

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL064030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TILLERY'S PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH TILLERY STREET ROCKY MOUNT, NC 27804
--	--

(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 survey on June 9, 2016.	C 000		
C 139	<p>10A NCAC 13G .0404 (2) Qualifications Of Activity Director</p> <p>10A NCAC 13G .0404 Qualifications Of Activity Director</p> <p>There shall be a designated family care home activity director who meets the following qualifications: qualifications set forth in this Rule.</p> <p>(2) The activity director hired on or after July 1, 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity Professional meets this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005.</p> <p>This Rule is not met as evidenced by: Based on review of personnel records and interview, the facility failed to have a designated family care home activity director who had completed the basic activity course within nine months of being assignment to this position.</p>	C 139		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL064030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TILLERY'S PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH TILLERY STREET ROCKY MOUNT, NC 27804
--	--

(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 139	Continued From page 1 The findings are: Review of Staff A's personnel record revealed: -She was hired as an administrator on 5/26/15. -No documentation of a job description for an activity director. -No documentation a basic activity course had been completed. Interview with the administrator on 06/09/16 at 3:30 p.m. revealed: -She was responsible for activities at the facility. -She completed the monthly activity calendars. -She had not had the basic activity course. -She was not aware the activity director had to complete a basic activity course. -She would complete the basic activity course.	C 139		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a prescribing practitioner for 1 (Resident #1) of 3 sampled residents who was administered remeron after it had been discontinued.	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL064030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TILLERY'S PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH TILLERY STREET ROCKY MOUNT, NC 27804
--	--

(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 330	<p>Continued From page 2</p> <p>The findings are:</p> <p>Review of Resident #1's most recent FL-2 dated 2/29/16 revealed: - Diagnoses included schizophrenia, hypertension, osteoporosis and gastroesophageal reflux disease (GERD). -A medication order for remeron 15 mg at hour of sleep. (Remeron is used for sleep). -A medication order for trazodone 150 mg at hour of sleep. (Trazodone is used for sleep).</p> <p>Review of a physician's note dated 4/22/16 for Resident #1 revealed: -Stopped remeron 15 mg 1 tablet before bedtime. -Continue trazodone 150 mg 1 tablet at bedtime. -[Resident #1] was sleeping for long periods of time which may be due to medications. -Remeron was discontinued to prevent over eating.</p> <p>Review of Resident #1's physician note dated 6/09/16 revealed: -Remeron was stopped on 04/22/16. -A discontinued order for remeron was given to the administrator on 4/22/16. -No discontinued order for remeron was sent from the physician's office to the pharmacy on 4/22/16.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for April 22-30, 2016 revealed remeron 15 mg had been discontinued on the MAR record.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for May 2016 revealed: -An entry for remeron 15 mg take 1 tablet by</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL064030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TILLERY'S PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH TILLERY STREET ROCKY MOUNT, NC 27804
--	--

(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 330	<p>Continued From page 3</p> <p>mouth every night at bedtime scheduled for administration at 8:00 p.m. -Documentation of administration nightly at 8:00 p.m.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for June 1-8, 2016 revealed: -An entry for remeron 15 mg take 1 tablet by mouth every night at bedtime scheduled for administration at 8:00 p.m. -Documentation of administration nightly at 8:00 p.m.</p> <p>Observation of Resident #1's medication on 6/09/16 at 10:30 a.m. revealed a package of remeron was on hand and stored with Resident #1's current medications.</p> <p>Interview with the administrator on 6/09/16 at 10:30 a.m. revealed: -Resident #1's remeron had been discontinued. -She had removed remeron from Resident #1's current medication supply. -The medication aide had put the remeron back in Resident #1's current medication supply. -She took remeron out of Resident #1's current medication supply on 6/09/16. -The remeron order on the MAR was discontinued on 6/09/16.</p> <p>Interview with the administrator on 06/09/16 at 2:45 p.m. revealed: -She notified Resident #1's physician on 6/09/16 after it was brought to her attention that remeron 15 mg continued to be given to the resident. -A discontinued order for remeron 15 mg was sent to the pharmacy on 6/09/16. -The physician's office usually fax medication changes to the resident's pharmacy.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL064030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TILLERY'S PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH TILLERY STREET ROCKY MOUNT, NC 27804
--	--

(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