

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2016
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NAME OF PROVIDER OR SUPPLIER A GOOD LIFE FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4013 TRYON ROAD RALEIGH, NC 27606
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey on September 28 and 29, 2016.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 3 residents (#1, #3) sampled were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 03/15/2016 revealed diagnoses included dementia and hypertension. Review of Resident #1's Resident Register revealed an admission date of 05/01/2013. Review of Resident #1's record for documentation of tuberculosis skin testing revealed:	C 202		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 202	<p>Continued From page 1</p> <p>-There was documentation for a TB skin test placed on 03/20/2013 with documentation for a negative reading on 03/23/2013.</p> <p>-There was no further documentation for TB tests administered.</p> <p>Interview with the Administrator on 09/28/2016 at 1:25pm revealed:</p> <p>-She knew Resident #1 had a 2-step TB skin test performed.</p> <p>-She was not able to find the results of the TB skin test for Resident #1.</p> <p>-She had made a note to herself in July 2016 to pick up TB skin testing results for Resident #1 from the resident's physician, but had not done it yet.</p> <p>-She had been reminded in July 2016 by the county Adult Home Specialist that the 2-step TB skin testing results for Resident #1 was not in the record.</p> <p>A second interview with the Administrator on 09/28/2016 at 2:40pm revealed:</p> <p>-Resident #1 had a TB skin test done at an urgent care clinic and another one at the physician's office.</p> <p>-The dates of the TB skin test were "close together".</p> <p>-The Administrator knew she would eventually find the TB skin test results, so wasn't too concerned about it.</p> <p>Interview with the Administrator on 09/29/2016 at 12:15pm revealed:</p> <p>-She was unable to locate documentation for a second step TB skin test for Resident #1.</p> <p>-She thought she had thrown away the documentation for the second step TB skin test.</p> <p>-She had not contacted the physician about any TB skin test results for Resident #1.</p>	C 202		

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C 202	<p>Continued From page 2</p> <p>-She had asked the pharmacist to check with the physician about a record of TB skin tests for Resident #1 but had not heard back from the physician or pharmacist.</p> <p>-She was aware of the 2-step TB requirement.</p> <p>-She was responsible to ensure documentation of the 2-step TB skin testing was in the resident's record.</p> <p>Based on record review and observations of Resident #1 on 09/28/2016 and 09/29/2016, she was determined not to be interviewable.</p> <p>2. Review of Resident #3's current FL-2 dated 02/29/2016 revealed diagnoses included dementia, benign hypertension, hyperlipidemia, muscle weakness, and vitamin B12 deficiency.</p> <p>Review of Resident #3's Resident Register revealed an admission date of 03/01/2014.</p> <p>Review of Resident #3's record for documentation of tuberculosis skin testing revealed:</p> <p>-There was documentation for a TB skin test placed on 01/06/2014 with documentation for a negative reading on 01/08/2014.</p> <p>-There was no further documentation for TB tests administered.</p> <p>Interview with the Administrator on 09/29/2016 at 12:15pm revealed:</p> <p>-She was unable to locate documentation for a second step TB skin test for Resident #3.</p> <p>-She "honestly" believed she had thrown away the documentation for the second step TB skin test.</p> <p>-She had not contacted the physician about any TB skin test results for Resident #3.</p> <p>-She was aware of the 2-step TB requirement.</p>	C 202		

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C 202	Continued From page 3 -She was responsible to ensure documentation of the 2-step TB skin testing was in the resident's record. Based on record review and observations of Resident #3 on 09/28/2016 and 09/29/2016, she was determined not to be interviewable.	C 202		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure an appropriate licensed	C 254		

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C 254	<p>Continued From page 4</p> <p>health professional participated in the on-site review and evaluation of the resident's health status and care provided for 1 of 3 residents (Resident #2) sampled who required finger stick blood glucose testing and insulin injections.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 03/16/2016 revealed: -Diagnoses included dementia, peripheral artery disease, and insulin dependent diabetes mellitus. -A physician's order for finger stick blood sugar testing every morning and as needed. -A physician's order for Lantus (a long acting insulin used to control high blood sugars) 4 units every night. -A physician's order for Humalog (a fast acting insulin used to lower high blood sugars) sliding scale as needed.</p> <p>Review of the Resident Register for Resident #2 revealed the resident was admitted to the facility 05/01/2012.</p> <p>Review of Resident #2's record revealed: -There was documentation of a Licensed Health Professional Support (LHPS) evaluation dated 03/14/2015. -There was documentation of a LHPS evaluation dated 08/25/2016. -There was no documentation of quarterly LHPS evaluations between 03/14/2015 and 08/25/2016.</p> <p>Interview with the Administrator on 09/28/2016 at 10:50am revealed: -She performed fingerstick blood sugar testing for Resident #2 every morning. -She administered insulin to Resident #2 every night.</p>	C 254		

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C 254	<p>Continued From page 5</p> <p>Review of a Blood Sugar Monitor Record for Resident #2 revealed: -Resident #2's blood sugar had been checked daily from 7/31/2016 through 9/28/2016. -Resident #2's documented blood sugar readings ranged from 92 to 223 from 7/31/2016 through 9/28/2016. -There was documentation for administration of a Humalog Insulin injection on 08/01/2016, 08/12/2016, 08/27/2016, 08/29/2016, 09/06/2016, and 09/13/2016 according to the physician ordered sliding scale parameters. -There was documentation for administration of a Lantus Insulin injection daily at bedtime from 07/31/2016 to 09/28/2016.</p> <p>A second interview with the Administrator on 09/28/2016 at 2:30pm revealed: -The LHPS reviews should be in the resident record. -LHPS reviews were done quarterly by the provider pharmacy nurse. -She was responsible to contact the pharmacy provider to let them know when an LHPS review needed to be done. -The first LHPS review done by the pharmacy nurse was completed on 08/25/2016. -Prior to the current pharmacy provider nurse, another pharmacy's nurse was completing the LHPS reviews, but that pharmacy went out of business. -The facility "probably had missed 6 months getting LHPS. Was waiting on the Nurse Practitioner to come. Time just went by".</p> <p>Interview with the Administrator on 09/29/2016 at 12:10pm revealed: -She had documentation for LHPS reviews for the resident for 03/14/2015 and 08/25/16.</p>	C 254		

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C 254	<p>Continued From page 6</p> <ul style="list-style-type: none"> -The facility "may not have any" LHPS reviews for the time period from 03/14/2015 to 08/25/2016. -She was aware of the requirement for quarterly LHPS reviews. -There had been a time period where things had not been done at the facility for personal reasons and the LHPS reviews "went lacking" during that timeframe. -Her process was to call the pharmacy and the pharmacy would make arrangements with the nurse to have the LHPS reviews completed. <p>Telephone interview with a Pharmacy Provider Representative on 9/29/2016 at 2:00pm revealed:</p> <ul style="list-style-type: none"> -The pharmacy had been the pharmacy provider for about one year. -LHPS reviews were a part of the pharmacy contract. -The facility was responsible to contact the pharmacy provider when the facility needed the LHPS reviews completed. -She was aware LHPS reviews had recently been done at the facility but did not know about previous LHPS reviews. -She usually got a copy of the LHPS reviews that had been completed for the facility. <p>Interview with a second Pharmacy Provider Representative on 09/29/2016 at 2:45pm revealed:</p> <ul style="list-style-type: none"> -He thought LHPS reviews were done by the pharmacy nurse on 08/25/2016. -He was not sure if the LHPS nurse had done any other LHPS reviews. 	C 254		
C 284	<p>10A NCAC 13G .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food</p>	C 284		

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C 284	<p>Continued From page 7</p> <p>Service</p> <p>(e) Therapeutic Diets in Family Care Homes:</p> <p>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure a therapeutic diet (1600 ADA) was served as ordered for 1 of 3 residents (Resident #2) sampled.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 03/16/2016 revealed: -Diagnoses included insulin dependent diabetes mellitus, dementia, and peripheral artery disease. -A physicians order for a 1600 ADA diet.</p> <p>Interview with the Administrator on 09/28/2016 at 10:50am revealed: -All residents at the facility were on a regular diet, including Resident #2. -Resident #2 was an insulin dependent diabetic. -Resident #2's finger stick blood sugar was checked every morning.</p> <p>Observation of the lunch meal served on 09/28/2016 at 12:40pm revealed: -The resident was served 3 serving spoonful (approximately 1 cup) of a corn and butterbean mix, 1 heaping serving spoonful (approximately 1 cup) of spaghetti and meat sauce, 1 slice of bread, ¼ square of cranberry sauce, 8 ounce cup of water, 12 ounce cup of tea, and 2 butter cookies. -Resident #2 was served the same foods and portion sizes as the other 4 residents who ate at the table with her.</p>	C 284		

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C 284	<p>Continued From page 8</p> <ul style="list-style-type: none"> -The resident fed herself. -The resident ate 100% of the food served. -The resident drank 100% of the water and tea. <p>Interview with the Administrator on 09/28/2016 at 12:40pm revealed:</p> <ul style="list-style-type: none"> -The tea served to Resident #2 was sweet tea. -The facility used "regular sugar, we do sweet tea". <p>Review of the 1600 calorie (cal)ADA diet posted on the left side of the refrigerator on 09/28/2016 revealed:</p> <ul style="list-style-type: none"> -There was no menu for the lunch meal served to Resident #2 on 09/28/2016. -On days when cookies were served, the menu indicated saltine type crackers, fat free cookies, or animal crackers. -The 1600 cal ADA diet menu posted indicated fresh fruits such as ½ banana, pears, oranges, 1 ¼ cubed watermelon, canned fruits packed in own juice, were to be served. -The 1600 cal ADA diet menu posted indicated non-caloric beverages were to be served. <p>Interview with Resident #2 on 09/29/2016 at 9:30am revealed:</p> <ul style="list-style-type: none"> -The Administrator cooked meals and was a good cook. -The resident got enough to eat. -The resident ate what was served to her. <p>Interview with the Administrator on 09/29/2016 at 2:55pm revealed:</p> <ul style="list-style-type: none"> -She had an old 1600 calorie ADA diet menu posted. -She did not go by the posted 1600 calorie ADA diet menu when Resident #2 was served the lunch meal on 09/28/2016. -She cut back on the portion size when Resident 	C 284		

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C 284	<p>Continued From page 9</p> <p>#2 was served.</p> <ul style="list-style-type: none"> -She had not posted a menu for a 1600 calorie ADA diet. -She had a 1500 calorie ADA diet menu, but no current 1600 calorie ADA diet menu. -She judged the serving size for Resident #2 on 09/28/2016 from memory. -She normally gave portion sizes to all residents according to an 1800 calorie diet menu. -She gave Resident #2 sweet tea to drink at the lunch meal on 09/28/2016 instead of a sugar free drink. -She gave Resident #2 butter cookies for dessert at the lunch meal on 09/28/2016 instead of a sugar free dessert. <p>Review of an 1800 calorie diabetic diet menu presented by the Administrator on 09/29/2016 revealed sugar free beverages, sugar free fruits, and fresh fruits were to be served.</p> <p>Review of the finger stick blood glucose flow sheet for Resident #2 revealed the resident's finger stick blood sugar result was 120 on 09/29/2016 at 8:00am.</p> <p>A new FL-2 for Resident #2 was received on 09/30/2016 with a diet order of Regular.</p>	C 284		
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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p>	C 330		

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C 330	<p>Continued From page 10</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 3 residents (Resident #3) sampled with orders for medications used to prevent blood clot formation, treat high blood pressure, Parkinson's disease, pain, and a dietary supplement.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 02/29/2016 revealed: -Diagnoses included dementia, benign hypertension, hyperlipidemia, muscle weakness, and vitamin B12 deficiency. -Medication orders on the 02/29/2016 FL-2 included Carbidopa-Levodopa (used to treat Parkinson's Disease) 25/100 tablet daily, and Norvasc (used to treat high blood pressure) 2.5mg tablet daily. -There were no physician orders on the FL-2 for Aspirin (used as a blood thinner), Meloxicam (used to treat pain), and Melatonin (a dietary supplement).</p> <p>A. Review of physician's orders for Resident #2 revealed there was a physician's order dated 09/16/2016 for Aspirin (ASA)81mg tablet every day.</p> <p>Review of the September 2016 Medication Administration Records (MARs) for Resident #2 revealed:</p>	C 330		

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C 330	<p>Continued From page 11</p> <ul style="list-style-type: none"> -There was no transcription to the MAR for ASA (used as a blood thinner) 81mg tablet every day. -There was no documentation for administration of ASA 81mg tablet every day from 09/16/2016 through 09/28/2016. <p>Observation of the medication on hand on 09/29/2016 revealed there was no ASA 81mg on hand for Resident #2.</p> <p>Interview with the Administrator on 09/29/2016 at 10:20am revealed:</p> <ul style="list-style-type: none"> -Resident #2 had not been getting the ASA 81mg tablet administered as ordered. -She was aware of the low dose ASA order. -The PCP had provided her a copy of the order for the low dose ASA 81mg everyday on 09/16/2016. -Resident #2 was admitted to the facility with low dose ASA, but the physician attending the resident at that time never gave an order for the ASA. -She had not contacted the pharmacy about the new medication order. -She contacted the pharmacy on 09/27/2016 to inquire about when the batch medications would be delivered, but not about Resident #2's new medications. <p>Interview with the Provider Pharmacy Representative on 09/29/2016 at 2:15pm revealed:</p> <ul style="list-style-type: none"> -There was no order for ASA 81mg tablet every day in the pharmacy profile for Resident #2. -The pharmacy provider had never dispensed ASA 81mg tablets to the facility for Resident #2. -The pharmacy had delivered medication to the facility on 09/29/2016, but ASA 81mg would not be in the pharmacy medication tote. 	C 330		

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C 330	<p>Continued From page 12</p> <p>Interview with the Primary Care Provider (PCP) on 09/29/2016 at 3:30pm revealed: -She was concerned that Resident #2 had not been administered the ASA. -Resident #2 had a previous hospital visit for symptoms of a stroke. -Resident #2 was at high risk for having another stroke. -Administration of the ASA daily was used as protection against having another stroke.</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 10:20am.</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 12:00pm.</p> <p>Refer to the interview with the Provider Pharmacy Representative dated 09/29/2016 at 2:00pm.</p> <p>B. Review of physician's orders for Resident #2 revealed: -On 02/29/2016, there was a physician's order for Carbidopa-Levodopa (used to treat Parkinson's disease) 25/100mg tablet daily. -On 08/09/2016, there was a physician's order to discontinue Carbidopa-Levodopa. -On 09/16/2016, there was a physician's order Carbidopa-Levodopa 25/100mg capsule three times a day.</p> <p>Review of the August 2016 Medication Administration Records (MARs) for Resident #2 revealed: -There was documentation of administration for Carbidopa-Levodopa 25/100mg capsule daily at 8:00pm from 08/01/2016 to 08/09/2016. -There was a handwritten notation on the MAR for "D/C 8/9/16".</p>	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2016
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NAME OF PROVIDER OR SUPPLIER A GOOD LIFE FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4013 TRYON ROAD RALEIGH, NC 27606
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C 330	<p>Continued From page 13</p> <p>Review of the September 2016 Medication Administration Records (MARs) for Resident #2 revealed:</p> <ul style="list-style-type: none"> -There were printed instructions on the MAR for Carbidopa-Levodopa 25/100mg take one tablet once daily at bedtime. -There was no documentation of administration for the Carbidopa-Levodopa 25/100mg tablet daily on the September 2016 MAR. -There was no transcription to the MAR for Carbidopa-Levodopa 25/100mg take one tablet three times a day. -There was no documentation of administration for Carbidopa-Levodopa 25/100mg tablet three times a day from 09/16/2016 through 09/28/2016. <p>Observation of the medication on hand for Resident #2 on 09/29/2016 revealed:</p> <ul style="list-style-type: none"> -There was a pharmacy labeled blister package for Carbidopa-Levodopa 25/100mg tablet take one tablet daily at bedtime, quantity of 30, dispensed on 08/31/2016 on hand for Resident #2. -There were 30 tablets of the Carbidopa-Levodopa 25/100mg tablets on hand. <p>Interview with the Administrator on 09/29/2016 at 10:20am revealed:</p> <ul style="list-style-type: none"> -She had not administered the Carbidopa-Levodopa 25/100mg capsule to Resident #2 as ordered because the medication had not been delivered to the facility according to the current instructions. -The Carbidopa-Levodopa 25/100mg one tablet daily had been discontinued on 08/09/2016. -She had taken the Carbidopa-Levodopa out of the medication storage area and was getting ready to send the medication back to the pharmacy because it had been discontinued. 	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2016
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C 330	<p>Continued From page 14</p> <p>-She had not administered the Carbidopa-Levodopa 25/100mg tablet three times a day from the medication on hand because she had decided to send the medication back to the pharmacy even though it was the same strength but different instructions.</p> <p>-She had not contacted the pharmacy about the new medication order.</p> <p>-She contacted the pharmacy on 09/27/2016 to inquire about when the batch medications would be delivered, but not about Resident #2 ' s new medications.</p> <p>Interview with the Provider Pharmacy Representative on 09/29/2016 at 2:15pm revealed:</p> <p>-The current order in the pharmacy profile for the Carbidopa-Levodopa was for 25/100mg tablet daily.</p> <p>-At one point, Resident #2 was prescribed the Carbidopa-Levodopa 25/100mg three times a day, but that order was written 07/06/2015 and changed to once daily in December 2015.</p> <p>-There was no order in the pharmacy profile increasing the Carbidopa-Levodopa 25/100mg back to three times a day.</p> <p>-The pharmacy did not have a copy of the physician's order dated 09/16/2016 for Carbidopa-Levodopa 25/100mg three times daily.</p> <p>Interview with the Primary Care Provider (PCP) on 09/29/2016 at 3:30pm revealed:</p> <p>-She was concerned that Resident #2 had not been administered the Carbidopa-Levodopa as ordered.</p> <p>-Resident #2 could have some "postural instability" making it difficult to move, transfer, and get comfortable in bed as a result of the medication not being administered as ordered.</p>	C 330		

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C 330	<p>Continued From page 15</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 10:20am.</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 12:00pm.</p> <p>Refer to the interview with the Provider Pharmacy Representative dated 09/29/2016 at 2:00pm.</p> <p>C. Review of physician's orders for Resident #2 revealed there was a physician's order dated 09/16/2016 for Meloxicam (used to treat pain) 15mg tablet every day.</p> <p>Review of the September 2016 Medication Administration Records (MARs) for Resident #2 revealed: -There was no transcription to the MAR for Meloxicam 15mg tablet every day. -There was no documentation for administration of Meloxicam 15mg tablet every day from 09/16/2016 through 09/28/2016.</p> <p>Observation of the medication on hand on 09/29/2016 revealed there was no Meloxicam 15mg on hand for Resident #2.</p> <p>Interview with the Administrator on 09/29/2016 at 10:20am revealed: -Resident #2 had not been getting the Meloxicam 15mg tablet administered as ordered. -She was aware of the physician's order for the Meloxicam. -The PCP had provided her a copy of the order for the Meloxicam 15mg everyday on 09/16/2016. -She had not contacted the pharmacy about the new medication order. -She contacted the pharmacy on 09/27/2016 to inquire about when the batch medications would be delivered, but not about Resident #2's new</p>	C 330		

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C 330	<p>Continued From page 16</p> <p>medications.</p> <p>Interview with the Provider Pharmacy Representative on 09/29/2016 at 2:15pm revealed:</p> <ul style="list-style-type: none"> -There was no order for Meloxicam 15mg tablet every day in the pharmacy profile for Resident #2. -The pharmacy provider had never dispensed Meloxicam tablets to the facility for Resident #2. -The pharmacy had delivered medication to the facility on 09/29/2016, but Meloxicam 15mg would not be in the pharmacy medication tote. -The pharmacy did not have a copy of the physician's order dated 09/16/2016 for Meloxicam 15mg tablet daily. <p>Interview with the Primary Care Provider (PCP) on 09/29/2016 at 3:30pm revealed:</p> <ul style="list-style-type: none"> -She was concerned that Resident #2 had not been administered the Meloxicam as ordered. -She was concerned that she was writing orders for the resident and no one was following up on the orders. -Resident #2 had significant osteoarthritis and can't really use her hands and knees. -The Meloxicam was ordered specifically for the osteoarthritis. -It was important for Resident #2 to have the Meloxicam. <p>Refer to the interview with the Administrator dated 09/29/2016 at 10:20am.</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 12:00pm.</p> <p>Refer to the interview with the Provider Pharmacy Representative dated 09/29/2016 at 2:00pm.</p> <p>D. Review of physician's orders for Resident #2</p>	C 330		

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C 330	<p>Continued From page 17</p> <p>revealed:</p> <ul style="list-style-type: none"> -On 02/29/2016, there was a physician's order for Norvasc (used to treat high blood pressure) 2.5mg tablet daily. -On 09/16/2016, there was a physician's order to discontinue Norvasc 2.5mg daily. -On 09/20/2016, there was a physician's order to continue Norvasc. -There was no frequency or dose given on the 02/29/2016 physician's order. <p>Review of the September 2016 Medication Administration Records (MARs) for Resident #2 revealed:</p> <ul style="list-style-type: none"> -Amlodipine Besylate 2.5mg take one tablet by mouth once daily in the morning was printed on the MAR (Amlodipine Besylate is the generic name for Norvasc) and scheduled for 9:00am. -There was documentation for administration of Norvasc 2.5mg daily from 09/01/2016 through 09/28/2016. <p>Observation of the medication on hand on 09/29/2016 revealed there was a blister pack labeled for Norvasc 2.5mg tablet one tablet once daily in the morning dispensed to the facility on 08/31/2016 with a quantity of 30. There were 9 tablets remaining in the pharmacy labeled blister pack of Norvasc.</p> <p>Interview with the Administrator on 09/29/2016 at 10:20am revealed:</p> <ul style="list-style-type: none"> -The physician for Resident #2 was responsible to send information/orders to the provider pharmacy because Resident #2 did not attend the doctor that worked with the facility provider pharmacy. -The facility did not have a role in ensuring medication orders were sent to the pharmacy. -The facility had not faxed any orders to the 	C 330		

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C 330	<p>Continued From page 18</p> <p>pharmacy for Resident #2.</p> <p>-The facility had received prescriptions from family members for copies.</p> <p>-If the Administrator received a hard copy of a prescription for Resident #2, the Administrator would give the prescription to the pharmacy provider when the provider delivered medications to the facility.</p> <p>-Resident #2 was always transported to physician appointments by a family member until the resident started seeing a Primary Care Provider who started providing care to the resident at the facility in August 2016.</p> <p>Observation of the Administrator on 09/29/2016 at 12:10pm revealed the Administrator checked Resident #2's blood pressure in the left arm with a digital blood pressure cuff. Resident #2's blood reading was 160/75.</p> <p>Interview with the Provider Pharmacy Representative on 09/29/2016 at 2:15pm revealed:</p> <p>-The current order for Norvasc was for 2.5mg tablet one every morning.</p> <p>-There had not been any changes to the Norvasc order that the pharmacy was aware of.</p> <p>-The last prescription order was dated 05/31/2016 for the Norvasc 2.5mg tablet daily.</p> <p>Interview with the Primary Care Provider (PCP) on 09/29/2016 at 3:30pm revealed:</p> <p>-The Norvasc was discontinued because Resident #2's blood pressure was low and continued to be low.</p> <p>-The PCP needed to correct the visit note for 09/20/2016 when the order was to continue the Norvasc.</p> <p>-The resident was not harmed by having gotten the Norvasc after it had been discontinued.</p>	C 330		

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C 330	<p>Continued From page 19</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 10:20am.</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 12:00pm.</p> <p>Refer to the interview with the Provider Pharmacy Representative dated 09/29/2016 at 2:00pm.</p> <p>E. Review of physician's orders for Resident #2 revealed there was no order in the residents' record for administration of Melatonin (a dietary supplement) 5mg as needed or routinely.</p> <p>Review of the August 2016 Medication Administration Records (MARs) for Resident #2 revealed: -Melatonin 5mg take one tablet once daily at bedtime as needed was printed to the MAR. -There was documentation of administration for Melatonin 5mg tablet at bedtime every night from 08/01/2016 to 08/31/2016. -There was no documentation on the MAR indicating the need for the Melatonin or evaluating the effectiveness of the medication.</p> <p>Review of the September 2016 Medication Administration Records (MARs) for Resident #2 revealed: -Melatonin 5mg take one tablet once daily at bedtime as needed was printed to the MAR. -There was documentation of administration for Melatonin 5mg tablet at bedtime every night from 08/01/2016 to 08/31/2016. -There was no documentation on the MAR indicating the need for the Melatonin or evaluating the effectiveness of the medication.</p> <p>Review of physician's orders for Resident #2</p>	C 330		

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C 330	<p>Continued From page 20</p> <p>revealed there was no order for Melatonin 5mg tablet to be administered.</p> <p>Observation of the medication on hand for Resident #2 on 09/29/2016 revealed:</p> <ul style="list-style-type: none"> -There was an opened over the counter bottle of Melatonin 5mg on hand. -There was no name on the bottle of Melatonin indicating who the medication was for. <p>Interview with the Administrator on 09/29/2016 at 12:20pm revealed:</p> <ul style="list-style-type: none"> -She did not have a physician's order to administer the Melatonin to Resident #2. -The instructions for Melatonin "came through on the MARs". -Resident #2's family member bought the Melatonin over the counter. -Resident #2 used to get the Melatonin back in the latter part of 2015. -She had never gotten a written order for the Melatonin. -The family member had informed her that Resident #2's previous physician had agreed the resident could use Melatonin at night to help the resident sleep. -She had not followed up with the PCP to get a written order for the Melatonin. <p>Interview with the Provider Pharmacy Representative on 09/29/2016 at 2:15pm revealed:</p> <ul style="list-style-type: none"> -There was an order in the pharmacy profile for Melatonin 5mg at bedtime as needed. -The original order for the Melatonin for Resident #2 was dated 09/29/2015. -The pharmacy records did not show there had been a change in the Melatonin order or if the Melatonin had been discontinued. 	C 330		

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C 330	<p>Continued From page 21</p> <p>Interview with the Primary Care Provider (PCP) on 09/29/2016 at 3:30pm revealed: -She did not remember giving an order for Melatonin 5mg. -It did not matter if the Melatonin was administered as needed or routinely. -The Melatonin was mostly taken every day. -She would provide an order to the facility for Resident #2 to have the Melatonin 5mg administered.</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 10:20am.</p> <p>Refer to the interview with the Administrator dated 09/29/2016 at 12:00pm.</p> <p>Refer to the interview with the Provider Pharmacy Representative dated 09/29/2016 at 2:00pm.</p> <p>_____ Interview with the Administrator on 09/29/2016 at 10:20am revealed: -The physician for Resident #2 was responsible to send information/orders to the provider pharmacy because Resident #2 did not attend the doctor that worked with the facility provider pharmacy. -The facility did not have a role in ensuring medication orders were sent to the pharmacy for Resident #2. -The facility had not faxed any orders to the pharmacy for Resident #2. -The facility had received prescriptions from family members for copies. -If the Administrator received a hard copy of a prescription for Resident #2, the Administrator would give the prescription to the pharmacy provider when the provider delivered medications to the facility.</p>	C 330		

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C 330	<p>Continued From page 22</p> <ul style="list-style-type: none"> -Resident #2 was always transported to physician appointments by a family member until the resident started seeing a Primary Care Provider who started providing care to the resident at the facility in August 2016. <p>A second interview with the Administrator on 09/29/2016 at 12:00pm.</p> <ul style="list-style-type: none"> -She was responsible to transcribe new orders to the MARs. -Sometimes the pharmacy would print a new MAR in the middle of the month. -If she received medication order changes over the telephone, she would make those changes to the MARs. -She made changes to the MARs when she was aware of the changes. <p>Interview with the Provider Pharmacy Representative on 09/29/2016 at 2:00pm revealed:</p> <ul style="list-style-type: none"> -The pharmacy was responsible to provide resident medications, print facility MARs, LHPS services, pharmacy reviews, and classes as needed. -The Administrator was supposed to notify the pharmacy of new orders and get a copy of the new order to the pharmacy. -The pharmacy had to visibly see an order before providing the medication to the facility. -Orders were not always sent to the pharmacy from the doctor. -Unless an order was E-scribed or faxed to the pharmacy, the pharmacy would not know about the order. -The facility usually notified the pharmacy of change orders within a few days of physician visits so the MARs could be corrected. -The facility was responsible to notate medication changes on the current MAR when an order is 	C 330		

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C 330	<p>Continued From page 23</p> <p>received, and then give the order to the pharmacy for corrections to the MARs.</p> <ul style="list-style-type: none"> -The pharmacy would print new MARs in the middle of the month if the facility made a request. -she could not recall if new MARs had been printed in the middle of the month for this facility. -New medications were delivered to the facility with 24 - 48 hours. -The pharmacy was supposed to get copies of new FL-2's for the residents. -If there were new FL-2's for the facility resident 's, the pharmacy did not have those. -The pharmacy got FL-2's when the pharmacy began to service the facility, which was about 05/26/2015 when the first cycle fill was provided. <p>Observation of Resident #2 on 09/28/2016 at 1:10pm revealed:</p> <ul style="list-style-type: none"> -The resident was lying in bed on her right side. -The Administrator assisted the resident to a sitting position. -The resident maintained herself in an upright position with the assistance of three pillows at her back. -The Administrator assisted the resident with eating the lunch meal by placing the food on the spoon and handing the spoon to the resident. <p>Following record review and observation of Resident #2 on 09/28/2016 and 09/29/2016, she was determined not to be interviewable.</p> <p>_____</p> <p>Review of the Plan of Protection submitted by the facility on 09/29/2016 revealed the following:</p> <ul style="list-style-type: none"> -The Administrator will ensure that orders for all residents will be ordered and discontinued according to doctor orders only. -The Administrator will ensure that meds are on hand in the facility at a reasonable time by (2 	C 330		
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C 330	<p>Continued From page 24</p> <p>days) by doing a follow up call with the doctor and/or pharmacy (3 days) to find out the status of the medication ordered.</p> <p>-The staff administering medication will ensure that the MARs are accurate and up to date upon receiving any new or changed medication orders.</p> <p>-The Administrator will review MARs, doctor orders, and FL-2's on a daily basis beginning immediately to ensure that all records are accurate and administration of all meds are correct.</p> <p>-The Administrator will ensure that the task has been completed by doing weekly reviews and signing appropriately.</p> <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2016.</p>	C 330		
C 912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with 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 assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration.</p> <p>The findings are:</p>	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2016
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NAME OF PROVIDER OR SUPPLIER A GOOD LIFE FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4013 TRYON ROAD RALEIGH, NC 27606
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C 912	Continued From page 25 Based on observations, interviews, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 3 residents (Resident #3) sampled with orders for medications used to prevent blood clot formation, treat high blood pressure, Parkinson ' s disease, pain, and a dietary supplement. . [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 912		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a	C 932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2016
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C 932	<p>Continued From page 26</p> <p>significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.</p> <p>f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.</p> <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.</p> <p>This Rule is not met as evidenced by: Based on review of staff personnel files, and interview, the facility failed to assure 1 of 2 staff (Administrator) sampled completed the state annual infection control training program.</p> <p>The findings are:</p> <p>Review of the Administrator/Medication Aide personnel file revealed: -The Administrator passed the medication aide testing on 05/16/2003. -The Administrator completed a state annual infection control training on 06/10/2015. -There was no documentation of a current state annual infection control training.</p> <p>Interview with the Administrator on 09/28/2016 at from 10:45am to 10:50am revealed: -She performed fingerstick blood sugar testing for Resident #2 every morning. -She administered insulin to Resident #2 every</p>	C 932		
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C 932	<p>Continued From page 27</p> <p>night.</p> <p>-She performed fingerstick blood sugar testing for another resident once a week.</p> <p>Interview with the Administrator on 09/29/2016 at 1:20pm revealed:</p> <p>-She was responsible to schedule the annual infection control training.</p> <p>-She was aware the state approved infection control training was supposed to be completed every year.</p> <p>-She had not scheduled the annual infection control training for this year.</p> <p>-She thought she was okay with the annual infection control training since she had the training in 2015 and the calendar year had not ended for 2016.</p>	C 932		