

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/28/2016
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NAME OF PROVIDER OR SUPPLIER MCLEOD FAMILY CARE CENTER OF FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 LIVERMORE DRIVE FAYETTEVILLE, NC 28314
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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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 04/27/16 - 04/28/16.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any	C 007		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 007	<p>Continued From page 1</p> <p>possible changes that may be required to the building.</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 notify the Division of Health Service Regulation that residents' evacuation capabilities were different from the evacuation capability listed on the home's license for 4 of 5 residents (#1, #2, #3, #4) residing in the facility who had cognitive and/or physical impairments which would prevent the residents from independently evacuating the facility. The findings are:</p> <p>Review of the facility's 2016 license revealed: -The facility was licensed for a capacity of 6 residents. -The facility was licensed for all ambulatory residents.</p> <p>1. Review of Resident #1's most current FL-2 dated 11/24/15 revealed: -The resident's diagnoses included protein calorie malnutrition, peripheral vascular disease, osteomyelitis right first toe, gangrene, and polyclonal gammopathy. -The resident was constantly disoriented and non-verbal. -The resident was non-ambulatory and required total care. -The resident was incontinent of bowel and bladder. -The resident had a stage 3 sacral decubitus. -The resident had a gastrostomy tube.</p>	C 007		

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C 007	<p>Continued From page 2</p> <p>Review of a previous FL-2 dated 06/25/15 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included chronic foley catheter with urethral stricture, urinary tract infection, debility contracture, sacral decubitus, mental retardation, anemia, and chronic recurrent blepharitis. -The resident had an indwelling catheter. -The resident had a sacral decubitus. -The resident had a gastrostomy tube. -The resident had an order for oxygen at 2 liters per minute as needed for shortness of breath. <p>Review of the Resident Register revealed Resident #1 was admitted to the facility on 10/03/05.</p> <p>Review of Resident #1's current assessment and care plan dated 06/17/15 revealed:</p> <ul style="list-style-type: none"> -The resident had limited ability with ambulation due to flexion contracture. -The resident's upper extremities had contractures. -The resident had a gastrostomy tube. -The resident was oriented but was forgetful and needed reminders. -The resident was totally dependent for all activities of daily living including eating, toileting, ambulation, bathing, dressing, grooming, and transferring. <p>Observation of Resident #1 on 04/27/16 at 10:30 a.m. revealed:</p> <ul style="list-style-type: none"> -The resident was lying in a hospital bed with both arms and legs contracted. -The resident was lying with his face toward the wall. -The resident would not reply when spoken to. <p>Interview with the Supervisor-in-Charge (SIC) on</p>	C 007		

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C 007	<p>Continued From page 3</p> <p>04/27/16 at 9:30 a.m. revealed: -Resident #1 was total care and had been bedbound for about a year due to a wound and contractures of his arms and legs. -One staff person could transfer and evacuate Resident #1 because he was so tiny. -She had not notified anyone at Division of Health Service Regulation (DHSR) that the capabilities of the resident did not match the capability listed on the facility's license.</p> <p>Interview with the Administrator on 04/27/16 at 3:15 p.m. revealed: -Resident #1 was non-verbal and did not speak. -Resident #1 was total care. -Resident #1 could get out of bed on his own. -Resident #1 required at least one person to transfer him into the wheelchair. -Resident #1 could not evacuate without assistance in the case of a fire. -Resident #1 had been in this condition for at least a couple of years. -She had not notified anyone at Division of Health Service Regulation (DHSR) that the capabilities of the resident did not match the capability listed on the facility's license.</p> <p>Attempts to contact Resident #1's physician were unsuccessful.</p> <p>2. Review of Resident #2's most current FL-2 dated 08/07/15 revealed: -The resident's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, rheumatoid arthritis, hypertension, and hypothyroidism. -The resident was ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bladder but continent of bowel.</p>	C 007		

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C 007	<p>Continued From page 4</p> <p>-The resident had an order for oxygen at 3.5 liters per minute continuous.</p> <p>Review of the Resident Register revealed Resident #2 was admitted to the facility on 08/01/15.</p> <p>Review of Resident #2's current assessment and care plan dated 08/09/15 revealed:</p> <p>-The resident had no problems with ambulation or upper extremities.</p> <p>-The resident was on oxygen and had shortness of breath periodically.</p> <p>-The resident was continent of bowel and bladder.</p> <p>-The resident was oriented and had adequate memory.</p> <p>-The resident required limited assistance with bathing and did not require assistance with any other activities of daily living.</p> <p>Observation of Resident #2 on 04/27/16 at 10:06 a.m. revealed:</p> <p>-Resident #2 was in her room sitting in a wheelchair.</p> <p>-The resident was wearing oxygen via nasal cannula.</p> <p>-The resident's oxygen concentrator was set at 4 liters per minute.</p> <p>-The resident had a nebulizer machine and a bedside toilet.</p> <p>Interview with Resident #2 on 04/27/16 at 10:06 a.m. revealed:</p> <p>-She could walk a little bit holding onto something.</p> <p>-She could transfer herself to and from the wheelchair.</p> <p>-She could self-propel the wheelchair.</p> <p>-She thought they had fire drills at the facility and</p>	C 007		

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C 007	<p>Continued From page 5</p> <p>it was loud but she was not sure. -She could not give any details about where she went during a fire drill or how she evacuated.</p> <p>Observation of Resident #2 on 04/28/16 at 11:54 a.m. revealed: -She was in her room sitting in wheelchair. -She was wearing oxygen via nasal cannula.</p> <p>Interview with Resident #2 on 04/28/16 at 11:54 a.m. revealed: -She could only walk small distances in her room independently. -She had a walker at home before she moved to the facility. -She did not have the walker anymore. -If there was a fire, she would have to go out the window in her room because she could not make it to the exit doors due to weakness and shortness of breath.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/27/16 at 2:45 p.m. revealed: -Resident #2 could bear weight and walk. -Resident #2 just walked in her room because she would get short of breath. -The resident did not usually come out of her room. -She had portable oxygen tanks if she wanted to come out. -The resident ate meals in her room and she did not like to come out of her room. -Resident #2 needed supervision with bathing and dressing. -The resident's oxygen was supposed to be on 3.5 liters per minute but the resident adjusted it at times.</p> <p>Interview with the SIC and the Administrator on 04/27/16 at 3:15 p.m. revealed:</p>	C 007		

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C 007	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Resident #2 could usually stand up to transfer herself and self-propel her wheelchair. -They thought the resident could evacuate using the wheelchair ramp at the back door exit. <p>Interview with a nurse from the primary physician's office on 04/28/16 at 10:35 a.m. revealed:</p> <ul style="list-style-type: none"> -The primary physician was unavailable for interview. -She was familiar with Resident #2 from her office visits. -Resident #2's family member usually pushed her in the wheelchair. -She had not observed Resident #2 self-propelling the wheelchair. -Resident #2 would need a walker to prevent her from falling to ambulate independently. -Resident #2 would require physical assistance to evacuate in case of a fire due to weakness and shortness of breath, especially if she had no walker. <p>3. Review of Resident #3's most current FL-2 dated 10/08/15 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included dementia, hypotension, and gastroesophageal reflux disease. -The resident was intermittently disoriented and was noted to be "a wanderer". -The resident was ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bladder but continent of bowel. <p>Review of the Resident Register revealed Resident #3 was admitted to the facility on 10/05/11.</p> <p>Review of Resident #3's current assessment and</p>	C 007		

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C 007	<p>Continued From page 7</p> <p>care plan dated 10/08/15 revealed:</p> <ul style="list-style-type: none"> -The resident had no problems with ambulation or upper extremities. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident's speech was slurred. -The resident required extensive assistance with bathing. -The resident required limited assistance with dressing and supervision with grooming. -The resident was independent with eating, toileting, and ambulation. <p>Review of a legal guardianship form dated 04/20/12 for Resident #3 revealed:</p> <ul style="list-style-type: none"> -The resident was only able to walk for very short distances without mechanical support such as cane or walker. -The resident clearly showed signs of dementia during conversation. -The resident wore adult undergarments and must be told exactly what to do when it came to relieving himself, feeding himself, when to bathe and other daily actions. -The resident still retained a desire to wander off without supervision and an alarm system had been installed at the facility. <p>Interview with Resident #3 on 04/27/16 at 10:40 a.m. revealed:</p> <ul style="list-style-type: none"> -The resident seemed confused when responding to questions. -The resident stated he lived next door when asked where his room was in the facility. <p>Observation of Resident #3 on 04/27/16 revealed:</p> <ul style="list-style-type: none"> -At 12:54 p.m., staff assisted Resident #3 stand up from the recliner, staff held his arm and led him into the dining room for lunch. The resident's gait was unsteady. 	C 007		

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C 007	<p>Continued From page 8</p> <p>-At 1:04 p.m., staff assisted Resident #3 from the dining room chair, staff held his arm and led him to the bathroom in the hallway, and staff stayed in the bathroom to help toilet the resident.</p> <p>Interview with the Administrator on 04/27/16 at 3:15 p.m. revealed: -She thought Resident #3 would know where to go if there was a fire. -She thought Resident #3 could make it to the mail box outside where they were supposed to meet in case of a fire. -She thought Resident #3 could evacuate without physical assistance.</p> <p>Interview with Resident #3 on 04/28/16 at 12:36 p.m. revealed: -When asked what he would do if there was a fire, the resident mumbled. -It sounded like he said "I don't know". -When asked about fire drills, the resident mumbled again but it was not clear what he was trying to say. -The resident stared into space during the interview and did not make eye contact with the surveyor.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 12:45 p.m. revealed: -If Resident #3 was in his room by himself, he would probably not respond to a fire alarm. -When they did fire drills, Resident #3 would follow the group. -Resident #3 had always been that way, needing to follow the group to evacuate.</p> <p>Attempts to contact Resident #3's physician were unsuccessful.</p> <p>4. Review of Resident #4's most current FL-2</p>	C 007		

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C 007	<p>Continued From page 9</p> <p>dated 10/12/15 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included mental retardation, generalized anxiety disorder, gastroesophageal reflux disease, and anemia. -The resident was intermittently disoriented and had sight limitations. -The resident was ambulatory but required total care. -The resident was incontinent of bowel and bladder. -The resident was documented as being a "wanderer". <p>Review of the previous FL-2 dated 10/16/14 revealed Resident #4 was also noted to be intermittently disoriented, ambulatory, total care, and a "wanderer" at that time.</p> <p>Review of the Resident Register revealed Resident #4 was admitted to the facility on 10/25/11.</p> <p>Review of Resident #4's current assessment and care plan dated 10/12/15 revealed:</p> <ul style="list-style-type: none"> -The resident had a history of severe mental retardation. -He was noted to be ambulatory alone but must be directed. -The resident was easily directed by staff verbally. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident was incontinent of bowel and bladder. -The resident's vision was limited. -The resident was totally dependent with bathing and grooming. -The resident required extensive assistance for toileting. -The resident required limited assistance for eating, ambulation, and dressing. 	C 007		

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C 007	<p>Continued From page 10</p> <p>-The resident was independent with transferring.</p> <p>Review of Resident #4's personal care log for April 2016 revealed Resident #4 must be verbally guided and directed for ambulation.</p> <p>Interview with Resident #4 on 04/28/16 at 12:38 p.m. revealed:</p> <ul style="list-style-type: none"> -If there was a fire drill, he would go outside. -The resident pointed to the back door. -He would follow and go out with everybody else. <p>Observation of Resident #4 on 04/27/16 revealed:</p> <ul style="list-style-type: none"> -At 12:56 p.m., staff assisted Resident #4 stand up from the recliner, one staff held his shirt in the chest area while leading the resident to a table for lunch, and another staff walked behind the resident. -The resident leaned forward and walked in a fast, shuffling, unsteady gait. <p>Interview with the Administrator on 04/27/16 at 3:15 p.m. revealed:</p> <ul style="list-style-type: none"> -If Resident #4 was in his room by himself, he would not know what to do if there was a fire or fire drill. -Resident #4 would follow the flow of everyone else in the facility. <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 12:45 p.m. revealed:</p> <ul style="list-style-type: none"> -If Resident #4 was in his room by himself, he would probably not respond to a fire alarm. -When they did fire drills, Resident #4 would follow the group. -Resident #4 had always been that way, needing to follow the group to evacuate. <p>Attempts to contact Resident #4's physician were unsuccessful.</p>	C 007		

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C 007	Continued From page 11 Review of the facility's plan of protection dated 04/27/16 revealed: -Battery operated smoke detectors would be placed in all residents' rooms. -The facility would implement 30 minute fire watch for all bedrooms, kitchen, laundry room, and hot water heater room 24 hours a day, 7 days a week. -The 30 minute fire watches will be documented on a log. -Two staff members will be on duty at the facility 24 hours a day, 7 days a week. -Once the Division of Health Service Regulation (DHSR) Construction Section comes to the facility next week, the facility will implement any systems recommended by the DHSR Construction Section. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 12, 2016.	C 007		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls and floors were in good	C 074		

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C 074	<p>Continued From page 12</p> <p>repair in 2 of 2 resident bathrooms, 4 of 4 resident bedrooms, the living room, the kitchen, and the hallway. The findings are:</p> <p>1. Observation of the hallway on 04/27/16 at 9:55 a.m. revealed:</p> <ul style="list-style-type: none"> -There was a piece of linoleum cracked and peeling up away from the floor about 4 inches long that had been covered with a piece of black duct tape that was on the left side of the hall just before the bathroom doorway. -There was a piece of linoleum cracked and peeling up away from the floor about 10 inches long in front of the hall closet door just beside Bedroom #3. -One end of the cracked linoleum had a piece of black duct tape that was about 3 inches long. -There was a piece of linoleum cracked and peeling up away from the floor 12 inches long at the far right end of the hallway, near the doorway of Bedroom #2. -There was clear tape covering the torn linoleum in front of Bedroom #2. <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>2. Observation of the residents' common bathroom on 04/27/16 at 9:59 a.m. revealed:</p> <ul style="list-style-type: none"> -The floor around the bottom of the toilet had brown, rusty stains all around the base of the toilet. -The linoleum flooring was peeling up and pulling away from the bottom edge of the tub. -There was a ripple in the linoleum flooring near the left bottom edge of the tub. -The wall paper beside the tub was peeling up away from the baseboard. -The wall paper around the metal hand rail on the wall beside the toilet was peeling up and sticking 	C 074		

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C 074	<p>Continued From page 13</p> <p>out.</p> <ul style="list-style-type: none"> -The large blue strip of wall paper on the wall beside the toilet was peeling away from the wall at the top and bottom edges of the blue strip. -The caulking holding the sink vanity to the wall was cracked and pulling away from the wall. -The wall paper beside the sink and near the door was peeling up away from the baseboard. <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>3. Observation of Resident #2's room (Bedroom #1) on 04/27/16 at 10:06 a.m. revealed:</p> <ul style="list-style-type: none"> -There was a crack in the door casing that went from the floor and up about 2 feet. -The wall on the left side of the room had an area about 3 feet long and 1 foot wide that was dented in and appeared to have been patched. -The linoleum was pulling away from the floor at the doorway and behind the door. <p>Observation of the bathroom in Resident #2's room (Bedroom #1) on 04/27/16 at 10:20 a.m. revealed:</p> <ul style="list-style-type: none"> -The wall paper beside the toilet and the shower was peeling away about 2 inches from the walls at the top and bottom edges. -The linoleum was peeling up away from the floor beside the wall near the toilet. -There was about a half inch gap in the linoleum floor on the right side of the sink cabinet. -There was 3 areas of linoleum floor near the doorway of the bathroom that had been patched causing the floor to be uneven. <p>Interview with Resident #2 on 04/27/16 at 10:06 a.m. revealed her room had been in this condition since she was admitted several months ago.</p>	C 074		

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C 074	<p>Continued From page 14</p> <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>4. Observation of Resident #5's room (Bedroom #2) on 04/27/16 10:27 a.m. revealed:</p> <ul style="list-style-type: none"> -There was an area on the left side of the wall behind the table lamp that was about 6 inches in diameter and appeared to have been patched. -There were cracks in the plaster around the edges of the patched area on the wall. -There was a hole about 2 inches long in the wall behind the door that appeared to be from the door knob hitting the wall. -There was an area small rips with jagged edges in the linoleum in front of the dresser. -There was a piece of torn linoleum about 3 inches in diameter sticking up near the trashcan. -There was an area of ripped linoleum about 18 inches long beside the floor vent. -There were multiple nails in the floor holding down the torn linoleum near the floor vent. -The nails were flush with the floor. -There were multiple scratch marks and tears in the linoleum floor between the bed and the bedside table. <p>Interview with Resident #5 on 04/27/16 at 10:27 a.m. revealed:</p> <ul style="list-style-type: none"> -She had moved into this room about a year ago. -The room had been in this condition since she moved to this room. <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>5. Observation of Resident #1's room (Bedroom #3) on 04/27/16 at 10:30 a.m. revealed:</p> <ul style="list-style-type: none"> -There was an area on the left side of the wall beside the closet door that was about 6 inches in diameter and appeared to have been patched. 	C 074		

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C 074	<p>Continued From page 15</p> <ul style="list-style-type: none"> -There were cracks in the plaster around the edges of the patched area on the wall. -There were two different colors of linoleum floor and there was a seam in the middle of the floor where they met. -There was a ripped area near the seam about 6 inches long with the subflooring exposed. -There was a large ripple about 2 feet long in the linoleum floor covering near the end of the bed. <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>6. Observation of the living room on 04/27/16 at 10:40 a.m. revealed:</p> <ul style="list-style-type: none"> -There was an area of cracked and peeling linoleum floor about 2 feet long near the furniture. -The was another area of torn linoleum that was peeling up and about 5 inches in diameter with a piece of clear tape on part of the ripped area. <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>7. Observation of Resident #3 and Resident #4's shared room (Bedroom #4) on 04/27/16 at 10:41 a.m. revealed:</p> <ul style="list-style-type: none"> -The wall beside the bed at the window had multiple large black scratch and scuff marks running up and down and side to side on the wall. -There were at least 8 linoleum floor sections used to patch the floor near the end of the bed beside the windows. -The area around the patched flooring was torn with missing floor covering. -The wall plate for an electrical socket on the wall opposite the beds was broken off at the bottom half of the plate. -There was scratch marks and worn off paint around the bottom third of the walls around the 	C 074		

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C 074	<p>Continued From page 16</p> <p>room.</p> <ul style="list-style-type: none"> -There was a large area about 2 feet x 1 foot in the closet that was taped with black duct tape. -There was a strip of black duct tape about 5 feet long taped across the baseboard. <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>8. Observation of the kitchen on 04/27/16 at 10:50 a.m. revealed:</p> <ul style="list-style-type: none"> -There was 2 areas of linoleum flooring patched in front of the refrigerator. -There was cracks around and in between the two patched areas. <p>Refer to interview with the Administrator on 04/27/16 at 10:35 a.m.</p> <p>_____</p> <p>Interview with the Administrator on 04/27/16 at 10:35 a.m. revealed:</p> <ul style="list-style-type: none"> -The do not have a maintenance staff person on duty at the facility. -She had an outside maintenance person who would come to the facility when she needed him to come for repairs. -It had been in this condition for "a while". -It had "been a while" since the maintenance person had been to the facility. -She was going to have him come around the first of May 2016 to repair the floors and walls. 	C 074		
C 155	<p>10A NCAC 13G .0501 (c) Personal Care Training And Competency</p> <p>10A NCAC 13G .0501 Personal Care Training And Competency</p>	C 155		

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C 155	<p>Continued From page 17</p> <p>(c) The facility shall assure that training specified in Paragraphs (a) and (b) of this Rule is successfully completed six months after hiring for staff hired after July 1, 2000. Staff hired prior to July 1, 2000, shall have completed at least a 20-hour training program for the performance or supervision of tasks listed in Paragraph (i) of this Rule or a 75-hour training program for the performance or supervision of tasks listed in Paragraph (j) of this Rule. The 20 and 75-hour training shall meet all the requirements of this Rule except for the interpersonal skills and behavioral interventions listed in Paragraph (j) of this Rule, within six months after hiring.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 1 of 2 staff (Staff B) employed by the facility prior to July 1, 2000 completed a 20 hour or 75 hour personal care training and competency program for performing personal care tasks including tasks for heavy care residents. The findings are:</p> <p>Review of Staff B's (Supervisor-in-Charge) personnel file revealed: -There was no hire date specified but the date of Staff B's employment application was 07/01/90. -There was no documentation that Staff B had been a nurse aide. -There was no documentation of Staff B completing a 20 hour or 75 hour personal care training course approved by the Department. -There was a certificate for "Training in Clinical Skills Review" by a "nurse competency agency" completed by Staff B on 07/19/07.</p> <p>Review of the Clinical Skills Review certificate</p>	C 155		

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C 155	<p>Continued From page 18</p> <p>revealed:</p> <ul style="list-style-type: none"> -Training in principles for the nursing assistant were listed. -Tasks listed included: transfer techniques, ambulation, measuring height and weight, intake and output, bed making, bed bath, perineal care, infection control, vital signs, proper positioning, range of motion, lifting, personal care skills, nutritional care, elimination care, communication, and documentation. -The certificate was signed by a registered nurse. -The certificate did not indicate how many credit hours were issued. -There was no documentation on the certificate that the training had been approved by the Department. <p>Interview with Staff B on 04/28/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> -She had never been a certified nursing assistant. -The only personal care training she had completed was the Clinical Skills Review course noted on the certificate in her personnel file. -She thought the course she took was about a 40 hour course but she could not recall for sure. -The registered nurse who taught the course was no longer in business. -She did not know if the course she took had been approved by the Department. -They had heavy care residents at the facility and she helped provide personal care to 4 of the 5 residents who required assistance. -Personal care tasks that she currently provided to residents included: transferring, assistance with ambulation, feeding assistance, feeding and giving medications through gastrostomy tube, emptying urinary catheter, bathing, dressing, grooming, toileting, taking vital signs and weights, turning and positioning, and care of a resident with a pressure ulcer. 	C 155		

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C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination</p> <p>(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 residents (#2) sampled was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:</p> <p>Review of Resident #2's most current FL-2 dated 08/07/15 revealed diagnoses included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, rheumatoid arthritis, hypertension, and hypothyroidism.</p> <p>Review of the Resident Register revealed Resident #2 was admitted to the facility on 08/01/15.</p> <p>Review of Resident #2's record revealed there was no documentation of any TB skin test.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/27/16 at 2:45 p.m. revealed: -She was responsible for making sure all</p>	C 202		

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C 202	<p>Continued From page 20</p> <p>residents had TB skin testing upon admission.</p> <ul style="list-style-type: none"> -Resident #2 was living at home prior to coming to the facility. -When Resident #2 was admitted to the facility, she was supposed to have a TB skin test. -She thought the physician was going to do the TB skin testing. -She failed to follow-up to make sure the TB skin testing was done for Resident #2. -Resident #2 was in the hospital prior to coming to the facility so she would check with the hospital to see if they had any TB skin tests on file. <p>Review of a TB test form for Resident #2 provided by the facility on 04/28/16 revealed:</p> <ul style="list-style-type: none"> -There was one TB skin test placed on 05/12/15 and read as negative on 05/14/15. -There was no documentation of any other TB skin test. 	C 202		
C 254	<p>10A NCAC 13G .0903(c) Licensed Health Professional Support</p> <p>10A NCAC 13G .0903 Licensed Health Professional Support</p> <p>(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:</p> <p>(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;</p>	C 254		

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C 254	<p>Continued From page 21</p> <p>(2) evaluating the resident's progress to care being provided;</p> <p>(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and</p> <p>(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure a registered nurse completed an on-site Licensed Health Professional Support (LHPS) review and physical assessment evaluation on a quarterly basis for 2 of 2 residents (#1, #2) sampled with required LHPS tasks of ambulation with assistance, urinary catheter, transfers, gastrostomy tube, oxygen, nebulizer, pressure ulcer, and dressing changes for Resident #1 and tasks of nebulizer and oxygen for Resident #2. The findings are:</p> <p>1. Review of Resident #1's most current FL-2 dated 11/24/15 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included protein calorie malnutrition, peripheral vascular disease, osteomyelitis right first toe, gangrene, and polyclonal gammopathy. -The resident was constantly disoriented and non-verbal. -The resident was non-ambulatory and required total care. -The resident was incontinent of bowel and bladder. -The resident had a stage 3 sacral decubitus. -The resident had a gastrostomy tube. -There was an order for oxygen at 2 liters per minute as needed for shortness of breath. -There was an order for Duoneb 1 vial via nebulizer every 6 hours as needed for shortness 	C 254		

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C 254	<p>Continued From page 22</p> <p>of breath.</p> <p>Review of the previous FL-2 dated 06/25/15 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included chronic foley catheter with urethral stricture, urinary tract infection, debility contracture, sacral decubitus, mental retardation, anemia, and chronic recurrent blepharitis. -The resident had an indwelling catheter. -The resident had a sacral decubitus. -The resident had a gastrostomy tube. -The resident had an order for oxygen at 2 liters per minute as needed for shortness of breath. <p>Review of the Resident Register revealed Resident #1 was admitted to the facility on 10/03/05 and he required total care.</p> <p>Review of Resident #1's current assessment and care plan dated 06/17/15 revealed:</p> <ul style="list-style-type: none"> -The resident had limited ability with ambulation due to flexion contracture. -The resident's upper extremities had contractures. -The resident had a gastrostomy tube. -The resident was oriented but was forgetful and needed reminders. -The resident was totally dependent for all activities of daily living including eating, toileting, ambulation, bathing, dressing, grooming, and transferring. <p>Review of the most current Licensed Health Professional Support (LHPS) review dated 09/23/15 revealed:</p> <ul style="list-style-type: none"> -The resident's LHPS tasks were catheter, transferring, pressure ulcer, gastrostomy tube, clean dressing changes, nebulizer and oxygen. -The LHPS review was completed by a Licensed 	C 254		

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C 254	<p>Continued From page 23</p> <p>Practical Nurse (LPN) instead of a registered nurse (RN) as required.</p> <ul style="list-style-type: none"> -The LPN noted the resident's wound was healing well and there was no signs and symptoms of infection. -The gastrostomy site was clean and functioning well. -The foley catheter was in place and flowing without difficulty. -The LPN noted no changes were needed in the resident's care. -The LPN did not address the resident's nebulizer treatment, oxygen, or transfers in the assessment. <p>Review of Resident #2's record revealed no other LHPS reviews for this resident.</p> <p>Observation of Resident #1 on 04/27/16 at 10:30 a.m. revealed:</p> <ul style="list-style-type: none"> -The resident was lying in a hospital bed with both arms and legs contracted. -The resident was lying with his face toward the wall. -The resident would not reply when spoken to. <p>Interview with the Supervisor-in-Charge (SIC) on 04/27/16 at 9:30 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 was total care and had been bedbound for about a year due to a wound and contractures of his arms and legs. -They fed him and gave his medications through the gastrostomy tube. -He had not needed to use the oxygen or nebulizers to her knowledge. -The home health nurse (HHN) came about twice a week to take care of the pressure wound, which was healing. -They emptied the catheter bag but the HHN nurse changed it during her visits. 	C 254		

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C 254	<p>Continued From page 24</p> <p>Review of a skilled nursing visit note by the HHN dated 04/22/16 revealed: -The HHN noted the wound was healing and there was no signs or symptoms of infection. -The catheter was changed and the resident tolerated it well.</p> <p>Attempts to contact the HHN by the end of the survey were unsuccessful.</p> <p>Refer to interview with the SIC on 04/27/16 at 2:45 p.m.</p> <p>Refer to interview with a RN with the contracted pharmacy provider on 04/28/16 at 8:06 a.m.</p> <p>Refer to interview with the LHPS RN on 04/28/16 at 9:16 a.m.</p> <p>Refer to interview with the SIC on 04/28/16 at 12:40 p.m.</p> <p>2. Review of Resident #2's most current FL-2 dated 08/07/15 revealed: -The resident's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, rheumatoid arthritis, hypertension, and hypothyroidism. -The resident was ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bladder but continent of bowel. -The resident had an order for oxygen at 3.5 liters per minute continuous.</p> <p>Review of the Resident Register revealed Resident #2 was admitted to the facility on 08/01/15 and she required assistance with bathing.</p>	C 254		

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C 254	<p>Continued From page 25</p> <p>Review of Resident #2's current assessment and care plan dated 08/09/15 revealed:</p> <ul style="list-style-type: none"> -The resident had no problems with ambulation or upper extremities. -The resident was on oxygen and had shortness of breath periodically. -The resident was continent of bowel and bladder. -The resident was oriented and had adequate memory. -The resident required limited assistance with bathing and did not require assistance with any other activities of daily living. <p>Review of physician's orders for Resident #2 revealed:</p> <ul style="list-style-type: none"> -There was an order dated 12/02/15 for Budesonide 0.25mg/2ml, use 1 vial via nebulizer twice daily. (Budesonide is used to treat breathing problems.) -There was an order dated 03/03/16 for Budesonide 0.25mg/2ml, use 1 vial via nebulizer 3 times daily. <p>Review of the most current Licensed Health Professional Support (LHPS) dated 08/23/15 revealed:</p> <ul style="list-style-type: none"> -The resident's LHPS tasks were nebulizer and oxygen. -The registered nurse (RN) noted the resident was progressing well at the facility and was eating regular meals and taking medications as prescribed. -The RN noted the resident had much better color to skin and the resident's overall demeanor was better. -The RN did not address the resident's nebulizer treatment or oxygen in the assessment. -The RN made no recommendations and noted 	C 254		

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C 254	<p>Continued From page 26</p> <p>there should be no change in the resident's plan of care.</p> <p>Review of Resident #2's record revealed no other LHPS reviews for this resident.</p> <p>Observation of Resident #2 on 04/27/16 at 10:06 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #2 was in her room sitting in a wheelchair. -The resident was wearing oxygen via nasal cannula. -The resident's oxygen concentrator was set at 4 liters per minute. -The resident had a nebulizer machine and a bedside toilet. <p>Interview with Resident #2 on 04/27/16 at 10:06 a.m. revealed:</p> <ul style="list-style-type: none"> -She could walk a little bit holding onto something. -She could transfer herself to and from the wheelchair. -She could self-propel the wheelchair. -She thought she was supposed to be on 2.5 liters of oxygen but she was not sure. -The oxygen concentrator was set and she did not mess with it. -She did not know what the oxygen was currently set on. <p>Interview with the Supervisor-in-Charge (SIC) on 04/27/16 at 2:45 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #2 could bear weight and walk. -Resident #2 just walked in her room because she would get short of breath. -The resident did not usually come out of her room. -She had portable oxygen tanks if she wanted to come out. 	C 254		

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C 254	<p>Continued From page 27</p> <ul style="list-style-type: none"> -The resident ate meals in her room and she did not like to come out of her room. -Resident #2 needed supervision with bathing and dressing. -The resident's oxygen was supposed to be on 3.5 liters per minute but the resident adjusted it at times. -The resident used the nebulizer 3 times a day. <p>Interview with Resident #2 on 04/28/16 at 11:54 a.m. revealed:</p> <ul style="list-style-type: none"> -She used the nebulizer to help with her breathing. -She denied any current symptoms of shortness of breath. <p>Observation of Resident #2 on 04/28/16 at 12:35 p.m. revealed she was wearing oxygen via nasal cannula and the oxygen concentrator was set on 3.5 liters per minute.</p> <p>Interview with a nurse from the primary physician's office on 04/28/16 at 10:35 a.m. revealed:</p> <ul style="list-style-type: none"> -The primary physician was unavailable for interview. -She was familiar with Resident #2 from her office visits. -Resident #2's family member usually pushed her in the wheelchair. -She had not observed Resident #2 self-propelling the wheelchair. -Resident #2 would need a walker to prevent her from falling to ambulate independently. -Resident #2 would require physical assistance to evacuate in case of a fire due to weakness and shortness of breath, especially if she had no walker. <p>Refer to interview with the SIC on 04/27/16 at</p>	C 254		

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C 254	<p>Continued From page 28</p> <p>2:45 p.m.</p> <p>Refer to interview with a RN with the contracted pharmacy provider on 04/28/16 at 8:06 a.m.</p> <p>Refer to interview with the LHPS RN on 04/28/16 at 9:16 a.m.</p> <p>Refer to interview with the SIC on 04/28/16 at 12:40 p.m.</p> <hr/> <p>Interview with the SIC on 04/27/16 at 2:45 p.m. revealed: -She realized last Thursday when a nurse from the contracted pharmacy came to the facility that the LHPS reviews were overdue. -A nurse came from the pharmacy about every 6 months to make sure everything was getting done. -The LHPS nurse from the contracted pharmacy always came on their own when the LHPS reviews were due. -The contracted pharmacy started charging for the LHPS reviews to be done a while back (could not say when) and she started getting some other nurses to do the LHPS reviews. -She did not realize an LPN could not do the reviews. -She planned to call the LHPS RN from the contracted pharmacy to start back doing the reviews.</p> <p>Interview with a RN with the contracted pharmacy provider on 04/28/16 at 8:06 a.m. revealed: -She used to do LHPS reviews at the facility but she had been moved to another position with the company. -The last time she did LHPS reviews at the facility was about 2 years ago.</p>	C 254		

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C 254	<p>Continued From page 29</p> <ul style="list-style-type: none"> -Their company did not employ Licensed Practical Nurses (LPNs) so if an LPN did the LHPS reviews; it was not someone from their company. -She currently went to facilities as a point of contact and checked for compliance like making sure fax machines worked, medication were being delivered on time, and helped with any concerns of the facility. -The RN was in the facility last week for a compliance visit and they noticed the LHPS reviews were late. -The RN told the facility staff to set up an appointment with the LHPS RN to come and do the LHPS reviews. -The RN did not know if the facility had scheduled an appointment with the current LHPS RN. <p>Interview with the LHPS RN on 04/28/16 at 9:16 a.m. revealed:</p> <ul style="list-style-type: none"> -She had not done any LHPS reviews at this facility yet. -She tried to contact the facility last year but was unable to reach anyone. -She had not heard from the facility. -The facility was supposed to call her or the contracted pharmacy to let them know if medication reviews was a service the facility wanted them to provide. <p>Interview with the SIC on 04/28/16 at 12:40 p.m. revealed:</p> <ul style="list-style-type: none"> -She spoke with the LHPS RN on the phone today and the earliest she could come to the facility was Monday, 05/02/16. -The RN would do the LHPS reviews on Monday, 05/02/16. 	C 254		

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C 286	Continued From page 30	C 286		
C 286	<p>10A NCAC 13G .0904(f)(2) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition And Food Service (f) Individual Feeding Assistance in Family Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide feeding assistance in a respectful and dignified manner for 2 of 2 residents (#3, #4) observed who required feeding assistance. The findings are:</p> <p>1. Review of Resident #4's most current FL-2 dated 10/12/15 revealed: -The resident's diagnoses included mental retardation, generalized anxiety disorder, gastroesophageal reflux disease, and anemia. -The resident was intermittently disoriented and sight limitations. -The resident was ambulatory but required total care with bathing, dressing, and feeding. -The resident was documented as being a "wanderer". -The resident had an order for a regular diet.</p> <p>Review of the Resident Register revealed Resident #4 was admitted to the facility on 10/25/11.</p> <p>Review of Resident #4's current assessment and care plan dated 10/12/15 revealed: -The resident had a history of severe mental retardation.</p>	C 286		

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C 286	<p>Continued From page 31</p> <ul style="list-style-type: none"> -He was noted to be ambulatory alone but must be directed. -The resident was easily directed by staff verbally. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident's vision was limited. -The resident required limited assistance for eating. <p>Observation of the lunch meal on 04/27/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #4 was seated at a bedside table in the living room. -The Administrator began feeding the lunch meal to the resident at 1:00 p.m. -The Administrator stood up and in front of the resident the entire time she fed him the lunch meal. -The Administrator would lean on the table at times by bending her back and resting her forearms and elbows on the table. -She would walk back and forth to the kitchen or dining room at times leaving the resident alone in the living room. -She finished feeding the resident at 1:12 p.m. <p>Interview with the Administrator on 04/27/16 at 3:05 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #4 always required feeding assistance. -Resident #4 had limited vision in his left eye. -She was aware that staff was supposed to sit at eye level when feeding residents. -She did not know why she stood up today to feed Resident #4. <p>2. Review of Resident #3's most current FL-2 dated 10/08/15 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included dementia, hypotension, and gastroesophageal reflux disease. 	C 286		

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C 286	<p>Continued From page 32</p> <ul style="list-style-type: none"> -The resident was intermittently disoriented and was noted to be "a wanderer". -The resident was ambulatory and required assistance with bathing and dressing. -There was an order for a regular diet. <p>Review of the Resident Register revealed Resident #3 was admitted to the facility on 10/05/11.</p> <p>Review of Resident #3's current assessment and care plan dated 10/08/15 revealed:</p> <ul style="list-style-type: none"> -The resident had no problems with ambulation or upper extremities. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident's speech was slurred. -The resident was independent with eating. <p>Observation of the lunch meal on 04/27/16 at 12:58 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #3 was seated at the dining room table. -The resident was trying to eat jello with a fork. -The Supervisor-in-Charge (SIC) came over to help the resident. -The SIC fed the jello to the resident with a spoon while standing up. -The SIC did not sit down and get at eye level with the resident. <p>Interview with the SIC on 04/27/16 at 3:05 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #3 sometimes needed assistance with feeding especially foods like jello. -She was aware that staff was supposed to sit at eye level when feeding residents. -She did not know why she stood up today to feed Resident #3. 	C 286		

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C 342	Continued From page 33	C 342		
C 342	<p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ul style="list-style-type: none"> (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (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>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure the medication administration records were accurate and complete for 2 of 3 residents (#2, #3) sampled including medications for high cholesterol and shortness of breath (#2) and a medication for depression (#3). The findings are:</p> <ul style="list-style-type: none"> 1. Review of Resident #2's current FL-2 dated 08/07/15 revealed the resident's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, rheumatoid arthritis, hypertension, and 	C 342		

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C 342	<p>Continued From page 34</p> <p>hypothyroidism.</p> <p>A. Review of Resident #2's current FL-2 dated 08/07/15 revealed there was an order for Zocor 20mg once daily at bedtime. (Zocor lowers cholesterol.)</p> <p>Review of the January 2016 - April 2016 medication administration records (MARs) revealed: -The order for Zocor was not transcribed on either of the MARs. -There was no documentation of any Zocor being administered from 01/01/16 - 04/27/16.</p> <p>Observation of medications on hand on 04/27/16 revealed: -There was one supply of Zocor 20mg tablets dispensed on 03/12/16. -There was 57 of 90 Zocor 20mg tablets remaining in the vial.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 5:00 p.m. revealed: -Zocor 20mg was administered to Resident #2 daily. -She must have forgotten to transcribe the order on the MARs.</p> <p>Interview with the nurse at the primary physician's office on 04/28/16 at 10:35 a.m. revealed: -The resident had an order for Zocor 20mg daily. -The resident's total cholesterol level was 263 in December 2015. -The resident's total cholesterol level was 243 on 03/23/16.</p> <p>B. Review of Resident #2's current FL-2 dated 08/07/15 revealed an order for Isordil 30mg daily. (Isordil is for heart/blood pressure.)</p>	C 342		

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C 342	<p>Continued From page 35</p> <p>Review of a physician's order dated 12/02/15 revealed an order for Isordil 10mg once daily.</p> <p>Review of the January 2016 - April 2016 medication administration records (MARs) revealed: -There was an entry for Isordil 30mg daily and it was scheduled to be administered at 7:00 a.m. -Isordil 30mg was documented as administered daily from 01/01/16 - 04/27/16.</p> <p>Observation of medications on hand on 04/27/16 revealed: -There was one supply of Isordil 10mg tablets dispensed on 04/06/16. -There was no Isordil 30mg tablets on hand.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 5:00 p.m. revealed: -She had not noticed the Isordil 30mg strength on the MAR did not match the Isordil 10mg on the medication label. -She had been administering the Isordil 10mg tablets. -She must have forgotten to change the MAR to 10mg when the order changed. -She would correct the MAR now.</p> <p>Interview with the nurse at the primary physician's office on 04/28/16 at 10:35 a.m. revealed Resident #2 was supposed to receive Isordil 10mg instead of 30mg daily.</p> <p>Review of the facility's monthly blood pressure log for Resident #2 revealed her blood pressure ranged from 120/64 - 123/64 from January 2016 - April 2016.</p> <p>C. Review of a physician's order dated 03/03/16</p>	C 342		

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C 342	<p>Continued From page 36</p> <p>for Resident #2 revealed an order for Albuterol HFA inhaler, 2 puffs as needed for shortness of breath. (Albuterol is used to treat breathing problems.)</p> <p>Review of the March 2016 and April 2016 medication administration records (MARs) revealed: -The order for Albuterol HFA inhaler was not transcribed on either of the MARs. -There was no documentation of any Albuterol being administered from 03/01/16 - 04/27/16.</p> <p>Observation of medications on hand on 04/27/16 revealed: -There was one Albuterol HFA inhaler dispensed on 01/26/16. -The inhaler was new and had not been opened.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 5:00 p.m. revealed: -She had not noticed the prn (as needed) order for Albuterol inhaler was not on the MARs. -She must have forgotten to transcribe the order onto the MARs. -The Albuterol inhaler was available for use but the resident had not requested to use the inhaler.</p> <p>Interview with Resident #2 on 04/28/16 at 11:54 a.m. revealed: -She did not know she had an Albuterol inhaler available for use as needed. -She denied any current shortness of breath. -She did not think she needed the inhaler because she used a nebulizer instead.</p> <p>2. Review of Resident #3's most current FL-2 dated 10/08/15 revealed: -The resident's diagnoses included dementia, hypotension, and gastroesophageal reflux</p>	C 342		

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C 342	<p>Continued From page 37</p> <p>disease.</p> <p>-There was an order for Celexa 20mg take ½ tablets once daily. (Celexa is an antidepressant.)</p> <p>Review of a physician's order dated 11/03/15 revealed an order to increase Celexa to 20mg take 1 tablet daily for depression.</p> <p>Review of the March 2016 and the April 2016 medication administration records (MARs) revealed:</p> <p>-The entry for Celexa was for 20mg take ½ tablet daily.</p> <p>-Celexa 20mg ½ tablet was documented as administered daily at 7:00 a.m. from 03/01/16 - 04/27/16.</p> <p>Observation of medications on hand on 04/27/16 revealed one supply of Celexa 40mg tablets with instructions to give ½ tablet daily.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/27/16 at 5:00 p.m. revealed:</p> <p>-She had administered ½ tablet of the 40mg tablets daily for a total of 20mg.</p> <p>-She had not noticed the MAR did not match the label on hand.</p> <p>-She should have transcribed the new order for 20mg daily on the MAR.</p>	C 342		
C 375	<p>10A NCAC 13G .1009(a)(1) Pharmaceutical Care</p> <p>10A NCAC 13G .1009 Pharmaceutical Care</p> <p>(a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of</p>	C 375		

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C 375	<p>Continued From page 38</p> <p>significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record;</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have medication reviews completed at least quarterly for 3 of 3 residents (#1, #2, #3) sampled including 2 residents who were identified to have inaccurate medication administration records (#2, #3). The findings are:</p> <p>1. Review of Resident #2's most current FL-2 dated 08/07/15 revealed the resident's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease,</p>	C 375		

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C 375	<p>Continued From page 39</p> <p>rheumatoid arthritis, hypertension, and hypothyroidism.</p> <p>Review of Resident #2's medication review form on 04/27/16 revealed: -The most recent medication review was completed by the pharmacist on 12/21/15 with no recommendations. -No quarterly medication review had been done since 12/21/15 in order to identify medication related problems.</p> <p>Observation, interview and record review revealed medication related problems with 3 of Resident #2's medications.</p> <p>Review of Resident #2's current FL-2 dated 08/07/15 revealed: -There was an order for Zocor 20mg once daily at bedtime. (Zocor lowers cholesterol.) -There was an order for Isordil 30mg daily. (Isordil is for heart/blood pressure.)</p> <p>Review of a physician's order dated 12/02/15 revealed an order for Isordil 10mg once daily.</p> <p>Review of a physician's order dated 03/03/16 for Resident #2 revealed an order for Albuterol HFA inhaler, 2 puffs as needed for shortness of breath. (Albuterol is used to treat breathing problems.)</p> <p>Review of the January 2016 - April 2016 medication administration records (MARs) revealed: -The order for Zocor was not transcribed on either of the MARs and none was documented as administered. -There was an entry for Isordil 30mg daily and it was documented as administered daily from</p>	C 375		

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C 375	<p>Continued From page 40</p> <p>01/01/16 - 04/27/16.</p> <p>-The order for Albuterol HFA inhaler was not transcribed on either of the MARs and none was documented as administered.</p> <p>Observation of medications on hand on 04/27/16 revealed:</p> <p>-There was one supply of Zocor 20mg tablets dispensed on 03/12/16.</p> <p>-There was one supply of Isordil 10mg tablets dispensed on 04/06/16.</p> <p>-There was one unopened Albuterol HFA inhaler dispensed on 01/26/16.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 5:00 p.m. revealed the problems with the Zocor, Isordil, and Albuterol were documentation issues but the medications were being administered as ordered.</p> <p>Interview with Resident #2 on 04/28/16 at 11:54 a.m. revealed:</p> <p>-She did not know she had an Albuterol inhaler available for use as needed.</p> <p>-She denied any current shortness of breath.</p> <p>-She did not think she needed the inhaler because she used a nebulizer instead.</p> <p>Refer to interview with the SIC on 04/27/16 at 9:20 a.m. and 3:05 p.m.</p> <p>Refer to interview with the Consultant Pharmacist (CP) on 04/28/16 at 10:05 a.m.</p> <p>2. Review of Resident #3's most current FL-2 dated 10/08/15 revealed the resident's diagnoses included dementia, hypotension, and gastroesophageal reflux disease.</p> <p>Review of Resident #2's medication review form</p>	C 375		

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C 375	<p>Continued From page 41</p> <p>on 04/27/16 revealed: -The most recent medication review was completed by the pharmacist on 12/21/15 with no recommendations. -No quarterly medication review had been done since 12/21/15 in order to identify medication related problems.</p> <p>Observation, interview and record review revealed a medication related problem with Resident #2's Celexa.</p> <p>Review of Resident #2's current FL-2 dated 10/08/15 revealed there was an order for Celexa 20mg take ½ tablets once daily. (Celexa is an antidepressant.)</p> <p>Review of a physician's order dated 11/03/15 revealed an order to increase Celexa to 20mg take 1 tablet daily for depression.</p> <p>Review of the March 2016 and the April 2016 medication administration records (MARs) revealed: -The entry for Celexa was for 20mg take ½ tablet daily. -Celexa 20mg ½ tablet was documented as administered daily at 7:00 a.m. from 03/01/16 - 04/27/16.</p> <p>Observation of medications on hand on 04/27/16 revealed one supply of Celexa 40mg tablets with instructions to give ½ tablet daily.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/27/16 at 5:00 p.m. revealed: -She had administered ½ tablet of the 40mg tablets daily for a total of 20mg. -She had not noticed the MAR did not match the label on hand.</p>	C 375		

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C 375	<p>Continued From page 42</p> <p>-She should have transcribed the new order for 20mg daily on the MAR.</p> <p>Refer to interview with the SIC on 04/27/16 at 9:20 a.m. and 3:05 p.m.</p> <p>Refer to interview with the Consultant Pharmacist (CP) on 04/28/16 at 10:05 a.m.</p> <p>3. Review of Resident #1's most current FL-2 dated 11/24/15 revealed: -The resident's diagnoses included protein calorie malnutrition, peripheral vascular disease, osteomyelitis right first toe, gangrene, and polyclonal gammopathy. -Resident #1 had orders for at least 12 different medications listed on his FL-2. -The resident had a gastrostomy tube.</p> <p>Review of Resident #1's medication review form on 04/27/16 revealed: -The most recent medication review was completed by the pharmacist on 12/21/15 with no recommendations. -No quarterly medication review had been done since 12/21/15 in order to identify medication related problems.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/27/16 at 5:00 p.m. revealed: -She administered Resident #1's medications through his gastrostomy tube. -She crushed the pills and diluted them and the liquid medications with water and administered them through the gastrostomy tube. -The resident tolerated the medications well through the gastrostomy tube.</p> <p>Refer to interview with the SIC on 04/27/16 at 9:20 a.m. and 3:05 p.m.</p>	C 375		

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C 375	<p>Continued From page 43</p> <p>Refer to interview with the Consultant Pharmacist (CP) on 04/28/16 at 10:05 a.m.</p> <hr/> <p>Interviews with the SIC on 04/27/16 at 9:20 a.m. and 3:05 p.m. revealed:</p> <ul style="list-style-type: none"> -The pharmacist from their contracted pharmacy usually did the medication reviews at the facility. -The consultant pharmacist usually came to the facility quarterly to do the medications reviews. -He was late and was due to come back last month. -She usually called the pharmacist if he did not come on time. -She just recently realized the medication reviews were late so she called the pharmacist about two weeks ago. -They set up an appointment for him to do the medication reviews tomorrow on 04/28/16. <p>Interview with the Consultant Pharmacist (CP) on 04/28/16 at 10:05 a.m. revealed:</p> <ul style="list-style-type: none"> -He and the facility usually correspond with each other to set up a time for him to come to the facility to do the medication reviews. -He thought the medication reviews were due in April 2016. -The facility staff contacted him around the first week of April 2016 about the medication reviews. -They set up a time for him to do the medication reviews today on 04/28/16. 	C 375		
C 912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with</p>	C 912		

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C 912	<p>Continued From page 44</p> <p>relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to the capacity of the facility. The findings are:</p> <p>Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation that residents' evacuation capabilities were different from the evacuation capability listed on the home's license for 4 of 5 residents (#1, #2, #3, #4) residing in the facility who had cognitive and/or physical impairments which would prevent the residents from independently evacuating the facility. [Refer to Tag C007 10A NCAC 13G .0206 Capacity (Type B Violation).]</p>	C 912		
C 934	<p>G.S.131D-4.5B (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount</p>	C 934		

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C 934	<p>Continued From page 45</p> <p>determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide mandatory annual infection prevention training for 2 of 2 medication aides (A, B) sampled that had been employed for more than one year. The findings are:</p> <p>1. Review of Staff A's (Administrator) personnel file revealed: -There was no hire date specified but the date of Staff A's employment application was 01/01/94. -She completed the medication aide clinical skills checklist on 02/20/04. -She passed the written medication aide exam on 08/16/00. -The annual state approved infection control training was completed on 07/17/14. -There was no documentation the annual state approved infection control training had been completed since 07/17/14.</p> <p>Interview with Staff A (Administrator) on 04/28/16 at 1:15 p.m. revealed: -She recalled having some infection control training in the past. -She could not recall when or if it was the state approved infection control training.</p> <p>Refer to interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 1:00 p.m.</p>	C 934		

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C 934	<p>Continued From page 46</p> <p>2. Review of Staff B's (Supervisor-in-Charge) personnel file revealed:</p> <ul style="list-style-type: none"> -There was no hire date specified but the date of Staff B's employment application was 07/01/90. -She completed the medication aide clinical skills checklist on 02/20/04. -She passed the written medication aide exam on 08/16/00. -The annual state approved infection control training was completed on 07/17/14. -There was no documentation the annual state approved infection control training had been completed since 07/17/14. <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> -She recalled having the state infection control training in 2014. -She had only completed the state infection control training once. <p>Refer to interview with the SIC on 04/28/16 at 1:00 p.m.</p> <hr/> <p>Interview with the SIC on 04/28/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> -She and the Administrator were the only two employees for the facility. -The SIC usually set up the trainings. -The nurse at their contracted pharmacy had provided the state infection control training in July 2014. -She had not rescheduled to have the state infection control training again because she did not realize it was required annually. -She would contact the nurse to schedule the training for both of them again. 	C 934		