabetes mellitus, hypertension, anemia, depression, and anxiety.</p> <p>Review of Resident #2's current FL2 dated 03/03/16 revealed: -A physician's order for Omeprazole 20mg take 2 capsules 30 minutes before breakfast daily. (A mediation used to treat acid reflux). -A physician's order for Fluocin Acetate solution 0.01% give 1 drop in both ears daily. (An ear medication used to treat eczema of the outer ear.</p>	D 358 D 358		

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D 358	<p>Continued From page 5</p> <p>Review of the April 2016 medication administration record (MAR) revealed: -An entry for Omeprazole 20mg take two capsules 30 minutes before breakfast, scheduled for 8 AM. -An entry for Fluocin Acetate solution 0.01% give 1 drop both ears daily, scheduled for 8 AM.</p> <p>Observation of the medication pass on 04/13/16 at 7:25 AM revealed: -The Medication Aide took out a pack of pills labeled Omeprazole 20 milligrams -The Medication Aide then placed the medications back into the cart but did not add any of this medication to Resident #2's pill cup to administer. -The Medication Aide administered Resident #2's pills and omitted administering the Omeprazole 20 milligrams.</p> <p>Observation of the mediation pass on 04/13/16 at 7:29 AM revealed: -The Medication Aide took out a bottle of drops labeled Fluocin Acetate Solution 0.01%. -The Medication Aide administered three drops into each ear of Resident #2.</p> <p>Interview with the Medication Aide on 04/13/16 at 9:17 AM revealed: -She had been working at the facility for about 2 years as a Personal Care Aide and a Medication Aide. -She was not aware that she had not given the Omeprazole medication, and that she put too many ear drops in Resident #2's ears. -She had received some training from the facility's LHPS nurse on how to pass medication and administer the proper dosage. -She would go back and administer the</p>	D 358		

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D 358	<p>Continued From page 6</p> <p>medications that she forgot to administer so that the resident would receive the medication.</p> <p>2. Review of Resident #5's current FL2 dated 11/18/15 revealed diagnoses of history of fracture of greater trochanter of the left femur, Gastro Esophageal Reflux Disease, Heart Disease, enlarged prostate, major depressive disorder, anxiety disorder, insomnia, hemiplegia, muscle weakness, and difficulty walking.</p> <p>Review of Resident #5's current FL2 dated 11/18/15 revealed:</p> <ul style="list-style-type: none"> -There was an order Plavix 75 milligrams take 1 tablet daily. (A medication used to prevent stroke, heart attack, and other heart problems). -There was an order for Proscar 5 milligrams 1 tablet daily scheduled for 8 AM. <p>Review of the April 2016 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Plavix 75 milligrams take 1 tablet daily scheduled for 8 AM. -There was an entry for Proscar 5 milligrams 1 tablet daily scheduled for 8 AM. <p>Observation of the medication pass on 04/13/16 at 7:39 AM revealed:</p> <ul style="list-style-type: none"> -The Medication Aide took out a pack of pills labeled Plavix 75 milligrams -The Medication Aide then placed the medication back into the medication cart and did not place any of this medication in Resident #5's pill cup. -The Medication Aide took out a pack of pills labeled Proscar 5 milligrams and showed the medication to the surveyor. -The Medication Aide then placed the medication pack back into the medication cart and did not place any of this medication in Resident #5's pill cup. 	D 358		

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D 358	<p>Continued From page 7</p> <p>-The Medication Aide administered Resident #5' s medication and omitted giving the Plavix 75 milligrams and the Proscar 5 milligrams.</p> <p>Interview with the Medication Aide on 04/13/16 at 9:17 AM revealed:</p> <p>-She was not aware that she had omitted Resident #5's Plavix 75 milligrams and Proscar 5 milligrams.</p> <p>-She would go back and administer the Plavix and the Proscar to Resident #5 so that the resident would receive those medications.</p> <p>Telephone interview with the facility's LHPS nurse on 04/14/16 at 9:30 AM revealed:</p> <p>-She does all the training for the Medications Aides at the facility.</p> <p>-The last training she had done was on 12/31/15, and was related to medication administration.</p> <p>-She did not feel that any of the Medication Aides at the facility were having any problems with passing medications.</p> <p>-She had instructed the Medication Aides to call her if they were having any problems or had any questions regarding medication administration.</p> <p>-She only does training with the Medication Aides when she is requested to by the facility staff.</p> <p>Telephone interview with the facility's onsite Pharmacist on 04/14/16 at 9:45 AM revealed:</p> <p>-She does not assess the way the medication carts are set up, and she does not assess the Medication Aides passing medications.</p> <p>-The only time that is warranted is when the facility calls and request some training or monitoring of the Medication Aides and passing medications.</p> <p>Interview with one of the Administrators on 04/13/16 at 1:48 PM revealed:</p>	D 358		

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D 358	<p>Continued From page 8</p> <ul style="list-style-type: none"> -The pharmacy does a medication pass assessment on the Medication Aides once or twice a year. -She has never had any problems with them having medication errors during these assessments. -The facility's LHPS nurse does all the training and check offs with the Medication Aides when they are first hired. -The Medication Aides do get some continuing education courses for passing meds that are done by the LHPS nurse. -The last one done was done sometime last quarter around January. -All of the Medication Aides were required to attend the training. 	D 358		