

PRINTED: 05/31/2016  
FORM APPROVED

Division of Health Service Regulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1888 CANAL ROAD PEMBROKE, NC 28372	
(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)
C 000	Initial Comments  The Adult Care Licensure Section and Robeson County Department of Social Services conducted an annual survey on 05/11/16-05/12/16.	C 000	Plan to ensure that before hire of each employee and criminal background will be done before hire. Addendum 6/30/16 10:30 AM Office Manager June 2016 will be responsible for assuring criminal background checks are completed prior to hire. Will complete state-wide check
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications  10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;  This Rule is not met as evidenced by: TYPE B VIOLATION  Based on personnel record reviews and interviews, the facility failed to assure a state-wide criminal background screening was completed for 2 of 3 staff sampled (A, C) upon hire in accordance with G.S. 131D-40.  The findings are:  1. Review of Staff A's personnel record revealed: -Staff A was hired 11/03/15 as a Live-In Aide. -There was documentation of a county criminal background screening for Staff A completed on 04/22/15. -There was no documentation of a state wide criminal background screening being completed for Staff A upon hire.  Staff A was not available for interview.  Refer to interview with the Office Manager (OM) on 05/12/16 at 2:20pm.	C 147	

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Ayula Brawl*  
TITLE  
Admin  
DATE  
6/16  
STATE FORM 100 881011 8 continuation sheet 1 of 25

Addendums Ayula Brawl 6-30-16  
POC & addendums received 6/30/16  
Jamara Talbot, RN  
DHSH/ACLS

P. 002

FAX No.

JUN/23/2016/THU 09:56 AM

F. 001/001

FAX No.

JUN/30/2016/THU 02:47 PM

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 147	<p>Continued From page 1</p> <p>Refer to the telephone interview with the Administrator on 05/12/16 at 10:00am.</p> <p>2. Review of Staff C's personnel record revealed: -Staff C was previously employed at the facility from 10/16/14-08/03/15 as a Medication Aide/Supervisor in Charge (MA/SIC). -Staff C was re-hired a second time on 09/23/15 as a MA/SIC. -There was documentation of a state wide criminal background screening completed prior to Staff A being hired the first time (on 09/22/14). -There was no documentation of a criminal background screening being completed upon Staff C's second date of hire (09/23/15). -There was documentation signed by Staff C and dated 10/01/14 consenting to a criminal background screening.</p> <p>Interview with Staff C on 05/12/16 at 12:50pm revealed Staff C did not recall providing consent or having a criminal background screening completed upon her first hire date or second hire date.</p> <p>Interview with the OM on 05/12/16 at 2:20pm revealed Staff C had left her employment with the facility for a one month time frame and the OM did not know Staff C required a criminal background screening at the time she was re-hired.</p> <p>Refer to the interview with the OM on 05/12/16 at 2:20pm.</p> <p>Refer to the telephone interview with the Administrator on 05/12/16 at 10:00am.</p> <p>Interview with the OM on 05/12/16 at 2:20pm revealed:</p>	C 147	<p><i>Admin / SIC will review workers chart monthly. SIC is the office Manager</i></p>	

Division of Health Service Regulation

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C 147	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>-The OM was aware that a state wide criminal background screen was required upon hire for all staff because the county Adult Home Specialist had "pointed it out" to the OM.</li> <li>-The OM was responsible for assuring criminal background screenings were completed for staff.</li> <li>-The facility used to do a national criminal background screening through an online service but the web site was not available any more.</li> <li>-The OM would assure a state-wide criminal background screening was done for all staff upon hire going forward.</li> <li>-The OM would assure all staff without a state-wide criminal background had the screening completed as soon as possible.</li> </ul> <p>Telephone interview with the Administrator on 05/12/16 at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>-The OM was responsible for staff personnel records.</li> <li>-The facility used to obtain criminal background screenings from the State Bureau of Investigation (SBI) but it was an added cost so the facility began using an online service.</li> <li>-There was a problem with the online service.</li> <li>-The facility will go back to using the SBI to obtain state-wide background screenings for staff.</li> </ul> <p>Review of the Plan of Protection dated 05/12/16 revealed:</p> <ul style="list-style-type: none"> <li>-No later than 05/20/16, the Office Manager would review all staff files.</li> <li>-Staff without a state criminal background screening completed upon hire would be required to have a state-wide criminal background screen completed.</li> </ul> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 06/26/16.</p>	C 147	<p>All staff records have been reviewed, all criminal checks (background) have been updated</p>	
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Using  
Been Verified, as of 6-22-16.  
Been Verified, will be used from now on.

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C 185	Continued From page 3	C 185		
C 185	<p>10A NCAC 13G .0601(a) Management and Other Staff</p> <p>10A NCAC 13G .0601Mangement and Other Staff</p> <p>(a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.</p> <p>This Rule is not met as evidenced by: Type A2 Violation</p> <p>Based on observations, interviews and record reviews, the administrator failed to assure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to provide appropriate care and services as evidenced by the failure to maintain substantial compliance with the rules and statutes regarding medication administration, health care, and staff qualifications, which is the responsibility of the administrator.</p> <p>The findings are:</p> <p>Non-compliance was identified in the following</p>	C 185	<p>Admin has always been @ Facility!</p> <p>Due to Family member sick!</p> <p>Could not Attend @ that time.</p> <p>Admin has a office manag and she is in charge @ all times, when Admin not available!</p>	

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C 185	<p>Continued From page 4</p> <p>areas during the survey on 05/11/16-05/12/16:</p> <p>1. Based on record reviews, and interviews, the facility failed to assure physician notification for 3 of 3 residents sampled (#1, #2, #3) as evidenced by failure to notify the primary care physician (PCP) of elevated blood sugars for one diabetic resident (#1), failure to notify the PCP of orders received for a resident (#3) upon discharge from the hospital on two occasions for 1 week and 2 week follow up appointments with the PCP, and failure to notify the PCP for referral to an orthopedic physician for a resident with knee pain (#2). [Refer to Tag D246, 10A NCAC 13G .0902(b) Health Care (Type B Violation)].</p> <p>2. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by the prescribing provider for 2 of 3 residents sampled (#1, #3) as related to failure to administer Lantus and Humalog insulins to a diabetic resident (#2) resulting in elevated finger stick blood sugars (FSBS), failure to administer Doxycycline and Prednisone per provider orders to a resident (#3) with diagnoses of chronic obstructive pulmonary disease (COPD) after hospitalization for shortness of breath and requiring additional hospital treatment for shortness of breath, and continuing to administer Tylenol to a resident (#3) after the order was discontinued. [Refer to Tag D330, 10A NCAC 13G .1004(a) Medication Administration (Type A2 Violation)].</p> <p>3. Based on observation, record reviews, and interviews, the facility failed to implement safe procedures for medication administration for 1 of 4 residents sampled (#4) as evidenced by staff pouring and leaving medications unsupervised to be taken at a later time and without observing the</p>	C 185	<p>Admin plans to ensure and will meet w med-techs on a weekly and will ensure that Admin/MT will go thru medications in cart to ensure that no meds are old. Addendum 6/30/16 at 10:30am Insulins will be stored in the refrigerator in each building in</p>	

a locked box and discarded at recommended discard date if unused. Medication audit will be done once weekly until corrected.

JUN/23/2016 THU 09:57 AM

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372	Addendum 6/30/16 at 10:30
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C 185	<p>Continued From page 5</p> <p>resident take the medications. [Refer to Tag D341, 10A NCAC 13G .1004(i) Medication Administration (Type B Violation)].</p> <p>4. Based on observations, interviews and record reviews, the facility failed to assure infection control procedures were maintained for the safe administration of Lantus and Humalog insulins by allowing the administration of unrefrigerated insulins past 60 days for 1 of 1 resident sampled (#1) receiving insulin. [Refer to Tag D346, 10A NCAC 13G .10041(n) Medication Administration (Type B Violation)].</p> <p>5. Based on personnel record reviews and interviews, the facility failed to assure a state-wide criminal background screening was completed for 2 of 3 staff sampled (A, C) upon hire in accordance with G.S. 131D-40. [Refer to Tag 147, 10A NCAC 13G .0406(a) (7) Other Staff Qualifications (Type B Violation)].</p> <p>Observation during the survey on 05/11/16-05/12/16 revealed: -The Administrator was not in the facility during the time of the survey. -The Administrator spoke with the Adult Home Specialist by telephone on 05/11/16 at 10:00am.</p> <p>Confidential interviews with two staff members revealed: -The Office Manager supervised staff on a daily basis. -The Administrator was usually in the office area of facility once weekly. -"Sometimes" the Administrator made rounds in each building of the facility. -Staff did not know the last time the Administrator made rounds in the facility. -The Administrator was available by telephone as</p>	C 185	<p>Admin hours will be from 8-5pm 5 days weekly and on call 24 hrs. a day 7 days a week. Admin will do rounds 5 days weekly. Plan to ensure that SBF cks will be done before hire. Admin / Office Manager will review books monthly to ensure that it been done. Office Mgr/S/C is</p>	
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Addendum 6/30/16 at 10:30 AM

responsible for all staff qualifications

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C 185	Continued From page 6 needed. -The Administrator came to the facility on week-ends  Telephone interview with the Administrator on 05/12/16 revealed: -The Administrator was not available to come to the survey on 05/11/16-05/12/16 due to the illness of a family member. -The Office Manager was in charge when the Administrator was not at the facility. -The Administrator was available by telephone 24 hours per day, 7 days per week.  Review of the Plan of Protection received from the Administrator by fax and dated 05/13/16 revealed: -Beginning 05/13/16, the Administrator would tour the facility three times weekly to assure the overall operations of the facility were in compliance. -The Administrator would review all resident records beginning 05/13/16. -The Administrator would conduct weekly staff meetings with all staff beginning 05/13/16.  THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 06/11/16.	C 185	Addendum 6/30/16 at Admin plan to 10:30 AM be on site 8 wk @ Facility will speak to residents and staff to assure that the rules are being met.  Admin will be onsite 5 days weekly.	
C 246	10A NCAC 13G .0902(b) Health Care  10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.  This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews, and interviews, the	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 7</p> <p>facility failed to assure physician notification for 3 of 3 residents sampled (#1, #2, #3) as evidenced by failure to notify the primary care physician (PCP) of elevated blood sugars for one diabetic resident (#1), failure to notify the PCP of orders received for a resident (#3) upon discharge from the hospital on two occasions for 1 week and 2 week follow up appointments with the PCP, and failure to notify the PCP for referral to an orthopedic physician for a resident with knee pain (#2).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 11/11/15 revealed diagnoses included Schizophrenia, Personality Disorder, Diabetes Mellitus and Hypertension.</p> <p>Review of a physician's order dated 2/29/16 revealed:</p> <p>-An order for Humalog SSI (sliding scale Insulin.) (Humalog is a fast acting insulin that lowers blood sugar levels.)</p> <p>-For FSBS (finger stick blood sugar) 200 - 250 give 2 units SQ (subcutaneous); FSBS 251 - 300 give 4 units SQ; FSBS 301 - 350 give 6 units SQ and FSBS 351 - 400 give 8 units SQ.</p> <p>-There were no orders on what to do for FSBS levels greater than 400.</p> <p>Record review for Resident #1 revealed there was no order for frequency of FSBS checks.</p> <p>Review of pharmacy dispensing records revealed directions to check FSBS twice daily with the Humalog SSI dated 12/15/15.</p> <p>Review of Resident #1's Blood Sugar Check sheet for March 2016 revealed:</p>	C 246	<p>Med aides will be responsible for contacting PCP for elevated blood sugars to get a verbal order and to ensure that documentation has been done.</p>	

Division of Health Service Regulation

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C 246	<p>Continued From page 8</p> <p>-There were 56 FSBS results documented ranging from 114 - Hi. -A "Hi" reading on Resident #1's glucometer (device used to measure blood sugar levels) indicated a blood sugar level greater than 600, according to the manufacturer. -The following 11 FSBS results were greater than 400: "Hi" on 3/1/16 at 5pm, 505 on 3/2/16 at 5pm, 420 on 3/3/16 at 5pm, 510 on 3/5/16 at 5pm, 475 on 3/6/16 at 5pm, 496 on 3/8/16 at 5pm, "Hi" on 3/12/16 at 5pm, 422 on 3/14/16 at 5pm, 479 on 3/22/16 at 5pm, 470 on 3/23/16 at 5pm, 458 on 3/24/16 at 5pm and 462 on 3/25/16 at 5pm.</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed a hand written entry for Humalog insulin/check FSBS twice a day at 8am and 5pm with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units.</p> <p>Review of a signed, undated physician order for Resident #1 revealed: -Fasting blood sugar check. -Greater than 400 give 10 units regular insulin. -Greater than 450 give 12 units.</p> <p>Record review for Resident #1 revealed no documentation of clarification for the frequency of fasting blood sugar checks.</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Humalog injection Check FSBS twice a day with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units. -There was a hand written entry just below the preprinted entry for over 400 give 10u [units], over 450 give 12u [units] and contact MD.</p>	C 246	<p>Med aide will be responsible when a resident is discharge from the hospital to 24hrs to contact PCP.</p>	<p>June 26, 2016</p>

Division of Health Service Regulation

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C 246	<p>Continued From page 9</p> <p>Review of Resident #1's Blood Sugar Check sheet for April 2016 revealed: -There were 54 FSBS results documented ranging from 105 - 445. -There was only 1 FSBS result documented greater than 400. -On 4/19/16 at 5pm the FSBS was documented as 445.</p> <p>Review of Resident #1's May 2016 Blood Sugar Check sheet on 5/12/16 revealed: -There were 19 FSBS results documented ranging from 134 - 510. -The following 2 FSBS were greater than 400: 510 on 5/6/16 at "supper" and 457 on 5/8/16 in the "am."</p> <p>Record review for Resident #1 revealed no documentation the physician or physician's assistant was notified or that Resident #1 was sent to the emergency room for FSBS results over 400.</p> <p>Review of primary care provider notes for Resident #1 revealed no notation regarding FSBS results over 400 on the following visits: 1/19/16, 1/27/16, 3/21/16, 4/4/16, 4/11/16 and 4/19/16.</p> <p>Review of the facility's "Diabetic Policy and Procedure" revealed: -The policy was posted on the refrigerator in the kitchen. -The policy read "If patient has blood sugar of greater than 400, contact med-tech if one on duty, they will contact [name of physician's office] if not 911 will be called."</p> <p>Interview with Resident #1 on 5/12/16 at 9:35am revealed if his FSBS was high staff would give</p>	C 246	<p>med aide will be responsible for letting PCP review discharge papers from hospital PCP will be responsible for giving a referral to see if Any orders to be done.</p> <p>Addendum 6/30/16 at Facility will notify 10:30</p>	

PCP p any hospitalization to check for new orders. Will be done within 24<sup>o</sup> of return to facility  
MA responsible

Division of Health Service Regulation

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C 246	<p>Continued From page 10</p> <p>him a shot and some water.</p> <p>Interview with a MA (medication aide) on 5/11/16 at 3:15pm revealed: -The doctor reviewed "all that stuff [MARs and FSBS results] when we bring it to their attention." -The only time the MA documented notifying the doctor was if an order was given.</p> <p>Interview with a second MA on 5/12/16 at 1:53pm revealed: -Live-in staff were responsible for checking the residents' FSBS levels. -MAs were responsible for administering SSI as needed. -The MA would ask the live-in what the FSBS was and administer SSI as ordered. -The MA reported while reviewing Resident #1's MAR, "I know what it looks like and it's hard to tell but I gave him his insulin and called the doctor."</p> <p>Interview with the first MA on 5/12/16 at 2:21pm revealed: -The MA initialed the MAR on 5/6/16 documenting that 16 units of Humalog Insulin was administered for a FSBS of 510. -This was the only time the MA called the physician. -The order was not in Resident #1's record, it was in a pile of papers on the MA's desk. -Prior to the undated order for fasting blood sugar check over 400 and over 450, the MA just went by the scale and had the live-in recheck the FSBS. -The additional FSBS checks were not written down anywhere. -Regarding the "Diabetic Policy and Procedures," the MA stated "I don't pay no attention to it."</p> <p>Review of a verbal order for Resident #1 dated 5/6/16 and signed by the MA revealed an order</p>	C 246		<p><i>June 26, 2016</i></p>

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NAME OF PROVIDER OR SUPPLIER  
**DIAL'S FAMILY CARE HOME #4**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**1698 CANAL ROAD  
PEMBROKE, NC 28372**

(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)	(X6) COMPLETE DATE
C 246	<p>Continued From page 11</p> <p>for, "Patient B/S [FSBS] 510 give 16u [units]sub q [subcutaneous injection] of Humalog, verbal order per [PA's name.]"</p> <p>Telephone interview with the Physician's Assistant (PA) on 5/12/16 at 10:45am revealed:</p> <ul style="list-style-type: none"> <li>-MAs were expected to call PA for FSBS over 400.</li> <li>-If the FSBS was "Hi" the PA expected the MA to send the resident to the emergency room.</li> <li>-MAs usually contacted the PA by phone.</li> <li>-The PA was unable to recall specific instances of FSBS over 400 or Hi because the resident's record was not available to him.</li> <li>-Resident #1 and facility staff were counseled on FSBS levels and diet.</li> <li>-Resident #1 was not compliant with dietary restrictions but the PA still expected MAs to call with FSBS over 400.</li> </ul> <p>Interview with the Office Manager (OM) on 5/12/16 at 3:44pm revealed:</p> <ul style="list-style-type: none"> <li>-The "Diabetic Policy and Procedure" sheet needed to be updated.</li> <li>-There were certain times the live-in should just call 911 instead of waiting for a MA because there wasn't always an MA on duty.</li> <li>-MAs worked from 7am until 7:30pm daily.</li> <li>-There was no MA on duty from 7:30pm until 7am daily.</li> <li>-The OM planned to work with the physician to develop standing diabetic orders with clear expectations for staff.</li> </ul> <p>Attempts to contact the Administrator on 5/11/16 were unsuccessful and the Administrator was not available for interview regarding Resident #1 on 5/12/16.</p> <p>2. Review of Resident #3's current FL-2 dated</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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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 248	<p>Continued From page 12</p> <p>04/28/16 revealed diagnoses included COPD, hypertension, schizophrenia, bipolar disorder, and metabolic encephalopathy.</p> <p>Interview with a staff member during the initial facility tour on 05/11/16 at 10:00am revealed: -Resident #3 was admitted to the hospital and was not in the facility. -Resident #3 was sent to the hospital on 05/10/16 for chest pain and shortness of breath.</p> <p>Review of the hospital discharge instructions dated 03/19/16 revealed: -Resident #3 was admitted to the hospital on 03/18/16 and discharged from the hospital on 03/19/16. -The admitting diagnosis was weakness. -There was an order for Resident #3 to have a follow-up appointment with his PCP in one week.</p> <p>Review of the hospital emergency department admission records dated 04/26/16 revealed: -"Last discharge summary 03/19/16: [Resident #3] with past medical history of bipolar disorder, schizophrenia, COPD, hypertension, who was sent from his local assisted living facility for evaluation for altered mental status. [Resident #3] seen in the emergency department ... [Resident #3] was admitted to inpatient for probable worsening psychosis ... [Resident #3] was seen by psychiatry and medications were optimized. [Resident #3] did well during the hospital course." -The chief complaint on 04/26/16 was shortness of breath and chest pain. -"History of present illness: [Resident #3] was sent from assisted living facility for evaluation for chest pain and shortness of breath. [Resident #3] does not reliably give a history of medical facility ... Spoke to the nurse there. Said [Resident #3] has been coughing that's unproductive, there is</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 13</p> <p>no fever, and has been more shortness of breath and drooling ....Said yesterday had chest pain,"</p> <p>-Resident #3 had a chest x-ray performed which was negative for pneumonia but revealed atelectasis. (Atelectasis is the collapse of the small air sacs in the lungs).</p> <p>Review of the hospital discharge summary dated 04/28/16 revealed:</p> <p>-Resident #3 was admitted to the hospital on 04/28/16 discharged from the hospital on 04/28/16.</p> <p>-The admitting diagnosis was "acute bronchitis." (Bronchitis is the inflammation of membranes lining the passages of the airways from the nose or mouth to the lungs).</p> <p>-There was an order for Resident #3 to have a follow up appointment with his PCP in 2 weeks.</p> <p>Review of Resident #3's record revealed:</p> <p>-There was no documentation that Resident #3 had a one week follow up appointment with the PCP after his hospital discharge on 03/19/16.</p> <p>-There was no documentation that Resident #3 had a follow up appointment with the PCP after his hospital discharge on 04/28/16.</p> <p>Review of the "Assisted Living Visit Record" forms for Resident #3 revealed Resident #3 was evaluated by the PCP or PA on 08/24/15, 11/23/15, 01/19/16, 04/04/16, and 04/19/16.</p> <p>Interview with Staff C, a Medication Aide (MA), on 05/11/16 at 1:29pm revealed:</p> <p>-The MAs were responsible for assuring provider orders were implemented.</p> <p>-The MAs were responsible for faxing provider orders to the pharmacy, transcribing the orders to the Medication Administration Records (MARs), and scheduling follow up appointments for all</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 14</p> <p>residents.</p> <p>-The facility had a contracted primary care physician (PCP) and Physician Assistant (PA) who came to evaluate and treat residents at the facility.</p> <p>-Either the PCP or the PA came to the facility once weekly, usually on Monday.</p> <p>-It was facility procedure for the facility to make a list of the residents that needed to be evaluated by the PCP or PA each week.</p> <p>-The MAs were responsible for making the list of residents who were supposed to see the PCP or PA.</p> <p>-When a resident was discharged from the hospital, the MAs were supposed to "read over" the hospital discharge instructions to check the physician's discharge orders for follow up appointments and new medication orders.</p> <p>-If the hospital discharge summary contained orders for the resident to follow up with their PCP, the MA was supposed to put the resident on the list to see the PCP or PA.</p> <p>-The PCP or PA evaluated the residents and reviewed the hospital discharge summaries at their weekly visits to the facility.</p> <p>-When the PCP or PA evaluated a resident, the PCP or PA completed the "Assisted Living Visit Record" form.</p> <p>-Staff C did not know why Resident #3 was not scheduled for a follow up appointment with the PCP or PA one week after his discharge from the hospital on 03/19/16.</p> <p>-Staff C did not know if the PCP or PA were notified of Resident #3's hospitalization from 04/26/16-04/28/16 for shortness of breath and chest pain.</p> <p>-Staff C did not know why Resident #3 did not have a follow up with the PCP or PA after his hospital discharge on 04/28/16; Resident #3 would be put on the schedule to see the PCP or</p>	C 246		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 CANAL ROAD PEMBROKE, NC 28372		
(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 246	Continued From page 15 PA the following week.  Interview with the Office Manager (OM) on 05/12/16 at 2:20pm revealed: -The facility had a problem with the PA not coming to the facility on a set day each week. -The OM contacted the PCP to obtain a specific day for the PCP or PA to come to the facility each week; the PCP or PA came to facility every Monday "right now." -The MAs were responsible for implementing provider orders. -The MAs were expected to review and implement all hospital discharge orders. -The MAs were supposed to fax provider orders to the pharmacy, write the orders on the MARs, make follow up appointments for residents as needed, and write the appointments on the calendar in the office.  Telephone interview with the PA on 05/11/16 at 2:00pm revealed: -The facility usually notified the PA when a resident had been hospitalized "after the fact" on his next (weekly) visit to the facility; the PA evaluated the resident at that time. -The PA expected to be notified by the facility during his weekly visit if a resident had been to the hospital. -The PA expected the facility to notify him as needed "based on the severity" of each resident's condition. -If a resident was hospitalized for chest pain or shortness of breath, the PA expected to be notified by the MA. -When it was "after hours" and there was not a MA working, it could be 12-14 hours before the MA was back on duty to notify him; the PA expected to be notified when the MA was back on duty.	C 246		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372		
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C 246	Continued From page 16  -The PA did not recall being notified by staff and was not aware Resident #3 was hospitalized from 04/26/16-04/28/16 for shortness of breath and chest pain. -The PA expected to be notified of Resident #3's hospitalization because Resident #3 had shortness of breath and chest pain. -The PA was not in the facility "most of April" (2016), but the PCP was in the facility. -The PA was last in the facility on 05/02/16. -The PA requested the dates Resident #3 was admitted to the hospital from the surveyor. -The PA would have evaluated Resident #3 on 05/02/16 if he had been notified of Resident #3's recent hospitalization for shortness of breath and chest pain. -The PA was not aware Resident #3 was sent to the hospital on 05/10/16 for shortness of breath and chest pain. -The PA would evaluate Resident #3 at his next weekly visit on 05/16/16.  Telephone interview with the PCP on 05/12/16 at 11:10am revealed: -The PCP could not recall the last time she evaluated Resident #3 without reviewing Resident #3's record. -The PCP did not recall being notified by the facility of Resident #3's hospitalizations in March 2016, April 2016, and current hospitalization beginning 5/10/16. -The PCP was not aware Resident #3 was currently hospitalized. -Overall, the facility was good about notifying the PCP of changes in residents' conditions. -The PCP or PA came to the facility weekly. -The facility was responsible for making a schedule of residents to be evaluated and treated by the PCP or PA at the weekly visit to the facility. -The PCP expected to be notified of residents	C 246		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372		
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C 246	Continued From page 17  with hospitalizations requiring follow up care. -The PA expected the facility to notify the PCP or PA of hospitalizations at the weekly visit so the resident could be evaluated when the PCP or PA was in the facility. -The facility was supposed to fax non-urgent orders to the PCP for review. -The facility was supposed to notify her of more urgent orders by telephone or text. -The PCP expected all hospital discharge orders to be implemented to prevent any delay in care.  Telephone interview with the Administrator on 05/12/16 at 3:33pm revealed: -The MAs were responsible for scheduling residents to see the PCP or PA each week. -Resident #3 should have been evaluated by the PCP or PA after discharge from the hospital. -The Administrator did not know why the MA would not schedule Resident #3 to see the PCP or PA after his hospital discharges.  3. Review of Resident #2's current FL-2 dated 9/22/15 revealed: - Diagnoses included schizophrenia and severe conversion disorder. - Resident #2 was intermittently disoriented. - Resident #2 was semi-ambulatory.  Review of the hospital discharge instructions from an emergency department visit dated 10/05/15 revealed: - Resident #2 was diagnosed with knee pain, general. - Resident #2 was given follow up instructions to be seen by an orthopedic specialty provider in 3 - 5 days.  Review of a physician's visit note dated 4/11/16 revealed:	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- Resident #2 was seen by the facility's primary care physician (PCP) due to knee pain.</li> <li>- The PCP documented Resident #2 had a swollen, tender left knee and wrote an order for Tramadol 50mg twice a day for pain.</li> </ul> <p>Review of Resident #2's record revealed there was no documentation Resident #2 had been evaluated by an orthopedic provider or that the primary care physician was made aware of the emergency department visit and discharge instructions (dated 10/05/15).</p> <p>Telephone interview with staff in the orthopedic office on 5/11/16 at 4:05pm revealed Resident #2 had not ever been seen in the office and did not have an appointment scheduled.</p> <p>Interview with Resident #2 on 5/11/16 at 2:00pm revealed:</p> <ul style="list-style-type: none"> <li>- Resident #2 went to the hospital due to knee pain and had an x-ray.</li> <li>- Resident #2 was not aware of being referred to an orthopedic physician, and had not seen any specialist for his knee.</li> <li>- Resident #2 stated he had knee pain every day.</li> </ul> <p>Interview with Resident #2's PCP on 5/12/16 at 10:40am revealed:</p> <ul style="list-style-type: none"> <li>- The PCP could not recall being made aware that Resident #2 was seen in the emergency department on 10/05/15 for knee pain.</li> <li>- The PCP would have wanted Resident #2 to follow up with an orthopedic in accordance with the hospital discharge instructions.</li> <li>-The PCP would need to write a referral for Resident #2 to be seen by an orthopedic.</li> </ul> <p>Interview on 5/12/16 at 10:50am with the Medication Aide (MA) revealed:</p>	C 246		

Division of Health Service Regulation

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C 248	Continued From page 19  -When a resident returned from a hospital visit the MA on duty was responsible for reviewing discharge instructions and informing the PCP. - A procedure was in place now to make a copy of the discharge instructions and put the instructions in the PCP's box so the PCP could review and write a referral if needed. - The MA was not sure who was working when Resident #2 returned from the hospital on 10/05/15 and was not sure why a referral was not completed.  Review of the Plan of Protection dated 05/12/16 revealed: -The MAs, and Administrator or designee would conduct a chart audit beginning 05/16/16 to assure health care referral and follow up had been completed for all residents. -After the chart audit was completed, all physician orders would be reviewed by two different MAs to assure no orders were missed. -Charts with outstanding physician orders would remain "flagged" until all provider orders had been implemented.  THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 06/26/16.	C 246		
C 315	10A NCAC 13G .1002(a) Medication Orders  10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or	C 315	Plan to ensure that medication orders that Med-Techs will	

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1688 CANAL ROAD PEMBROKE, NC 28372		
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C 315	<p>Continued From page 20</p> <p>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify orders for medications including Lisinopril, Olanzapine, Lorazepam, Trazadone, Vitamin E and Clotrimazole cream for 1 of 4 sampled residents (Resident #1.)</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 11/11/15 revealed diagnoses included Schizophrenia, Personality Disorder, Diabetes Mellitus and Hypertension.</p> <p>A. Review of Resident #1's current FL-2 dated 11/11/15 revealed an order for Lisinopril 20mg daily. (Lisinopril is used to treat high blood pressure.)</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a preprinted entry for Lisinopril 20mg by mouth twice daily at 7am and 7pm. -The entry was initialed as administered 3/1/16 through 3/31/16 twice daily. -A blood pressure result of 138/80 was recorded on 3/27/16.</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Lisinopril 20mg</p>	C 315	<p>Contact PCP for all clarification orders. Will put in policy that be for Admission order will be clarified by PCP.</p> <p>MA responsible</p> <p>MA will receive additional training from an RN on 6/30/16 on Medication orders, medication administration, Medication Safety.</p>	<p>MA's responsible for notifying the PCP</p> <p>Saw 26/2/16</p> <p>Addendum 6/30/16 at 10:30 am</p>

Addendum 6/30/16 at 10:30 am  
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C 315	<p>Continued From page 21</p> <p>twice daily at 7am and 7pm. -The entry was initialed as administered 4/1/16 through 4/30/16. -A blood pressure result of 128/69 was recorded on 4/1/16.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -There was a preprinted entry for Lisinopril 20mg by mouth twice daily at 7am and 7pm. -The entry was initialed as administered 5/1/16 through 5/11/16 7am. -There was no blood pressure recorded.</p> <p>Record review for Resident #1 revealed: -There was no subsequent order for Lisinopril. -There was no 6 month medication review form.</p> <p>Interview with the pharmacist on 5/11/16 at 4:07pm revealed: -The pharmacy did not have an order for twice daily dosing of Lisinopril. -It may have been changed on the 6 month medication review sheet.</p> <p>Interview with the Physician Assistant (PA) on 5/12/16 at 10:45pm revealed if the resident's blood pressure was elevated, the PA would "usually move to something besides Lisinopril because of the risk of angioedema (swelling under the skin similar to hives)."</p> <p>B. Review of Resident #1's current FL-2 dated 11/11/15 revealed an order for Olanzapine Zydys 10mg twice daily at bedtime. (Olanzapine is used to treat mental disorders including schizophrenia.)</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a preprinted entry for Olanzapine</p>	C 315		

Division of Health Service Regulation

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C 315	<p>Continued From page 22</p> <p>20mg at 7pm. -The entry was initialed as administered 3/1/16 through 3/31/16.</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Olanzapine 20mg at 7pm. -The entry was initialed as administered 4/1/16 through 4/30/16.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -There was a preprinted entry for Olanzapine 20mg at 7pm. -The entry was initialed as administered 5/1/16 through 5/11/16.</p> <p>Record review for Resident #1 revealed: -There was no subsequent or clarification order from 10mg twice daily at bedtime to 20mg at bedtime. -There was no 6 month medication review form.</p> <p>Interview with the pharmacist on 5/11/16 at 4:07pm revealed the pharmacy had an order for Olanzapine 20mg at bedtime on a 6 month medication review sheet.</p> <p>Review of the "6 month medication review sheet" faxed on 5/11/16 from the pharmacy revealed: -The forms were MARs from Resident #1's previous facility dated 12/1/15 - 12/31/15. -There was no physician order, signature or date on the forms.</p> <p>Interview with the PA on 5/12/16 at 10:45pm revealed Olanzapine would have been a mental health medication and the PA did not recall starting that medication.</p>	C 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372		
(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 315	Continued From page 23  C. Review of Resident #1's current FL-2 dated 11/11/15 revealed there was no order for Lorazepam on the FL-2. (Lorazepam is a sedative used to relieve anxiety.)  Record review for Resident #1 revealed: -There was a pharmacy request dated 12/15/15 for clarification for Lorazepam 0.5mg by mouth every 4 hours as needed for muscle movement. -There was a hand written order in the response section for Lorazepam 0.5mg 4 times daily signed by the physician's assistant and dated 12/28/15. -The form had a note at the top from pharmacy "Is this still PRN [as needed]?" - "This is to remain PRN " was hand written also at the top of the page, which did not have a signature or date. -The fax to and from dates ranged from 12/15/15 through 12/30/15. -There were no other orders for Lorazepam.  Observation of medications on hand for Resident #1 on 5/11/16 at 4:00pm revealed: -There was a bubble pack with a pharmacy label that read: Lorazepam 0.5mg every 4 hours as needed for muscle movement dispensed on 12/15/15. -There were 27 of 30 tablets remaining.  Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a preprinted entry for Lorazepam 0.5mg 4 times a day as needed for muscle movement. -There were no doses documented as administered.  Review of Resident #1's April 2016 MAR	C 315		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372		
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C 315	<p>Continued From page 24</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-There was a preprinted entry for Lorazepam 0.5mg 4 times a day by mouth as needed for muscle movement.</li> <li>-There were no doses documented as administered.</li> </ul> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed:</p> <ul style="list-style-type: none"> <li>-A preprinted entry for Lorazepam 0.5mg 4 times a day by mouth as needed for muscle movement.</li> <li>-There were no doses documented as administered.</li> </ul> <p>D. Review of Resident #1's current FL-2 dated 11/11/15 revealed an order for Trazodone 100mg as needed at bedtime for sleep. (Trazodone is an antidepressant and sedative used to treat depression and insomnia.)</p> <p>Record review for Resident #1 revealed:</p> <ul style="list-style-type: none"> <li>-There was a preprinted pharmacy request dated 12/15/15 for clarification for Trazodone 100mg by mouth at bedtime as needed for sleep.</li> <li>-There was a hand written order in the response section for Trazodone 100mg at bedtime signed but not dated by the PA.</li> <li>-The form had a note at the top from pharmacy "Continue PRN [as needed] dose or change to HS [bedtime]?"</li> <li>- "This is PRN" was hand written also at the top of the page, which did not have a signature or date.</li> <li>-The fax to and from dates ranged from 12/15/15 through 12/30/15.</li> </ul> <p>Observation of medications on hand for Resident #1 on 5/11/16 at 4:00pm revealed there was no Trazodone on hand for Resident #1.</p> <p>Review of Resident #1's March 2016 MAR</p>	C 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 315	<p>Continued From page 25</p> <p>(medication administration record) revealed: -There was a preprinted entry for Trazodone 100mg at bedtime as needed for sleep. -There were no doses documented as administered.</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Trazodone 100mg at bedtime as needed for sleep. -There were no doses documented as administered.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -There was a preprinted entry for Trazodone 100mg at bedtime as needed for sleep. -There were no doses documented as administered.</p> <p>Interview with the pharmacist on 5/11/16 at 4:07pm revealed the pharmacy had not received clarification order back from the facility for the Trazodone.</p> <p>E. Review of Resident #1's current FL-2 dated 11/11/16 revealed there were no orders for Vitamin E on the FL-2. (Vitamin E is used as a nutritional supplement.)</p> <p>Record review for Resident #1 revealed there was no order for Vitamin E.</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a preprinted entry for Vitamin E 400 IU (international units) every morning. -The entry was initialed as administered daily 3/1/16 through 3/31/16.</p>	C 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 315	<p>Continued From page 26</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Vitamin E 400 IU every morning. -The entry was initialed as administered daily 4/1/16 through 4/30/16.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -There was a preprinted entry for Vitamin E 400 IU by mouth every morning. -The entry was initialed as administered daily 5/1/16 through 5/11/16.</p> <p>Interview with the Pharmacist on 5/12/16 at 1:19pm revealed the Pharmacist was unable to locate an order for Vitamin E for Resident #1.</p> <p>F. Review of Resident #1's current FL-2 dated 11/11/15 revealed an order for Clotrimazole topical cream 1%. (Clotrimazole cream is used to treat fungal infections on the skin.)</p> <p>Record review for Resident #1 revealed: -There was no subsequent or clarification order for how frequent or where to apply the Clotrimazole Cream. -There was no 6 month medication review form.</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a preprinted entry for Clotrimazole Cream 1% apply a thin layer to affected area once a day as needed. -There were no doses documented as administered.</p> <p>Review of Resident #1's April 2016 MAR revealed: -A preprinted entry for Clotrimazole Cream 1%</p>	C 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 315	<p>Continued From page 27</p> <p>apply a thin layer to affected area once a day as needed. -There were no doses documented as administered.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -A preprinted entry for Clotrimazole Cream 1% apply a thin layer to affected area once a day as needed. -There were no doses documented as administered. -The word "completed" was hand written next to the entry.</p> <p>Interview with the PA on 5/12/16 at 10:45pm revealed the PA did not recall clarifying an order for the Clotrimazole cream.</p> <p>Interview with a MA (Medication Aide) on 5/11/16 at 12:15pm revealed: -The MA was responsible for physician orders, faxing them to the pharmacy and transcribing on the MAR. -Orders were written on doctor visit sheets or on a "script."</p> <p>Interview with the PA on 5/12/16 at 10:45am revealed: -Staff usually had questions/clarifications written on a note. -The PA would clarify the orders when he saw the written note.</p> <p>Interview with the pharmacist on 5/11/16 at 4:07pm revealed: -The facility was "difficult to get clarifications from because the doctor was not on site." -Pharmacy staff made "notes in the system" that the pharmacy spoke with someone at the facility</p>	C 315		

Division of Health Service Regulation

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C 315	<p>Continued From page 28</p> <p>12/15/15 and 12/16/15 and received verbal medication clarifications. -The pharmacy "notes" indicated facility staff would get written clarifications from the physician.</p> <p>Interview with the Office Manager (OM) on 5/12/16 at 10am revealed: -For new residents the FL-2 was faxed to the pharmacy as well as any additional orders from the hospital. -Resident #1 coming from another facility made it unclear what to do with his orders and paperwork. -The orders, FL-2 and previous facility's MAR should have been compared and any questions should have been clarified with the doctor. -The clarification sheets for Lorazepam and Trazodone were a question for the Administrator.</p> <p>Attempts to contact the Administrator in 5/11/16 were unsuccessful and the Administrator was not available for interview regarding Resident #1 on 05/12/16.</p>	C 316	<p>Addendum 6/30/16 at 10:30AM</p> <p>Random medication pass audit will be done once weekly by the Admin/sic/office manager until corrected.</p> <p>MA's will receive additional training</p>	
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p>	C 330	<p>Admin shall assure that med-techs are responsible for</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 330	<p>Continued From page 29</p> <p>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by the prescribing provider for 2 of 3 residents sampled (#1, #3) as related to failure to administer Lantus and Humalog insulins to a diabetic resident (#2) resulting in elevated finger stick blood sugars (FSBS), failure to administer Doxycycline and Prednisone per provider orders to a resident (#3) with diagnoses of chronic obstructive pulmonary disease (COPD) after hospitalization for shortness of breath and requiring additional hospital treatment for shortness of breath, and continuing to administer Tylenol to a resident (#3) after the order was discontinued.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 11/11/15 revealed diagnoses included Schizophrenia, Personality Disorder, Diabetes Mellitus and Hypertension.</p> <p>A. Review of a physician order dated 2/29/16 revealed a physician order for Lantus insulin 20 units SQ (subcutaneous) injection every morning and 35 units SQ every night at bedtime. (Lantus is a long acting insulin that works to lower blood sugar levels.)</p> <p>Observation on 5/11/16 at 4:00pm revealed: -There was a prescription bottle on top of the medication cart labeled with Resident #1's name, Lantus Injection 10 milliliters, directions for use and "Date Opened" sticker with a hand written entry "3/5/16." -There was a vial of Lantus insulin inside the prescription bottle which was approximately 1/3 full and had a pharmacy sticker on it dated 2/29/16.</p>	C 330	<p>Signing MAR's @ the time meds are administered. Admon / SIC will will do a MAR Audit q week to assure that All documentation is being correct.</p>	

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 330	Continued From page 30  Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a hand written entry for Lantus 20 units SQ every morning, initialed as administered at 8am 3/5/16 through 3/31/16. -There was a hand written entry for Lantus 35 units SQ every night at bedtime, initialed as administered at 5pm 3/5/16 through 3/31/16.  Review of Resident #1's Blood Sugar Check sheet for March 2016 revealed: -There were 56 FSBS (finger stick blood sugar) results documented ranging from 114 - Hi. -A "Hi" reading on Resident #1's glucometer (device used to measure blood sugar levels) indicated a blood sugar level greater than 600, according to the manufacturer. -The following 11 FSBS results were greater than 400: "Hi" on 3/1/16 at 5pm, 505 on 3/2/16 at 5pm, 420 on 3/3/16 at 5pm, 510 on 3/5/16 at 5pm, 475 on 3/6/16 at 5pm, 496 on 3/8/16 at 5pm, "Hi" on 3/12/16 at 5pm, 422 on 3/14/16 at 5pm, 479 on 3/22/16 at 5pm, 470 on 3/23/16 at 5pm, 458 on 3/24/16 at 5pm and 462 on 3/25/16 at 5pm.  Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Lantus 20 units SQ every morning, initialed as administered 4/1/16 through 4/30/16 except 4/16/16 (no initials), 4/17/16 (circled initials) and 4/30/16 (no initials.) -There was a hand written entry on the back of the MAR dated 4/17/16 8am documenting "Rsd [resident] refused his insulin this morning. Rsd [resident] stated his blood sugar was not high but it was 191." -There was a preprinted entry for Lantus 35 units SQ at bedtime, initialed as administered 4/1/16	C 330	Admin / SEC will be responsible for watching med - Techs to do a med-pass to assure that meds are being given correctly and review diabetes logs and make sure Insulin is being	
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Division of Health Service Regulation

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C 330	<p>Continued From page 31</p> <p>through 4/30/16 except the following dates which had no initials entered: 4/4/16, 4/13/16, 4/14/16, 4/15/16, 4/29/16 and 4/30/16.</p> <p>Review of Resident #1's Blood Sugar Check sheet for April 2016 revealed: -There were 54 FSBS results documented ranging from 105 - 445. -There was only 1 FSBS result documented greater than 400. -On 4/19/16 at 5pm the FSBS was documented as 445.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -There was a preprinted entry for Lantus 20 units SQ every morning, initialed as administered from 5/1/16 through 5/12/16. -There was a preprinted entry for Lantus 35 units SQ at bedtime, initialed as administered from 5/1/16 through 5/10/16. -There were no initials entered on 5/11/16 for the bedtime (5pm) dose of Lantus.</p> <p>Review of Resident #1's May 2016 Blood Sugar Check sheet on 5/12/16 revealed: -There were 19 FSBS results documented ranging from 134 - 510. -The following 2 FSBS were greater than 400: 510 on 5/6/16 at "supper" and 457 on 5/8/16 in the "am."</p> <p>Interview with a Medication Aide (MA) on 5/12/16 at 1:53pm revealed: -The MA's initials were documented on Resident #1's March, April and May 2016 MARs as administering Lantus in the morning and evening. -Lantus was given as ordered. -There was no explanation for how 1 vial lasted more than 2 months.</p>	C 330	<p>Given AS orders.</p> <p><i>June 26, 2016</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 330	Continued From page 32  Interview with a second MA on 5/12/16 at 2:29pm revealed: -The MA's initials were documented on Resident #1's March, April and May 2016 MARs as administering Lantus in the morning and evening. -Resident #1 received 20 units of Lantus in the morning and 35 units at night. -Resident #1 was the only one receiving any type of insulin in the building.  Telephone interview with the pharmacist on 5/12/16 at 1:19pm revealed: -The 10mL Lantus vial contained 1000 units which would last Resident #1 approximately 20 days receiving 20 units every morning and 35 units every evening. -Pharmacy dispensed 1 vial of Lantus for Resident #1 on 2/29/16 and on 5/12/16.  B. Review of subsequent orders revealed: -There was a physician order dated 2/29/16 for Humalog SSI (sliding scale insulin): For FSBS (finger stick blood sugar) 200 - 250 give 2 units SQ (subcutaneous); FSBS 251 - 300 give 4 units SQ; FSBS 301 - 350 give 6 units SQ and FSBS 351 - 400 give 8 units SQ  Review of pharmacy dispensing records dated 12/15/15 revealed directions to check FSBS twice daily with the Humalog SSI.  Observation on 5/11/16 at 4:00pm revealed: -There was a prescription bottle on top of the medication cart labeled with Resident #1's name, Humalog Injection 10 mLs, directions for use and "Date Opened" sticker with hand written entry "3/5/16." -There was a vial of Humalog insulin inside the prescription bottle which was approximately 1/3	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 330	<p>Continued From page 33</p> <p>full and had a pharmacy sticker on it dated 2/29/16.</p> <p>Review of Resident #1's Blood Sugar Check sheet for March 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There were 56 FSBS results documented ranging from 114 - Hi. (A "Hi" reading on Resident #1's glucometer (device used to measure blood sugar levels) indicated a blood sugar level greater than 600, according to the manufacturer.)</li> <li>-There were 41 FSBS results greater than 200 requiring SSI coverage, for example: 354 on 3/2/16 at 7am, 294 on 3/3/16 at 7am, 280 on 3/4/16 at 7am, 330 on 3/10/16 at 5pm and 238 on 3/18/16 at 5pm.</li> </ul> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed:</p> <ul style="list-style-type: none"> <li>-There was a hand written entry for Humalog insulin/check FSBS twice a day with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units at 8am and 5pm.</li> <li>-There were entries that did not include FSBS result, amount of Humalog insulin given, and Medication Aide initials, for example: on 3/2/16 at 8am there were no initials or FSBS result documented; on 3/5/16 at 8am there was an 8 and 2 sets of initials and on 3/9/16 at 5pm there were only initials entered.</li> <li>-There was no documentation of SSI being administered for FSBS results documented as 354 on 3/2/16 at 7am, 294 on 3/3/16 at 7am, 280 on 3/4/16 at 7am and 330 on 3/10/16 at 5pm.</li> <li>-There was 8 units of SSI documented as administered for FSBS of 238 on 3/18/16 at 5pm.</li> </ul> <p>Review of Resident #1's Blood Sugar Check sheet for April 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There were 54 FSBS results documented</li> </ul>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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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 330	<p>Continued From page 34</p> <p>ranging from 105 - 446.</p> <p>-There were 33 FSBS results greater than 200 requiring SSI coverage, for example: 376 on 4/2/16 at 5pm, 209 on 4/9/16 at 5pm, 300 on 4/13/16 at 5pm, 322 on 4/22/16 at 6am and 254 on 4/31/16 at 6am.</p> <p>Review of Resident #1's April 2016 MAR revealed:</p> <p>-There was a preprinted entry for Humalog injection Check FSBS twice a day with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units at 8am and 7pm.</p> <p>-There was a hand written entry just below the preprinted entry for over 400 give 10u [units], over 450 give 12u [units] and contact MD.</p> <p>-There was no documentation of SSI being administered for 3 FSBS results: 376 on 4/2/16 at 5pm, 209 on 4/9/16 at 5pm and FSBS of 254 on 4/31/16 at 6am.</p> <p>-There 6 units of SSI documented as administered for FSBS of 300 on 4/13/16 at 5pm.</p> <p>Review of Resident #1's May 2016 Blood Sugar Check sheet on 5/12/16 revealed:</p> <p>-There were 19 FSBS results documented ranging from 134 - 510.</p> <p>-There were 10 FSBS results greater than 200 requiring SSI coverage, for example: 333 on 5/4/16 at "supper" and 510 on 5/6/16 at "supper."</p> <p>-On 5/1/16 at "supper" and 5/2/16 "am" there were no FSBS results documented.</p> <p>Observation on 5/11/16 at 4:35pm revealed:</p> <p>-There was a glucometer in a container labeled with Resident #1's name.</p> <p>-The glucometer contained FSBS results identical to those recorded on Resident #1's Blood Sugar Sheet.</p> <p>-On 5/1/16 at 5:39pm the FSBS was 390.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 330	<p>Continued From page 35</p> <p>-On 5/2/16 at 7:24am the FSBS was 234.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed:</p> <ul style="list-style-type: none"> <li>-There was a preprinted entry for Humalog injection Check FSBS twice a day with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units at 8am and 7pm.</li> <li>-There was a hand written entry just below the preprinted entry for over 400 give 10u [units], over 450 give 12u [units] and contact MD.</li> <li>-There was no documentation of SSI being administered for 5/1/16 at 7pm or 5/2/16 at 7am where Resident #1's glucometer showed FSBS results of 390 and 234 respectively.</li> <li>-There was a dark ink circle for 5/4/16 at 7pm; therefore unable to determine the amount of SSI given.</li> <li>-For FSBS 510 on 5/6/16 at 7pm, 16u [units] was documented as given.</li> </ul> <p>Interview with Resident #1 on 5/12/16 at 9:35am revealed:</p> <ul style="list-style-type: none"> <li>-He received "sometimes 2 shots a day" for his sugar depending on if it was "high or not."</li> <li>-When asked if he received a shot in the morning and a shot in the evening no matter what for his blood sugar, he replied, "It depends on if it's high or not."</li> </ul> <p>Interview with a MA (medication aide) on 5/12/16 at 1:53pm revealed:</p> <ul style="list-style-type: none"> <li>-Live-in staff were responsible for checking the resident's FSBS levels.</li> <li>-MAs were responsible for administering SSI as needed.</li> <li>-The MA would ask the live-in what the FSBS was and administer SSI as ordered.</li> <li>-The MA reported while reviewing Resident #1's MAR, "I know what it looks like and it's hard to tell</li> </ul>	C 330		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1688 CANAL ROAD PEMBROKE, NC 28372
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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 330	<p>Continued From page 36</p> <p>but I gave him his insulin. I gave what was on the med cart."</p> <p>Record review for Resident #1 revealed: -Laboratory results for a hemoglobin A1C level dated 2/2/16. (Hemoglobin A1C is a blood test that reflects an 8 to 12 week average of blood sugar levels.) -Resident #1's hemoglobin A1c result was 8.8. (The American Diabetes Association recommends a hemoglobin A1C level of 7 for people with diabetes mellitus.)</p> <p>C. Further review of Resident #1's current FL-2 date 11/11/15 revealed an order for Vitamin D2 by mouth every Wednesday.</p> <p>Observation of medications on hand for Resident #1 on 5/11/16 at 4pm revealed there was no Vitamin D2 50,000 units on hand for Resident #1.</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a preprinted entry for Vitamin D2 capsule 50,000 units once weekly on Wednesdays at 7am. -The entry was initialed as given on 3/2/16, 3/9/16, 3/16/16, 3/23/16 and 3/30/16.</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Vitamin D2 capsule 50,000 units once weekly on Wednesdays at 7am. -The entry was initialed as given on 4/6/16, 4/13/16, 4/20/16 and 4/27/16.</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -There was a preprinted entry for Vitamin D2</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1998 CANAL ROAD PEMBROKE, NC 28372
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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 330	<p>Continued From page 37</p> <p>capsule 50,000 units by mouth once weekly on Wednesdays at 7am. -The entry was initialed as given on 5/1/16 through 5/11/16 with an "X" marked over each initial.</p> <p>Telephone interview with the pharmacist on 5/12/16 at 1:19pm revealed: -A 30 day supply (4 capsules) of Vitamin D was dispensed on 12/15/15, 1/7/16 and 5/11/16. -The Vitamin D was not on batch refill and refills needed to be requested from the facility staff.</p> <p>Interview with a MA (medication aide) on 5/12/16 at 2:29pm revealed: -When medications were once per week it was usually highlighted on the MAR which day it was due. -The May 2016 MAR was not highlighted "so it probably just got signed." -The MA could not speak to what had been administered in March and April with the dispensing information from the pharmacy.</p> <p>Interview with a MA on 5/11/16 at 10:48am revealed: -There were 3 MA's who worked 12 hour shifts, 7am - 7:30pm covering 7 FCH buildings. -For 3 days per week there were 2 MA's working together and for 4 days per week 1 MA worked alone to cover the 7 FCHs. -There was no MA on duty from 7:30pm - 7am. -Live in staff did not administer medications. -Medication aides were observed administering medications and insulin by the LHPS nurse (Licensed Health Professional Support.) -All medications were given according to how they were documented on the MAR.</p>	C 330		

Division of Health Service Regulation

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C 330	Continued From page 38  Telephone interview with the physician on 5/12/16 at 11:20am revealed: -The MA's needed "to be a little more careful but the do the best they can." -"I have nothing but good things to say about them."  Attempts to contact the Administrator in 5/11/16 were unsuccessful and the Administrator was not available for interview regarding Resident #1 on 5/12/16.  2. Review of Resident #3's current FL-2 dated 04/28/16 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, schizophrenia, bipolar disorder, and metabolic encephalopathy.  Review of the hospital admission records for Resident #3 dated 04/26/16 revealed: -The chief complaint on 04/26/16 was shortness of breath and chest pain. -"History of present illness: [Resident #3] was sent from assisted living facility for evaluation for chest pain and shortness of breath...Spoke to the nurse there. Said [Resident #3] has been coughing that's unproductive, there is no fever, and has been more shortness of breath and drooling ...Said yesterday had chest pain." -Resident #3 had a chest x-ray performed which was negative for pneumonia but revealed atelectasis. (Atelectasis is the collapse of the small air sacs in the lungs).  Review of the hospital discharge summary for Resident #3 dated 04/28/16 revealed: -Resident #3 was admitted to the hospital on 04/28/16 and discharged from the hospital on 04/28/16. -The admitting diagnosis was "acute bronchitis."	C 330		
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Division of Health Service Regulation

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C 330	<p>Continued From page 39</p> <p>(Bronchitis is the inflammation of membranes lining the passages of the airways from the nose or mouth to the lungs).</p> <p>Interview with a staff member during the initial facility tour on 05/11/16 revealed Resident #3 was not currently at the facility because he was sent to the hospital on 05/10/16 for shortness of breath and chest pain and was still in the hospital.</p> <p>A. Review of Resident #3's current FL-2 dated 04/28/16 revealed there was an order for Doxycycline 100mg every 12 hours. (Doxycycline is a medication used to treat a variety of bacterial infections).</p> <p>Review of the hospital discharge summary for Resident #3 dated 04/28/16 revealed there was an order for Doxycycline 100mg every 12 hours with "prescription created" documented beside the order.</p> <p>Review of the hospital prescriptions dated 04/28/16 for Resident #3 revealed there was a prescription for Doxycycline 100mg. every 12 hours; "dispense 14 (fourteen)."</p> <p>Review of Resident #3's April 2016 Medication Administration Records (MARs) revealed: -There was a handwritten entry for Doxycycline 100mg " 1 by mouth every day for 7 days. -Doxycycline was documented as being administered to Resident #3 once daily at 08:00am on 04/29/16 and 04/30/16.</p> <p>Interview with Staff C, a Medication Aide (MA), on 05/12/16 at 2:00pm revealed: -Resident #3 should have received Doxycycline twice daily on 04/29/16 and 04/30/16 but only received Doxycycline one time on 04/29/16 and</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372		
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C 330	<p>Continued From page 40</p> <p>04/30/16. -It was "my error"; Staff C transcribed the Doxycycline order incorrectly to Resident #3's April 2016 MARs. -Resident #3's physician had not been notified of the error.</p> <p>Review of Resident #3's May 2016 MARs revealed: -There was a computer generated entry for Doxycycline 100mg "Take one capsule by mouth every 12 hours for 7 days" with administration times of 8:00am and 8:00pm. -Doxycycline was documented as being administered to Resident #3 at 08:00am and 8:00pm on 05/01/16, 05/03/16, and 05/05/16. -Doxycycline was not documented as being administered to Resident #3 on 05/02/16 and 05/04/16. -"Stop" was handwritten beside the Doxycycline entry on 05/06/16.</p> <p>Observation of the medication cart on 05/11/16 at 3:17pm revealed: -Resident #3 had one card of Doxycycline 100mg on hand. -There were 3 capsules of Doxycycline on the card. -The Doxycycline on hand had a dispense date of 04/28/16.</p> <p>Observation of the medication cart on 05/12/16 at 09:30am revealed there was no Doxycycline on the medication cart for Resident #3</p> <p>Interview with Staff B, a Medication Aide (MA), on 05/12/16 at 09:45am revealed: -Resident #3 did not have any Doxycycline on hand at that time (05/12/16) because Resident #3 took all of the ordered doses.</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 41</p> <ul style="list-style-type: none"> <li>-Upon review of Resident #3's May MARs, Staff B noticed Doxycycline was not documented as being administered to Resident #3 on 05/02/16 and 05/04/16.</li> <li>-Staff B should have signed/initialed the MARs when administering the Doxycycline to Resident #3 on 05/02/16 and 05/04/16 but Staff B did not sign the MARs.</li> <li>-Staff B did not know why he did not document administering Resident #3's Doxycycline on 05/02/16 and 05/04/16.</li> <li>-"That's on me."</li> <li>-The MAs were supposed to initial each residents' MARs after administration of their medications.</li> <li>-Staff B acknowledged the importance of accuracy of the MARs.</li> </ul> <p>Interview Staff C, a MA, on 05/12/16 at 2:00pm revealed:</p> <ul style="list-style-type: none"> <li>-"Whoever worked" 05/02/16 and 05/04/16 "did not sign for giving" Resident #3 his Doxycycline.</li> <li>-If the MAR was not initialed "it basically wasn't done."</li> <li>-Staff C denied knowledge of Doxycycline being on the medication cart for Resident #3 on 05/11/16.</li> <li>-Resident #3 "got the Doxycycline"; Staff C was on duty on 05/05/16 and recalled administering the last dose of Doxycycline to Resident #3 that day.</li> <li>-"He got it all."</li> </ul> <p>Review of the pharmacy dispensing records revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy dispensed a seven day supply (a total quantity of fourteen capsules) Doxycycline 100mg for Resident #3 on 04/28/16.</li> <li>-There was no record of additional Doxycycline dispensed for Resident #3.</li> </ul>	C 330		

Division of Health Service Regulation

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C 330	Continued From page 42  Refer to the interview with Staff C on 05/11/16 at 1:29pm.  Refer to the interview with the Office Manager (OM) on 05/11/16 at 10:13am.  Refer to the interview with the OM on 05/11/16 at 2:22pm.  Refer to the telephone interview with the Physician Assistant (PA) on 05/11/16 at 2:00pm.  Refer to the telephone interview with the PA on 05/12/16 at 11:24am.  Refer to the telephone interview with Resident #3's Primary Care Physician (PCP) on 05/12/16 at 11:10am.  Refer to the telephone interview with the Administrator on 05/12/16 at 3:33pm.  B. Review of Resident #3's current FL-2 dated 04/28/16 revealed there was an order for Prednisone 20mg daily. (Prednisone is a medication used to treat conditions such as allergies and breathing problems).  Review of the hospital discharge summary for Resident #3 dated 04/28/16 revealed there was an order for Prednisone 20mg. daily with "prescription created" documented beside the order.  Review of the hospital prescriptions dated 04/28/16 for Resident #3 revealed there was a prescription for Prednisone 20mg daily; "dispense 5 (five)."  Review of Resident #3's April 2016 MARs	C 330		

Division of Health Service Regulation

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C 330	Continued From page 43  revealed: -There was a handwritten entry for Prednisone 20mg every day for 5 days. -Prednisone was documented as being administered to Resident #3 once daily at 08:00am on 04/29/16 and 04/30/16.  Review of Resident #3's May 2016 MARs revealed: -There was a computer generated entry for Prednisone 20mg "Take one tablet by mouth every day for 5 days." -Prednisone was documented as being administered on 05/01/16 at 08:00am. -There were no other dates that Prednisone was documented as being administered.  Review of the pharmacy dispensing records revealed the pharmacy dispensed a five day supply (total quantity of 5 tablets) of Prednisone 20mg for Resident #3 on 04/28/16.  Observation of the medication cart on 05/11/16 at 3:17pm revealed there was no Prednisone stocked on the medication cart for Resident #3.  Interview Staff C on 05/12/16 at 2:00pm revealed: -Resident #3 received all ordered doses of Prednisone. -Staff C recalled administering the last dose of Prednisone to Resident #3 on 05/05/16. -If Resident #3's MAR was not initialed "it basically wasn't done."  Refer to the interview with Staff C on 05/11/16 at 1:29pm  Refer to the interview with the OM on 05/11/16 at 10:13am.	C 330		

Division of Health Service Regulation

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C 330	Continued From page 44  Refer to the interview with the OM on 05/11/16 at 2:22pm.  Refer to the telephone interview with the PA on 05/11/16 at 2:00pm.  Refer to the telephone interview PA on 05/12/16 at 11:24am.  Refer to the telephone interview with Resident #3's PCP on 05/12/16 at 11:10am.  Refer to the telephone interview with the Administrator on 05/12/16 at 3:33pm.  C. Review of Resident #3's physician orders dated 02/02/16 revealed there was an order for Acetaminophen 325mg. three times daily. (Acetaminophen is an over the counter medication used to treat minor aches and pains).  Review of the hospital discharge instructions for Resident #3 dated 04/28/16 revealed there was an order to discontinue Acetaminophen 325mg three times daily.  Review of Resident #3's May 2016 MARs revealed: -There was a handwritten entry for "Tylenol 325mg." (Acetaminophen is generic Tylenol) three times daily at 8:00am, 1:00pm, and 7:00pm. -Acetaminophen was documented as being administered to Resident #3 three times daily on 05/01/16 and 05/03/16-05/09/16.  Observation of the medication cart on 05/11/16 at 3:20pm revealed there were 2 cards of MPAP (MPAP is generic Tylenol/Acetaminophen) on hand for Resident #3.	C 330		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372		
(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 45</p> <p>Telephone interview with a Pharmacist at the facility's contracted pharmacy on 05/11/16 at 3:55 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3's Acetaminophen order was discontinued 04/28/16.</li> <li>-Monthly MARs were "usually" printed on the first day of every month.</li> <li>-The facility was responsible for checking MARs for accuracy.</li> <li>-The facility was supposed to "cross off" discontinued orders from the MARs.</li> <li>-The May 2016 MAR generated by the pharmacy for Resident #3 did not contain an entry for Acetaminophen because the order was discontinued on 04/28/16.</li> </ul> <p>Interview with Staff C on 05/12/16 at 10:45am revealed:</p> <ul style="list-style-type: none"> <li>-Staff C recalled transcribing a handwritten entry for "Tylenol" on Resident #3's May 2016 MARs.</li> <li>-When Staff C compared Resident #3's April 2016 and May 2016 MARs, she noticed Acetaminophen was not on the May 2016 MAR so Staff C handwrote the entry on the May 2016 MARs.</li> <li>-Staff C did not check the physician orders in Resident #3's record before making the entry on Resident #3's May 2016 MARs.</li> <li>-"That was my error."</li> <li>-Staff C would contact the PA that day (05/12/16) to clarify the Acetaminophen order.</li> </ul> <p>Refer to the interview with Staff C on 05/11/16 at 1:29pm.</p> <p>Refer to the interview with the OM on 05/11/16 at 10:13am.</p> <p>Refer to the interview with the OM on 05/11/16 at 2:22pm.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 330	Continued From page 46  Refer to the telephone interview with the Physician Assistant (PA) on 05/11/16 at 2:00pm.  Refer to the telephone interview PA on 05/12/16 at 11:24am.  Refer to the telephone interview with Resident #3's PCP on 05/12/16 at 11:10am.  Refer to the telephone interview with the Administrator on 05/12/16 at 3:33pm.  Interview with Staff C on 05/11/16 at 1:29pm revealed: -The MAs were responsible for assuring provider orders were implemented. -When a resident was discharged from the hospital, the MAs were supposed to "read over" the hospital discharge instructions to check the physician's discharge orders for follow up appointments and new medication orders. -The MAs were responsible for faxing provider orders to the pharmacy, transcribing the orders to the MARs, and scheduling follow up appointments for all residents.  Interview with the Office Manager (OM) on 05/11/16 at 10:13am revealed the MAs were expected to initial the MARs after administering medications as documentation the medication was given.  Interview with the OM on 05/11/16 at 2:22pm revealed: -The MAs were responsible for implementing provider orders. -The MAs were expected to review and implement all hospital discharge orders. -The MAs were supposed to fax provider orders	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 330	<p>Continued From page 47</p> <p>to the pharmacy, write the orders on the MARs, and make follow up appointments for residents as needed.</p> <p>Telephone interview with the Physician Assistant (PA) on 05/11/16 at 2:00pm revealed:                      -The PA was unaware Resident #3 was hospitalized from 04/26/16-04/28/16.                      -The facility had not notified the PA of Resident #3's hospitalization from 04/26/16-04/28/16 and current hospitalization beginning 05/10/16.                      -The PA had not evaluated Resident #3 after Resident #3's hospital discharge on 04/28/16.</p> <p>Telephone interview with the PA on 05/12/16 at 11:24am revealed:                      -The hospital provided prescriptions for medications ordered by the hospital provider at the time of discharge.                      -The PA expected the hospital discharge orders and prescription orders to be implemented as written, "especially antibiotics."                      -The PA was unaware Resident #3 had orders for Doxycycline and Prednisone.                      -The PA did not know why the facility would skip doses of antibiotics.                      -The PA had noticed the facility had a change in MA staff over the last three months.                      -The PA had not been notified by the facility of any medication errors for Resident #3.                      -The PA expected to be notified of medication errors.</p> <p>Telephone interview with Resident #3's Primary Care Physician (PCP) on 05/12/16 at 11:10am revealed:                      -The PCP expected all hospital discharge orders to be implemented to prevent any delay in care.                      -The PCP did not recall being notified by the facility of any medication errors for Resident #3.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 330	Continued From page 48 -Resident #3 should have received Doxycycline and Prednisone for the total treatment time, per the hospital discharge orders. -There was a possibility that Resident #3's condition could have deteriorated if he did not get the Doxycycline and Prednisone as ordered. -The PCP was not aware Resident #3 was currently hospitalized for the same complaints he was hospitalized for from 04/26/16-04/28/16.  Telephone interview with the Administrator on 05/12/16 at 3:33pm revealed the MAs were responsible for assuring medications were administered per provider orders and the documentation was correct on the MARs.  Review of the Plan of Protection submitted 05/12/16 revealed: -The OM would contact the contracted pharmacy provider no later than 05/16/16 to schedule an audit of the medication cart and observe a medication pass to be conducted as soon as possible. -All MA staff would be re-trained beginning 05/16/16 by a Registered Nurse (RN). -Weekly staff meetings will be conducted starting 05/25/16 with the OM, MAs, and Administrator in attendance.  THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 06/11/16.	C 330		
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C 341	10A NCAC 13G .1004 (i) Medication Administration  10A NCAC 13G .1004 Medication Administration  (i) The recording of the administration on the medication administration record shall be by the	C 341	Admin / SIC will have meeting w med-techs (staff)	
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FGL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 341	<p>Continued From page 49</p> <p>staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, record reviews, and interviews, the facility failed to implement safe procedures for medication administration for 1 of 4 residents sampled (#4) as evidenced by staff pouring and leaving medications unsupervised to be taken at a later time and without observing the resident take the medications.</p> <p>The findings are:</p> <p>Observation during the initial facility tour in Room #2 on 05/11/16 at 09:58am revealed: -There was a resident (Resident #4) laying in the bed in prone position. -Resident #4 was asleep. -There was a disposable medication cup on Resident #4's bedside table which contained five pills.</p> <p>Review of Resident #4's current FL-2 dated 04/04/16 revealed: -Diagnoses included schizophrenia and intellectual functioning disability. -There were physician orders including: Benzotropine 1 mg. twice daily (Benzotropine is a medication used to treat Parkinson's Disease and involuntary muscle movements due to side effects of certain antipsychotic drugs);</p>	C 341	<p>to make sure that they are watching there pts swallow there meds and MAR will only be signed after the med - Techs watch them take the <del>meds</del> meds.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 341	<p>Continued From page 50</p> <p>Propranolol 20mg. twice daily (Propranolol is a medication used to treat high blood pressure, tremors, and other conditions); Lisinopril 5mg. daily (Lisinopril is a medication used to treat high blood pressure); Gabapentin 300mg. three times daily (Gabapentin is a medication used to control and prevent seizures and treat nerve pain); Depakote 500mg. three times daily (Depakote is a medication used to treat seizures and certain psychiatric conditions); and Invega ER 6 mg. every morning (Invega is an antipsychotic medication used to treat schizophrenia).</p> <p>Review of the physician orders dated 05/01/16 revealed there was an order to increase Resident #4's Invega dose to 12mg. every morning.</p> <p>Observation of Resident #4 on 05/11/16 at 1:45 pm revealed: -Resident #4 was in his room sitting upright on his bed. -Resident #4 was dressed in a white t-shirt and tan pants. -The cup with five pills observed on the bedside table earlier that morning was no longer on the bedside table.</p> <p>Interview with Resident #4 on 05/11/16 at 1:45 pm revealed: -Resident was alert and oriented. -Resident #4 woke up and found his morning medications "in a cup" on his bedside table (Resident #4 pointed to the bedside table). -Resident #4 took the medications that were in the cup when he woke up earlier in the day (05/11/16). -Resident #4 was not sure what time he awakened and took the medications that morning (05/11/16). -Resident #4 was not sure what medications he</p>	C 341	<p>Admin / SIC will meet w med-techs to assure that no meds are being left w pts to take @ a later time, or no meds left on bed side tables.</p>	

Division of Health Service Regulation

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C 341	<p>Continued From page 51</p> <p>was prescribed or what medications were in the cup.</p> <p>-Staff B had left Resident #4's medications in a cup on his (Resident #4's) bedside table a "couple times."</p> <p>-Resident #4 was unsure of the last time his medications were left on the bedside table prior to that day (05/11/16), but it was "not often" that Staff B left his medications on the bedside table.</p> <p>Review of Resident #4's May 2016 Medication Administration Records (MARs) revealed:</p> <p>-Resident #4 had a total of 6 medications scheduled for administration every morning.</p> <p>-There was a computer generated entry for Invega ER 6mg. Take 2 tablets every morning at 08:00am.</p> <p>-Invega was documented as being administered to Resident #4 on 05/11/16 at 8:00am.</p> <p>-There was a computer generated entry for Lisinopril 5mg. once daily with an administration time of 07:00am.</p> <p>-Lisinopril was documented as administered to Resident #4 on 05/11/16 at 07:00am.</p> <p>-There was a computer generated entry for Benztropine 1mg. Take one tablet twice daily with administration times of 07:00am and 7:00pm.</p> <p>-Benztropine was documented as administered to Resident #4 on 05/11/16 at 07:00am.</p> <p>-There was a computer generated entry for Propranolol 20mg. one tablet twice daily at 7:00am and 7:00pm.</p> <p>-Propranolol was documented as administered to Resident #4 on 05/11/16 at 07:00am.</p> <p>-There was a computer generated entry for Divalproex DR (generic Depakote) 500mg. three times daily with administration times of 07:00am, 1:00pm, and 7:00pm.</p> <p>-Divalproex was documented as administered to Resident #4 on 05/11/16 at 07:00am.</p>	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 341	<p>Continued From page 52</p> <ul style="list-style-type: none"> <li>-There was a computer generated entry for Gabapentin 300mg. three times daily at 07:00am, 1:00pm, and 7:00pm.</li> <li>-Gabapentin was documented as administered to Resident #4 at 07:00am.</li> </ul> <p>Interview with Staff B, a Medication Aide, on 05/11/16 at 3:05pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 came to the medication room that morning (05/11/16) for his 08:00am medications.</li> <li>-Staff B observed Resident #4 put the medications in his mouth and provided Resident #4 with a cup of water.</li> <li>-When Staff B went to Resident #4's room to administer Resident#4's 12:00pm medications on 05/11/16, Staff B "noticed 3 or 4 pills" in a cup on Resident #4's bedside table.</li> <li>-Staff B asked Resident #4 about the pills; "he (Resident #4) would not tell me anything."</li> <li>-Staff B threw the pills in the trash can in the medication room.</li> <li>-Today (05/11/16) was the first time Staff B had noticed any problems with Resident #4 not taking his medications.</li> <li>-Staff B had documented administering Resident #4's 8:00am/morning medications on the MARs because Staff B thought Resident #4 took the medications.</li> <li>-Staff B did not document the pills that were thrown in the trash can as not administered on Resident #4's MARs.</li> <li>-Staff B poured each resident's medication by reading the resident's MAR, administered the medication to the resident, and initialed the MAR after the resident took the medication.</li> <li>-Staff B usually visualized each resident take their medications</li> <li>-Staff B did not pour and leave medications unattended for residents to take later.</li> </ul>	C 341		

Division of Health Service Regulation

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C 341	<p>Continued From page 53</p> <p>Confidential interview with a resident revealed: -There was one day during the week beginning 05/08/16 when "[Staff B's name] told me my medicine was in my room." -The resident went to his room and took the medication. -Staff B did not watch the resident take the medication.</p> <p>Confidential interview with a second resident revealed: -"Sometimes" the MA put his medications on his "nightstand in a cup." -The resident took the medications later. -The resident was unsure of the last time a MA left his medications on his nightstand.</p> <p>Interview with a second MA on 05/11/16 at 1:29pm revealed: -MA staff were supposed to use each resident's MAR to pull the medications and "pop" the medication into the medication cup, administer the medications to the correct resident with a cup of water, watch to make sure the resident took the medications, and initial the resident's MAR that the medications were given after the resident took the medications. -The MA thought the facility had a policy on Medication Administration; the MA would ask the Office Manager for the policy.</p> <p>Review of the "Med-Tech Job Description and Rules and Guidelines to Follow for Administration of Medicine" policy revealed: - "Welfare of the client is a priority, distribution of medicine is very important, should be done timely, accurately, courteously, ..." -"Employee is responsible for accuracy of paperwork ... Documentation of prescribed medicine, dosage and time should also be</p>	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 341	<p>Continued From page 54</p> <p>initialed."</p> <p>- "Do not administer medication you have not poured yourself ..."</p> <p>- The policy does not include information on the observation of each resident taking prescribed medications.</p> <p>Interview with the Office Manager (OM) on 05/11/16 at 2:22pm revealed:</p> <p>- MAs were responsible for assuring medications were administered according to the facility policy and physician orders.</p> <p>- Medications were not supposed to be poured and left for any resident.</p> <p>- The MAs were supposed to notify the OM of any problems related to medication administration.</p> <p>Telephone interview with the Administrator on 05/12/16 at 3:33pm revealed:</p> <p>- The Administrator had no knowledge of any instances when residents' medications were poured and left unattended to be taken later.</p> <p>- Medications should not be poured and left unattended because it was a safety concern.</p> <p>- The Administrator would "follow up" to assure medications were not being poured and left unattended for residents to take later.</p> <p>- The MAs had been trained and knew the facility expectations on safe medication administration.</p> <hr/> <p>Review of the Plan of Protection dated 05/11/16 revealed:</p> <p>- Medications would not to be poured and left unattended.</p> <p>- MAs would observe each resident take their medications.</p> <p>- The OM would review the facility's policy and procedures for medication administration with all</p>	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 341	Continued From page 55  MAs beginning 05/12/16, -All MAs would be re-trained on safe medication administration procedures. -The OM would contact the contracted Registered Nurse on 05/12/16 to schedule MA re-training .  THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 06/26/16.	C 341		
C 346	10A NCAC 13G .1004(n) Medication Administration  10A NCAC 13G .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.  This Rule is not met as evidenced by: TYPE B VIOLATION  Based on observations, interviews and record reviews, the facility failed to assure infection control procedures were maintained for the safe administration of Lantus and Humalog insulins by allowing the administration of unrefrigerated insulins past 60 days for 1 of 1 resident sampled (#1) receiving insulin.  The findings are:  Review of Resident #1's current FL-2 dated 11/11/15 revealed diagnoses including Schizophrenia, Personality Disorder, Diabetes Mellitus and Hypertension.  a. Review of a subsequent physician order dated	C 346	Admin/SEC plan to contact <sup>Nurse</sup> Admin to have them to come out and do a Insurer class $\bar{c}$ med-Tests on infection control  →	

Division of Health Service Regulation

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C 346	<p>Continued From page 58</p> <p>2/29/16 revealed an order for Lantus insulin 20 units SQ (subcutaneous) injection every morning and 35 units SQ every night at bedtime. (Lantus is a long acting insulin that works to lower blood sugar levels.)</p> <p>Observation on 5/11/16 at 4:00pm revealed: -There was a prescription bottle on top of the medication cart labeled with Resident #1's name, Lantus Injection 10 milliliters, directions for use, discard 28 days after opening and "Date Opened" sticker with hand written entry "3/5/16." -There was a vial of Lantus Insulin inside the prescription bottle which was approximately 1/3 full and had a pharmacy sticker on it dated 2/29/16. -There was no medication refrigerator in the medication room of the facility.</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed: -A hand written entry for Lantus 20 units SQ every morning initialed as administered at 8am 3/5/16 through 3/31/16. -A hand written entry for Lantus 35 units SQ every night at bedtime initialed as administered at 5pm 3/5/16 through 3/31/16.</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Lantus 20 units SQ every morning initialed as administered 4/1/16 through 4/30/16 except 4/16/16 (no initials), 4/17/16 (circled initials) and 4/30/16 (no initials). -There was a preprinted entry for Lantus 35 units SQ at bedtime, discard 28 days after opening initialed as administered 4/1/16 through 4/30/16 except on 4/4/16, 4/13/16, 4/14/16, 4/15/16, 4/29/16 and 4/30/16 which had no initials entered.</p>	C 346	<p>Admin / SFC will be responsible for making rounds to each facility -</p> <p>check all med rooms to assure Insulin are up to date and being order as <del>less</del> necessary.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DJAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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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
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C 346	Continued From page 57  Review of Resident #1's May 2016 MAR on 5/12/16 revealed: -There was a preprinted entry for Lantus 20 units SQ every morning initialed as administered 5/1/16 through 5/12/16. -There was a preprinted entry for Lantus 35 units SQ at bedtime, discard 28 days after opening initialed as administered 5/1/16 through 5/10/16. -There were no initials entered on 5/11/16 for the bedtime (5pm) dose of Lantus.  Interview with a medication aide (MA) on 5/12/16 at 1:53pm revealed: -MA's initials were documented on Resident #1's March, April and May 2016 MARs as administering Lantus in the morning and evening. -Lantus was given as ordered. -There was no explanation for how 1 vial lasted more than 2 months. -The MA gave the Lantus that was on the medication cart without looking at the date on the vial. -Insulins were kept on the medication cart.  Interview with a second MA on 5/12/16 at 2:29pm revealed: -The MA's initials were documented on Resident #1's March, April and May 2016 MARs as administering Lantus in the morning and evening. -The MA did not "pay no attention" to the date on the Lantus vial. -Resident #1 gets 20 units of Lantus in the morning and 35 units at night. -He was the only one receiving any type of insulin in the building.  Telephone interview with the pharmacist on 5/12/16 at 1:19pm revealed: -The 10 milliliter Lantus vial contained 1000 units	C 346		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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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 346	<p>Continued From page 58</p> <p>which would last Resident #1 approximately 20 days receiving 20 units every morning and 35 units every evening. -Pharmacy dispensed 1 vial of Lantus for Resident #1 on 2/29/16 and on 5/12/16.</p> <p>b. Review of a subsequent physician order dated 2/29/16 revealed a physician order for the following Humalog SSI (sliding scale insulin): for FSBS (finger stick blood sugar) 200 - 250 give 2 units SQ (subcutaneous); FSBS 251 - 300 give 4 units SQ; FSBS 301 - 350 give 6 units SQ and FSBS 351 - 400 give 8 units SQ.</p> <p>Review of pharmacy dispensing records revealed directions to check FSBS twice daily with the Humalog SSI.</p> <p>Observation on 5/11/16 at 4:00pm revealed: -There was a prescription bottle on top of the medication cart labeled with Resident #1's name, Humalog Injection 10 milliliters, directions for use, discard 28 days after opening and "Date Opened" sticker with hand written entry "3/5/16." -There was a vial of Humalog insulin inside the prescription bottle which was approximately 1/3 full and had a pharmacy sticker on it dated 2/29/16.</p> <p>Review of Resident #1's Blood Sugar Check sheet for March 2016 revealed: -There were 56 FSBS (finger stick blood sugar) results ranging from 114 - Hi, (A "Hi" on the glucometer (device used to measure blood sugar levels) usually indicate a blood sugar level greater than 600.) -There were 41 FSBS results greater than 200 requiring SSI coverage, for example: 354 on 3/2/16 at 7am, 294 on 3/3/16 at 7am, 280 on 3/4/16 at 7am, 330 on 3/10/16 at 5pm and 238 on</p>	C 346		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 346	<p>Continued From page 59</p> <p>3/18/16 at 5pm.</p> <p>Review of Resident #1's March 2016 MAR (medication administration record) revealed: -There was a hand written entry for Humalog insulin/check FSBS twice a day with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units at 8am and 5pm. -There was a total of 202 units of Humalog insulin documented as administered.</p> <p>Review of Resident #1's Blood Sugar Check sheet for April 2016 revealed: -There were 54 FSBS results ranging from 105 - 445. -There were 33 FSBS results greater than 200 requiring SSI coverage, for example: 376 on 4/2/16 at 5pm, 209 on 4/9/16 at 5pm, 300 on 4/13/16 at 5pm, 322 on 4/22/16 at 6am and 254 on 4/31/16 at 6am.</p> <p>Review of Resident #1's April 2016 MAR revealed: -There was a preprinted entry for Humalog injection. Check FSBS twice a day with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units at 8am and 7pm. -The preprinted entry included documentation to discard 28 days after opening. -There was a hand written entry just below the preprinted entry for over 400 give 10u [units], over 450 give 12u [units] and contact MD. -There was a total of 106 units of Humalog SSI documented as administered, with 98 units being given after 4/5/16.</p> <p>Review of Resident #1's May 2016 Blood Sugar Check sheet on 5/12/16 revealed: -There were 19 FSBS results ranging from 134 - 510.</p>	C 346		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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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 348	<p>Continued From page 60</p> <p>-There were 10 FSBS results greater than 200 requiring SSI coverage, for example: 333 on 5/4/16 at "supper" and 510 on 5/6/16 at "supper."</p> <p>Review of Resident #1's May 2016 MAR on 5/12/16 revealed:</p> <p>-A preprinted entry for Humalog injection Check FSBS twice a day with SSI 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units at 8am and 7pm.</p> <p>-The preprinted entry included documentation to discard 28 days after opening.</p> <p>-A hand written entry just below the preprinted entry for over 400 give 10u [units], over 450 give 12u [units] and contact MD.</p> <p>-There was a total of 66 units of Humalog SSI documented as administered 5/1/16 through 5/12/16.</p> <p>Interview on 5/12/16 at 9:35am with Resident #1 revealed:</p> <p>-He received "sometimes 2 shots a day" for his sugar depending on if it was "high or not."</p> <p>-When asked if he received a shot in the morning and a shot in the evening no matter what for his blood sugar, he replied, "It depends on if it's high or not."</p> <p>Interview with a MA on 5/12/16 at 1:53pm revealed:</p> <p>-Live-in staff were responsible for checking the resident's FSBS levels.</p> <p>-MAs were responsible for administering SSI as needed.</p> <p>-The MA would ask the live-in what the FSBS was and administer SSI as ordered.</p> <p>-The MA reported "I gave what was on the med cart. I didn't look at the date that was on the bottle."</p> <p>-Insulins were kept on the medication cart.</p>	C 348		June 26, 2016

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD PEMBROKE, NC 28372
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C 346	Continued From page 61  Telephone interview with the pharmacist on 5/12/16 at 1:19pm revealed: -Pharmacy dispensed 1 vial of Humalog for Resident #1 on 2/29/16 and on 5/12/16. -Discard recommendations were from concern for decreased potency and risk of bacterial growth/contamination.  Telephone interview with the physician on 5/12/16 at 11:20am revealed: -The MA's needed "to be a little more careful but the do the best they can." -"I have nothing but good things to say about them."  Attempts to contact the Administrator in 5/11/16 were unsuccessful and the Administrator was not available for interview regarding Resident #1 on 5/12/16.  Review of the Plan of Protection dated 05/12/16 revealed: -The MAs would not administer expired medications. -The Office Manager would contact the facility's contracted pharmacy no later than 05/16/16 to conduct an audit of the medication carts and observe a medication pass as soon as possible. -MAs would be retrained on safety and infection control related to medication administration beginning 05/16/16 by a Registered Nurse.  CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED 06/26/16.	C 346		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 1898 CANAL ROAD PEMBROKE, NC 28372
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C 912	<p>Continued From page 62</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 relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration, health care, management of the facility, and staff qualifications.</p> <p>The findings are:</p> <p>1. Based on record reviews, and interviews, the facility failed to assure physician notification for 3 of 3 residents sampled (#1, #2, #3) as evidenced by failure to notify the primary care physician (PCP) of elevated blood sugars for one diabetic resident (#1), failure to notify the PCP of orders received for a resident (#3) upon discharge from the hospital on two occasions for 1 week and 2 week follow up appointments with the PCP, and failure to notify the PCP for referral to an orthopedic physician for a resident with knee pain (#2). [Refer to Tag D246, 10A NCAC 13G .0902(b) Health Care (Type B Violation)].</p> <p>2. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by the prescribing provider for 2 of 3 residents sampled (#1, #3) as related to failure to administer Lantus and Humalog insulins to a diabetic resident (#2) resulting in elevated finger stick blood sugars</p>	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 912	<p>Continued From page 63</p> <p>(FSBS), failure to administer Doxycycline and Prednisone per provider orders to a resident (#3) with diagnoses of chronic obstructive pulmonary disease (COPD) after hospitalization for shortness of breath and requiring additional hospital treatment for shortness of breath, and continuing to administer Tylenol to a resident (#3) after the order was discontinued. [Refer to Tag D330, 10A NCAC 13G .1004(a) Medication Administration (Type A2 Violation)].</p> <p>3. Based on observation, record reviews, and interviews, the facility failed to implement safe procedures for medication administration for 1 of 4 residents sampled (#4) as evidenced by staff pouring and leaving medications unsupervised to be taken at a later time and without observing the resident take the medications. [Refer to Tag D341, 10A NCAC 13G .1004(i) Medication Administration (Type B Violation)].</p> <p>4. Based on observations, interviews and record reviews, the facility failed to assure infection control procedures were maintained for the safe administration of Lantus and Humalog insulins by allowing the administration of unrefrigerated insulins past 60 days for 1 of 1 resident sampled (#1) receiving insulin. [Refer to Tag D346, 10A NCAC 13G .1004(n) Medication Administration (Type B Violation)].</p> <p>5. Based on personnel record reviews and interviews, the facility failed to assure a state-wide criminal background screening was completed for 2 of 3 staff sampled (A, C) upon hire in accordance with G.S. 131D-40. [Refer to Tag 147, 10A NCAC 13G .0406(a) (7) Other Staff Qualifications (Type B Violation)].</p> <p>6. Based on observations, interviews and record</p>	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C 912	Continued From page 64  reviews, the administrator failed to assure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to provide appropriate care and services as evidenced by the failure to maintain substantial compliance with the rules and statutes regarding medication administration, health care, and staff qualifications, which is the responsibility of the administrator. [Refer to Tag D186, 10A NCAC 13G .0601(a) Management and Other Staff (Type A2 Violation)].	C 912		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for  G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.  (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 96 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or	C992	Admin / Site responsible for re drug testing All employees that had Marijuana only. Facility has put in place a new	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C992	Continued From page 65  psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a complete screening and examination for the presence of controlled substances was performed for 2 of 3 staff sampled (A, C) hired after 10/01/13.  The findings are:  1. Review of Staff A's personnel record revealed Staff A was hired 11/03/15 as a Live-In Aide.  Review of the "Drug Screen Results Form" dated 11/04/15 and signed by the Office Manager (OM) revealed: -Staff A signed the Drug Screen Results Form to consent to the screening. -The Drug Screen Results form listed 14 different substances and had 3 columns with corresponding check boxes labeled "Negative", "Presumptive Positive", and "Not tested." -There was documentation that Staff A was only tested for one controlled substance: marijuana. -"Not tested" was checked in the boxes for cocaine, opiates/morphine, amphetamines, meth-amphetamines, phencyclidine, benzodiazepine, barbiturates, oxycodone, MDMA,	C992	drug test that tests for Amphetamines, Methamphetamine, Ecstasy, Marijuana, Cocaine, opiates.  Have already been put in place.	Sub 241 2016
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2016
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C992	<p>Continued From page 66</p> <p>propoxyphene, tricyclic antidepressants, and methadone</p> <p>Staff A was not available for interview on the afternoon of 05/11/16 or 05/12/16.</p> <p>Refer to the interview with the OM on 05/11/16 at 2:22pm.</p> <p>Refer to interview with the OM on 05/12/16 at 2:20pm.</p> <p>Refer to the telephone interview with the Administrator on 05/12/16 at 10:00am.</p> <p>2. Review of Staff C's personnel record revealed: -Staff C was previously employed at the facility from 10/16/14-08/03/15 as a Medication Aide/Supervisor in Charge (MA/SIC). -Staff C was re-hired a second time on 09/23/15 as a MA/SIC. -There was documentation Staff C had a controlled substance screening performed at an outside facility on 09/25/14 (prior to her first hire date).</p> <p>Review of the "Drug Screen Results Form" dated 09/25/15 and signed by the Office Manager (OM) revealed: -Staff C signed the Drug Screen Results Form to consent to the screening. -The Drug Screen Results form listed 14 different substances and had 3 columns with corresponding check boxes labeled "Negative", "Presumptive Positive", and "Not tested." -There was documentation that Staff C was only tested for one controlled substance: marijuana. -"Not tested" was checked in the boxes for cocaine, opiates/morphine, amphetamines, meth-amphetamines, phencyclidine.</p>	C992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FGL078077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/12/2016
NAME OF PROVIDER OR SUPPLIER  DIAL'S FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 1698 CANAL ROAD * PEMBROKE, NC 28372		
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C992	Continued From page 67  benzodiazepine, barbiturates, oxycodone, MDMA, propoxyphene, tricyclic antidepressants, and methadone  Interview with Staff C on 05/12/16 at 12:50pm revealed: -Staff C was sent to an outside urgent care facility to complete a controlled substance screening when she was hired at the facility the first time. -When Staff C was re-hired, a second drug screening was completed at the facility by the OM. -Staff C did not know what controlled substances she was screened for at either test.  Refer to the interview with the OM on 05/11/16 at 2:22pm.  Refer to interview with the OM on 05/12/16 at 2:20pm.  Refer to the telephone interview with the Administrator on 05/12/16 at 10:00am.  Interview with the OM on 05/11/16 at 2:22pm revealed: -The facility performed their own controlled substance screenings. -The OM was responsible for the controlled substance screenings. -The facility bought the drug testing kits at "Wal-Mart." -Some staff members had only been tested for marijuana.  Telephone interview with the Administrator on 05/12/16 at 10:00am revealed: -The OM was responsible for staff personnel records. -The facility purchased controlled substance test	C992		

Division of Health Service Regulation

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C992	Continued From page 68  kits and completed their own controlled substance screenings to save money. -For a short time, the facility used a controlled substance test kit that only tested for marijuana, which did not meet the rule requirements. -The facility used the kit that only tested for marijuana a couple of times. -The facility had started purchasing and using kits that tested for 12 drugs.  Interview with the OM on 05/12/16 at 2:20pm revealed a new controlled substance screening would be completed for Staff A and Staff C as soon as possible.	C992		